Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-009

Report to the Legislature

As required by RCW 72.09.770

October 13, 2023

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
cheryl.strange@doc.wa.gov

Table of Contents

Unexpected Fatality Review Committee Report

UFR-23-009 Report to the Legislature–600-SR001

Legislative Directive and Governance

RCW 72.09.770 requires the Department of Corrections (DOC) to convene an unexpected fatality review (UFR) committee to review any case in which the death of an incarcerated individual was unexpected, or in any case identified by the Office of the Corrections Ombuds (OCO) for review.

The purpose of the unexpected fatality review is to develop recommendations for DOC and the legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for incarcerated individuals in DOC's custody.

This report describes the results of one such review and presents recommendations. Within ten days of the publication of this report, DOC must publish an associated corrective action plan. DOC will then have 120 days to implement that plan.

Disclosure of Protected Health Information

RCW 72.09.770 requires DOC to disclose protected health information - including mental health and sexually transmitted disease records - to UFR committee members. Under federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying information to state, federal, or local agencies in the course of conducting audits or evaluations mandated by statute or regulation.

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on September 11, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary
- Dr. Karie Rainer, Director of Mental Health
- Dr. Zainab Ghazal, Administrator
- Rae Simpson, Director – Quality Systems
- Patty Paterson, Director of Nursing
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Lorne Spooner, Correctional Operations Program Manager

DOC Risk Mitigation

- Mick Pettersen, Director

DOC Reentry Centers

- Susan Leavell, Senior Administrator

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Senior Corrections Ombuds – Policy
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Hannah Carmichael, Health Services Consultant 3, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Judy Zerzan, Medical Director

This report includes a summary of the unexpected fatality, committee discussion, findings, and recommendations.

Fatality Summary

Year of Birth: 1994 (29-years-old)

Date of Incarceration: February 2021

Date of Death: June 2023

At the time of his death, this incarcerated individual was housed in a mental health residential treatment unit. The cause of death was closed traumatic head injury causing anoxic brain injury. The manner of death was suicide.

Below is a brief timeline of events leading up to the incarcerated individual's death:

One day prior to death	Event
07:23 hours	• 3rd tier cell doors opened after tier check.
07:24 hours	• Incarcerated individual exits his cell, climbs railing, and dives to the floor. • Medical staff arrive and begin rendering aid.
07:28 hours	• Mental health and classification staff arrive on tier.
07:29 hours	• CPR initiated.
07:39 hours	• Community emergency medical services (EMS) arrive on unit and assume resuscitation efforts.
07:54 hours	• Community EMS transport the individual to the hospital.
Day of death	**Event**
07:49 hours	• Incarcerated Individual was pronounced deceased by hospital staff.

UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee and the DOC Critical Incident Review. The UFR Committee members considered the information from both reviews in formulating recommendations for corrective action.

A. The DOC Mortality Review Committee (MRC) reviewed the medical record, the care delivered and provided the following findings and recommendations:

1. The committee found:

a. The incarcerated individual to be a 29-year-old man housed in a mental health residential treatment unit carrying diagnoses of schizophrenia, schizoaffective disorder, psychosis, bipolar disorder, anxiety, and substance use disorder.

b. He had episodic, problem-focused primary care visits.

c. He took his own life by jumping from the upper tier in his living unit causing anoxic brain injury and multiple closed fractures of the thoracic and lumbar vertebrae.

d. Staff and EMS were able to return spontaneous circulation and he died the next morning at the hospital.

2. The committee noted that consuming too much coffee by those housed in a residential treatment unit may exacerbate their mental health symptoms and recommended exploring options to limit the amount of coffee purchased by residents.

3. The committee recommended making an annual primary care visit standard for each incarcerated individual in prison.

4. The committee recommended continuing to pursue an electronic health record (EHR) when legislative funding becomes available to facilitate team communication and automate notifications if an individual has not had a routine primary care visit in the last year.

5. Upon conclusion of this review, no corrective action items were identified. The committee noted that safety screens and barriers were already being installed on the second and third tiers of the mental health residential treatment units.

B. Independent of the mortality review, the DOC conducted a critical incident review (CIR) to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operational procedures. The CIR found:

1. The incarcerated individual was housed in a mental health residential treatment unit. Residential treatment is provided for individuals with significant mental disorders resulting in serious impairment in adaptive functioning and may include a safety risk for the individual and/or others.

2. The incarcerated individual received an intake mental health screening but was not prioritized for a mental health appraisal at the reception center. He received the appraisal four months after his transfer to the parent facility. He did receive a psychiatric assessment within three weeks of transferring to his parent facility. The delay in completing the formal mental health appraisal did not appear to impact his treatment.

3. Documentation and interviews reflect that he did not indicate he was experiencing suicidality during his time in the residential treatment unit.

4. Upon conclusion of this incident review, no corrective actions were identified except for safety screens/barriers being installed on the second and third tiers of the residential treatment units. At the time of the incident review, this infrastructure upgrade had already started.

5. Additional CIR recommendations did not directly correlate to the cause of death and will be remediated per DOC Policy 400.110 Reporting and Reviewing Critical Incidents.

C. The Department of Health (DOH) representative supported the recommendations and requested further discussion regarding electronic health records, safety barriers, and the

delay in receiving a mental health appraisal. DOH recommended that DOC investigate how other systems have limited coffee intake and still preserve an incarcerated individual's rights. The DOH representative provided kudos to the staff proving the emergency response.

Note: DOC discussed the delay in completing the mental health appraisal. The initial delay did not have a long-term impact on his care.

D. The Health Care Authority (HCA) Representative provided information on caffeine intake and mental illness. The HCA representative had no additional recommendations and appreciated the hard work happening to prevent these cases.

E. Office of the Corrections Ombuds (OCO) discussed their analysis of the case and submitted the following recommendations for UFR committee discussion:

1. The OCO continued the discussion regarding coffee intake. The OCO supports DOC's exploration of a "barista" program which could help to reduce caffeine intake. The OCO pointed to models including the one in operation at Clallam Bay Corrections Center pre-COVID and one observed in operation at a prison in Norway.
2. The OCO discussed the delayed mental health appraisal and asked whether the improved confidential space at the reception center is reducing system delays.

   Note: DOC indicated they are reviewing the intake process on a systems level and will address the factors that may be creating current delays. The incarcerated individual was admitted to DOC during the COVID pandemic which negatively impacted timeframes.
3. The OCO inquired into whether a timely mental health appraisal would have prevented the need for the incarcerated individual to request protective custody or be placed in a close observation area (COA).

   Note: DOC shared the possibility that the individual may not have chosen protective custody, but there is no way to assess if he would have been directly referred to residential treatment level housing from the initial appraisal. He may not have been exhibiting significant mental health symptoms at that time. Individuals are placed in the COA for safety regardless of where they are housed.

Committee Findings

The manner of the incarcerated individual's death was suicide. The cause of death was closed traumatic head injury causing anoxic brain injury.

Committee Recommendations

The UFR Committee did not offer any recommendations for corrective action.

Consultative remarks that do not directly correlate to cause of death, but should be considered for review by the Department of Corrections:

A. The UFR committee recommended exploring options to limit the amount of coffee purchased by residents of a residential treatment unit.

B. The committee recommended making an annual primary care visit standard for each incarcerated individual in prison.

C. The committee recommended continuing to pursue an electronic health record (EHR) when full legislative funding becomes available to automate notifications if an individual has not had a routine primary care visit in the last year.

D. The committee recommended DOC conduct an educational Morbidity & Mortality conference to educate staff.