Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-007

Report to the Legislature

As required by RCW 72.09.770

October 9, 2023

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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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. Federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying substance use 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 March 9, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Karie Rainer, Director-Mental Health
- Dr. Zainab Ghazal, Administrator
- Patty Peterson, Director of Nursing
- Rae Simpson, Director – Quality Systems
- Dawn Williams, Program Manager – Substance Abuse Recovery Unit
- Brooke Amyx, Reentry Administrator
- Mary Beth Flygare, Project Manager
- Deborah Roberts, Program Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Lorne Spooner, Correctional Operations Program Manager
- Jason Bennett, Superintendent Stafford Creek Corrections Center
- Don DeShazer, Correctional Unit Supervisor, Airway Heights Corrections Center

DOC Risk Mitigation

- Michael Pettersen, Director

DOC Reentry Centers

- Scott Russell, Deputy Assistant Secretary
- Susan Leavell, Senior Administrator

DOC Graduated Reentry – Community Corrections

- Kristine Skipworth, Regional Administrator – East
- Kelly Miller, Administrator
- Autumn Dell-Witten, 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: 2000 (23-years-old)

Date of Incarceration: February 2022

Date of Death: June 2023

The incarcerated individual was a 23-year-old man who had his first admission to prison in June 2022. He was housed in a mental health residential treatment unit. His cause of death was blunt force trauma to the head due to a fall. The manner of his death was suicide.

A brief timeline of events prior to the incarcerated individual's death:

Day of Death	Event
13:35 hours	• He exits his cell, ascends the tier stairs, climbs the railing, leans over, and falls to the floor.
13:36 hours	• Custody staff arrive and begin first aid to include CPR.
13:38 hours	• Medical staff arrive and began directing first aid efforts.
13:47 hours	• Fire Department Emergency Medical Services arrive and assume care.
13:52 hours	• He was pronounced deceased by Emergency Medical Services.

Committee Discussion

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

1. The individual arrived at the reception center taking suboxone for opioid use disorder and was tapered off per DOC protocol due to the length of his sentence.
2. He had episodic follow up with Primary Care.
3. The incarcerated individual was appropriately coded as seriously mentally ill and:
    a. He was in a highly structure residential treatment unit to closely monitor his status and encourage pro-treatment behaviors:
    b. He had a positive trusting relationship with his primary therapist;
    c. He had relatively few protective factors including lack of family support and few prosocial peers;
    d. He was housed without a cellmate;

e. He had a history of substance use including increased coffee intake;

f. He had minimal adherence to treatment recommendations; and

g. His symptoms did not rise to the level of requiring court ordered involuntary medication administration.

4. He took his own life by jumping from the upper tier in his living unit causing head injuries incompatible with life.

5. DOC Staff and community Emergency Medical Services (EMS) were unable to return spontaneous circulation and he was declared deceased at the scene.

6. The committee identified a missed opportunity for a relationship with the primary care team which could have acted as an additional supportive factor.

7. The committee supports health services working towards offering an annual primary care visit for each incarcerated individual.

8. The Mortality review committee did not identify any opportunities to prevent a similar death in the future.

B. Independent of the mortality review, 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 appropriately followed and supported by his mental health treatment team. It was noted that some mental health treatment plans, a suicide risk screening, and a mental health screening were not completed within policy timeframes. This did not appear to have an impact on his treatment or the outcome.

2. There were no safety barriers on the upper tiers of the residential treatment units. Safety barriers are being installed.

3. The 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 offered the following input and recommendations:

1. DOH asked if all incarcerated individuals are tapered off suboxone at the reception center.

Note: DOC shared that due to current funding capacity, individuals with a sentence longer than 6 months are tapered off medication assisted treatment for opioid use disorder. If the individual's sentence is shorter than 6 months, DOC continues providing the medication assisted treatment.

2. DOH recommends DOC explore options for monitoring coffee intake and the possibility of limiting caffeine intake while still supporting the incarcerated individual's decisional autonomy.

3. The DOH representative supported the recommendations discussed within the committee.

D. The Health Care Authority (HCA) representative noted that patients with persistent mental health conditions will use coffee intake to self-medicate to alleviate symptoms. HCA supports all proposed recommendations.

E. The Office of the Corrections Ombuds (OCO) discussed their analysis of the case, asked for additional information, and submitted the following for UFR committee discussion:

1. The OCO continued the conversation on coffee intake and asked if all the coffee available to purchase is instant coffee. The OCO encourages DOC to explore other options for providing coffee to residential treatment unit residents similar to the coffee program in the Norway Amend program.

   Note: DOC responded that currently, all coffee available through the DOC commissary is instant coffee.

2. OCO requests a discussion of the dynamics related to suicide risk factors when being housed alone without cellmates in the residential treatment unit.

   Note: DOC explained that historically, single person cells were thought to provide more privacy and a quieter environment which would assist incarcerated individuals with their mental health conditions. Additionally, some individuals have difficulty having a cellmate due to their behavioral issues and vulnerability. Currently, many of the cells are set up for single person housing. DOC acknowledges that being housed without a cell mate eliminates one possible protective factor for the incarcerated individual.

3. OCO inquired about DOC's determination of mental health coding of incarcerated individuals.

   Note: DOC explained that an individual's mental health code indicates their current level of functioning and their active mental health symptoms. Codes are intended to be fluid.

Committee Findings

The incarcerated individual died as a result of suicide. The cause of death was blunt force trauma to the head secondary to a fall.

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:

1. DOC should explore options for coffee access in residential treatment units.
2. DOC should continue to pursue an electronic health record as full legislative funding becomes available.
3. DOC should continue to pursue options for utilization of the 988-suicide prevention hotline.