Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-004

Report to the Legislature

As required by RCW 72.09.770

June 20, 2023

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

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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. 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 May 20, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary Health Services
- Dr. Karie Rainer, Director of Behavioral Health
- Rae Simpson, Quality Systems Director
- Danielle Moe, Chief Nursing Officer
- Paul Clark, Health Services Administrator
- Dr. Zainab Ghazal, Health Services Administrator
- Mary Beth Flygare, Program Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Eric Jackson, Deputy Assistant Secretary
- Melissa Andrewjeski, Superintendent
- Lorne Spooner, Correctional Operations Program Manager

DOC Risk Mitigation

- Michael Pettersen, Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Senior Corrections Ombuds – Policy

Department of Health (DOH)

- Brittany Tybo, Director – Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Sophie Miller, Medical Officer

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

Fatality Summary

Date of Birth: 1965 (57-years-old)

Date of Incarceration: December 2022

Date of Death: February 2023

The incarcerated individual had been involved with the criminal justice system since 1985. He had recently transferred to his home facility and had not yet been referred for any programming. He was appropriately screened per DOC policy upon prison admission and his mental health support needs were appropriately identified. He had a history of suicidal ideation and previous suicide attempts. His health record documented multiple emergency room visits in 2021 and 2022 for ingesting foreign bodies or acts of self-harm. His death was the result of asphyxia due to ligature strangulation. The manner of his death was suicide.

Below is a brief timeline of events leading up to his death.

Days Prior to Death	Event
5	• The incarcerated individual was transported to the community emergency room (ER) to be evaluated for chest pain. His work-up was unremarkable and he was discharged back to the facility with a diagnosis of stress and pain from his neck that radiated into his chest.
4	• He reported not feeling well after ingesting several foreign objects one week prior that he was not passing naturally. He was again transported to the community ER. It was noted that he had ingested: ○ 2 ea. AAA batteries ○ 2 ea. eyeglasses ○ 9 ea. toothbrushes • The community medical provider recommended continuing to allow the objects to pass naturally without a surgical intervention if possible. ○ He was discharged back to the facility and placed in the close observation area for safety monitoring. ○ Mental health clinician ordered a 15-minute safety watch to be conducted by custody staff which was supplemented by monitoring video feed from the cell.

	○ The conditions of confinement for the incarcerated individual allowed a suicide prevention smock, blanket, mattress, and a soft-covered book.
2	• He was transported to the community ER for an abdominal x-ray to see if the foreign bodies had passed. ○ The x-ray showed some of the items had not yet passed through his system. ○ The community emergency room staff cleared him to be transported back to the facility for continued safety monitoring.
0	• A psychologist conducted a cell-front assessment in the morning and relaxed his conditions of confinement based on a brief conversation with the incarcerated individual who indicated he was not suicidal. ○ After his shower, per the new CONDITIONS OF CONFINEMENT he was provided thermals (long underwear) and a t-shirt to wear. ○ The safety checks were decreased to every 30 minutes. • He appeared to be unresponsive during the custody tier check. • Custody officers entered the cell and found him not breathing with a ligature tied around his neck. • Resuscitation efforts were unsuccessful, and he was pronounced deceased by community Emergency Medical Services.

Committee Discussion

A. The DOC mortality review determined the following topics warranted further discussion and UFR committee consideration:

1. The incarcerated individual had a history of degenerative disc disease in his lower neck that occasionally caused pain to radiate into his chest and arms.

2. He had previously been diagnosed with opioid use disorder and treated with suboxone.

3. His mental health diagnoses included bipolar disorder, borderline personality disorder and antisocial personality disorder. His treatment plan included medication and supportive therapy.

4. He had a history of several self-harm events, expressed suicidal ideation, and reported suicide attempts that included:

    A. Drinking water to the point of water intoxication causing low sodium levels requiring medical treatment;

    B. Repeated episodes of ingesting foreign bodies requiring medical procedures for removal;

C. A left wrist laceration that required hospital treatment;

D. Overdose events and

E. A gunshot wound.

5. The day of his death, the conversations between the incarcerated individual and medical/mental health staff occurred through his closed cell door. Not utilizing a confidential space may have hindered him from communicating his level of mental distress.

