



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-010 Report to the Legislature

As required by RCW 72.09.770

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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. Under federal law, substance use information was not disclosed unless the next of kin authorized release.

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on June 9, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Karie Rainer, Director of Mental Health
- Dr. Zainab Ghazal, Administrator - Command A
- David Flynn, Assistant Secretary
- Ken Taylor, Deputy Director Health Services
- Rae Simpson, Director of Nursing Services
- Dawn Williams, Program Manager – Substance Abuse Recovery Unit
- Brooke Amyx, Psychiatric Social Worker 4

DOC Office of Correctional Operations

- Tom Fithian – Senior Director – Correctional Operations

DOC Prisons Division

- Jeffrey Uttecht – Deputy Assistant Secretary of Prisons

DOC Reentry Division

- Susan Leavell, Senior Administrator
- Dave Ganas, Reentry Center Administrator

DOC Risk Management

- Michael Pettersen, Risk Mitigation Director

Office of the Correction Ombuds (OCO)

- Caitlin Robertson, Director

Department of Health (DOH)

- Tyler McCoy, Health Services Consultant, Healthy and Safe Communities

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

Fatality Summary

Date of Birth: 1959 (62 years old)

Date of Incarceration: June 2001

Date of Death: March 2022

This 62-year-old individual was incarcerated for over twenty years. The incarcerated individual lived in a facility infirmary for Americans with Disabilities (ADA) needs until 2019, then was transferred to a close custody housing unit where his ADA needs were able to be met. At the time of his death, he was housed in the east side of a close custody Covid-19 quarantine unit per DOC COVID-19 Infection Control Guidelines. The Walla Walla coroner ruled this death as a homicide. The law enforcement investigation into this incident is on-going.

Prior to his incarceration, the individual was injured causing paraplegia which impacted his health. While incarcerated, he declined aspects of medical care including vaccination, colonoscopy, and self-catheterization management. In 2019 and 2020 he also declined evaluation for anemia and medical supplies for self-care of his bladder condition. He declined vaccinations when offered. Most recently in 2021, he declined COVID-19 and influenza vaccines. His last visit with a primary care provider occurred in March of 2020.

On the date of his death, at approximately 13:05 an incarcerated individual activated the emergency call button in his cell and informed the Correctional Officer (CO) in the east side control booth to come and check the showers because there appeared to be blood on the dayroom floor coming out of the shower room. The booth CO was unable to visualize the shower in question from his location. He radioed the unit COs from the west side and requested an immediate inspection. Upon entering the shower, they discovered a critically injured incarcerated individual. He was unresponsive and bleeding. The CO made a radio call for a medical emergency to facility staff and included a request to call 911 to summon community emergency services. When facility nursing staff arrived on scene, they determined the injured incarcerated individual had sustained fatal injuries. The community emergency services crew arrived onsite at approximately 13:15 and contacted the community emergency room physician who pronounced the death of the injured incarcerated individual.

Corrections staff established a crime scene per DOC protocol. COs identified and contained an incarcerated individual as a potential suspect in the assault. When community law enforcement arrived on scene, they were briefed and assumed responsibility for the criminal investigation. The Critical Incident Stress Management (CISM) team was deployed to the facility the day of the assault for staff support. Due to the incident occurring on a Sunday, mental health staff were deployed to the unit the following day to check on the well-being of the resident incarcerated individuals and to provide services for any individuals requesting support.

Committee Discussion

- A. The DOC mortality review determined the following topics warranted further discussion and UFR committee consideration:
1. This incarcerated individual did not receive follow-up medical care for his chronic medical conditions. Gaps were identified in the documentation regarding his declinations of medical care.
- 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 actual time documented for the initial emergency call was 13:05 compared to the time noted on the video surveillance system timestamp which was 13:16, which is an eleven-minute difference. The video also has periodic jumps in the recording, (i.e., a person suddenly appears in the video without first walking into view).
 2. Two correctional officers conducted the required tier check on the east side of the housing unit between 12:23 and 12:48. There did not appear to be any officers on the east side of the unit after the tier check was completed.
 3. The incarcerated individual, suspected of committing the assault, can be seen on video of the east side common area doing stretches, swinging his arms, wringing his hands, and pacing in a circle while maintaining a visual focus of the shower area. His behavior continued for 11 minutes before he is seen walking directly to the shower area occupied by the incarcerated individual who was assaulted.
 4. There is no documentation that the DOC Primary Therapist protocol was followed requiring submission of a completed mental health assessment or update to the Psychologist 4 by the primary mental health therapist prior to decreasing the S-code (mental health needs indicator) of the incarcerated individual who allegedly committed the assault.
 5. The DOC Shift Commander checklist forms completed for this incident were outdated versions.
- C. The Office of the Corrections Ombuds (OCO) discussed their analysis of the case and submitted the following recommendations for UFR committee discussion:
1. DOC should use this incident video in initial and annual staff trainings, as a clear example of observable behaviors that should be noticed during active and alert observation in an officer's "zone of control." Moreover, the observable bystander behavior displayed by numerous other incarcerated individuals in the dayroom provides a key learning opportunity for all staff, not only officers.
 2. The OCO received numerous requests for assistance from incarcerated individuals housed in the

east pod at the time of the incident. The primary request was for additional mental health services. The CIR noted that the DOC immediately deployed CISM for staff support; however, mental health staff rounds for incarcerated individuals were initiated the following day.

D. The Department of Health (DOH) representative did not offer additional recommendations.

Committee Findings

1. While in the custody of DOC this incarcerated individual died as the result of injuries sustained during an assault.
2. The east side housing unit does not have a staffed officers' station.
3. Prior to his death the incarcerated individual did not receive follow-up medical care for his chronic medical conditions. Gaps were identified in the documentation regarding his declinations of medical care.
4. Mental health staff did not follow the DOC Primary Therapist protocol when lowering the mental health needs code for the incarcerated individual suspected of committing the assault.
5. DOC staff did not recognize the behaviors being exhibited by the suspect prior to the incident as an indication that he was preparing to assault someone.
6. Due to the incident occurring on a Sunday, mental health staff were deployed to the unit the next day to check on the well-being of the incarcerated individuals residing on the unit to provide services for any individuals requesting support.
7. Prior to his death the incarcerated individual resided in a DOC facility infirmary from 2001 until he transitioned into a single-man cell, close custody living unit in 2019. During his annual classification review DOC staff supported a classification promotion to a medium custody housing unit. He requested to remain in his current housing unit for an additional year to continue adjusting to living outside of an infirmary setting. The DOC HQ classification committee continued his close custody classification status.

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. Maintain a security presence on the entire unit for direct monitoring and early detection of possible safety concerns.
2. During DOC initial and annual staff trainings, consider using the surveillance video of the time preceding this event as an example of observable behaviors that may indicate a need for staff intervention.

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

1. Develop and implement policy/protocol to ensure that documented follow-up occurs with incarcerated individuals when they have declined recommended care to help promote improved understanding of the rationale, alternative options that might be available, and risks associated with declining care.
2. Ensure DOC staff use the current version of the Shift Commander checklist forms.
3. Ensure all mental health staff follow the DOC Primary Therapist protocol prior to lowering a mental health needs code.
4. The DOC should modify the membership of all HQ classification committees to include equitable representation from the incarcerated individual’s current facility. Additionally, the DOC should update all HQ classification committee evaluation tools to better align with the agency’s stated goal of furthering pro-social improvements.
5. DOC should immediately initiate mental health rounds for the incarcerated individuals directly impacted by a traumatic event.