6. There was a lack of communication between medical, mental health and custody staff regarding the rationale and safety needs for his placement in the close observation area.

7. The psychological autopsy found:

   A. The incarcerated individual died a middle-aged man whose personality and mood problems, combined with sub-optimal compliance with treatment, kept him cycling back and forth between an itinerant lifestyle of thrill-seeking, drug dependent homelessness and the structure and familiarity of incarceration.

   B. He was readmitted to prison in December 2022 after his Drug Offender Sentencing Alternative was revoked due to non-compliance. He had an Earned Release Date in March of 2024.

   C. He had a long history of mental health concerns. The most concerning being his frequent self-harm behaviors often resulting in emergency medical trips to the community and close observation area placements.

   D. During the 62 days of his final incarceration, he was placed in the close observation area twice and had three medical trips in the community.

   E. The drivers for these self-harm behaviors tended to fall into three main categories:
      i. To regulate emotions and relieve boredom;
      ii. To affect housing and prison placement and
      iii. To "get back" at staff who he felt disrespected him.

   F. He frequently expressed suicidal ideation, but it is uncertain whether they reflected a genuine desire to end his life or were a component of his borderline and antisocial personality.

   G. He had several risk factors for suicide both static and dynamic including:

      i. A history of serious and persistent mental illness with few protective factors;
      ii. Impulsive behaviors;

iii. Poor coping skills;
iv. Limited frustration tolerance;
v. Enduring substance abuse;
vi. Early childhood trauma;
vii. Chronic physical pain;
viii. A lengthy history of suicidal statements and serious self-harm events;
ix. Feelings of helplessness and hopelessness;
x. Depressive symptoms;
xi. Agitation;
xii. Anxiety; and
xiii. Recent substance abuse.

H. He was designated as needing mental health services during this prison admission. After transferring to his home facility, he was unable to meet with his primary therapist due to being sent out to the community emergency room after swallowing foreign objects almost as soon as he arrived. Upon his return to the facility, he was placed in the close observation area for his safety.

I. Due to the short length of time he spent in close observation, starting Friday afternoon during a holiday weekend, he was unable to develop a therapeutic relationship with the mental health team. He died the following Monday.

J. Even though he was placed on a safety watch for self-harm and potential suicidal concerns, a formal suicide risk assessment was not conducted. As a result, the determination of his level of suicidal intent is based on his history, the known stressors in his life, and his pattern of communicating distress through suicidal statements, gestures, and non-suicidal self-injury.

K. Although accidental death cannot be definitively ruled out, the incarcerated individual's death was self-inflicted without any immediate influence on his actions by others. The available evidence supports the conclusion that his death appears to have been a suicide.

8. The mortality review committee members discussed the staff interviews from the critical incident review, which indicated that staff working in the close observation area may have become fatigued and desensitized to the environment.

B. Independent of the mortality review, the DOC conducted a critical incident review to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operational procedures. The Unexpected Fatality Committee reviewed the findings and recommendations of the critical incident review and have considered this information in formulating

the recommendations for corrective action.

C. The Health Care Authority (HCA) representative discussed multiple points where the safety system failed, and they agreed that staff may have become desensitized to the close observation area environment.

D. The Department of Health (DOH) representative confirmed that incarcerated individuals have mental health professionals available on-site during regular business hours, and medical staff on-site 24/7 if they need assistance. There is also a mental health professional on-call and available via phone during non-business hours for consultation and assistance. DOH offered resources for DOC to further support staff who are experiencing symptoms of burnout and compassion fatigue.

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

1. The OCO asked why the incarcerated individual was placed in the close observation area if no suicide risk assessment was performed?

    a) He was released from the community emergency room late in the day. Due to his recent ingestion and retention of foreign material it was determined the safest environment would be the close observation area until a suicide risk assessment could be done. He was not placed in the close observation area to monitor if he passed the material but to protect him from ingesting more. It was also easier to monitor if he was becoming distressed from an ingested object.

2. The OCO asked how often mental health staff take incarcerated individuals to a private area for discussions while they are housed in the close observation area?

    a) During regular business hours incarcerated individuals are taken to an interview room for assessments and mental health appointments.

    b) The mental health team conducts rounds (a brief wellness check) on weekends and holidays. They do not have staffing to support conducting assessments after hours.

3. The OCO asked if mental health staff can change the conditions of confinement over the phone?

    a) The mental health duty officer can change the conditions of confinement over the phone. Usually, the conditions of confinement are increased due to level of risk or behaviors being demonstrated, not decreased unless there is a pre-set plan in place that was previously agreed upon with the primary therapist and the incarcerated individual.

4. The OCO asked if would be too great of a resource drain to make a process that modifying conditions of confinement would only happen after an in-person assessment and meeting with a

senior custody staff member to discuss changes?

a) There is a multidisciplinary team meeting that happens during regular working hours and shared through shift reports that include the conditions of confinement and a support plan for moving forward. DOC mental health leadership will review and formalize this process.

5. The OCO asked what are the requirements to be a custody officer in the close observation area?

   a) The officer must meet the requirements of the bid criteria to obtain a permanent position. When there is a staff shortage and overtime is required, there is the possibility that the assigned officer may never have worked in that area.

6. The OCO recommends DOC explore the possibility of not utilizing overtime in the close observation area environment and reducing the number of cells that appear on the supplemental video feed being monitored.

   a) Custody posts and duties of the close observation area are covered by a collective bargaining agreement. Any changes related to utilization of overtime and post duties would require labor negotiations.

7. The OCO recommends changing the post order language from tier check to health and wellness check in a close observation area environment.

Committee Findings

1. The incarcerated individual was placed in the close observation area after regular business hours on a holiday weekend when mental health staff were not present. Nursing staff did not conduct a suicide risk assessment per DOC protocol.

2. There was a lack of communication between medical, mental health and custody staff regarding the rationale and safety needs for his placement in the close observation area.

3. The conditions of confinement were decreased without a suicide risk assessment being conducted and the conversation between the mental health staff member and the incarcerated individual did not occur in a confidential manner.

4. DOC does not have an electronic health record and the psychologist who relaxed the conditions of confinement did not have the benefit of having the incarcerated individual's mental health history readily available.

5. The close observation area post orders were not consistently followed by custody staff when conducting tier checks, searching the incarcerated individual's cell, and monitoring the supplemental video.

6. DOC Policy 890.620 Emergency Medical Treatment was not followed during the medical emergency response. A nurse did not immediately respond to the location, and the emergency response kit was not fully stocked.

7. The UFR Committee members raised concerns that staff in COA may be at increased risk for desensitization and fatigue due to the repetitive nature of the duties they are required to perform. Appropriate countermeasures to support staff are warranted.

Committee Recommendations

Table 1 presents the UFR Committee's recommendations to prevent similar fatalities and further strengthen safety and health protections for incarcerated individuals. As required, the DOC will develop, publish, and implement an associated corrective action plan within 10 days following the publishing of this report.

Table 1. ***UFR Committee Recommendations***
1. Conduct a statewide survey of staff who work in or with incarcerated individuals housed in the close observation area (i.e., medical providers, religious coordinators, custody officers, classification counselors, hearings officers, nurses, mental health staff) to identify opportunities to increase staff engagement and promote safety for the incarcerated individuals in their care.
2. Review and recommend updates to the suicide prevention policy and associated forms at the next scheduled mental health leadership meeting.
3. Tier checks should be completed in accordance with post orders and align with the conditions of confinement.
4. Recommend changing the language in the post orders from a tier check to a "health and wellness" check and provide additional training.
5. DOC should resume annual in-person suicide prevention training.
6. DOC should require medical emergency response drills with medical and custody staff.
7. Formalize and standardize onboarding and ensure mental health staff are trained related to conducting close observation area assessments in a confidential manner, and how to utilize and implement conditions of confinement.

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 continue the implementation of the Patient Centered Medical Home care model at their facilities.