Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-001

Report to the Legislature

As required by RCW 72.09.770-

May 1, 2023

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

Table of Contents

Table of Contents 1
Legislative Directive and Governance 2
Disclosure of Protected Health Information 2
UFR Committee Members 3
Fatality Summary 4
Committee Discussion 5
Committee Findings 8
Committee Recommendations 8
Consultative Remarks: 8

Unexpected Fatality Review Committee Report

UFR-23-001 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 April 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
- Rae Simpson, Chief Quality Officer
- Danielle Moe, Chief Nursing Officer
- Paul Clark, Administrator
- Dr. Zane Ghazal, Administrator
- Dr. Karie Rainer, Behavioral Health Director
- Mary Beth Flygare, Program Manager
- Keith Parris, Health Services Manager

DOC Prisons Division

- Eric Jackson, Deputy Director
- Jeff Uttecht, 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: 1978 (44-years-old)

Date of Incarceration: September 2022

Date of Death: January 2023

The incarcerated individual was a 44-year-old man who had been involved with the criminal justice system since 1995. He had a long history of substance use with one six-month period of sobriety post substance abuse treatment. He was readmitted to prison in September 2022 for failure to register as a felony sex offender for the second time, with an anticipated release date in September 2045. He was classified as close custody and transferred to his parent facility approximately three weeks prior to his death. His cause of death was self-inflicted hanging. The manner of his death was suicide.

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

Days Prior to Death	Event

36	• He met with his classification counselor to review his initial facility custody plan.
	  ○ He reported no new medical or mental health issues.
	  ○ He stated his parent facility preference.
	  ○ He requested substance abuse treatment, education services and a job for programming.
	  ○ He was targeted to promote to medium custody in one year.

18	• He transferred to his parent facility and was assigned to a housing unit. Due to population levels in his unit and classification status, he was assigned a cell without a cell mate.

1 – 17	• He resided in his living unit without problem.
	  ○ He received no infractions and there were no behavior observations documented.
	  ○ He did not request to be seen by medical or mental health.

0	• He was found in his cell unresponsive with a bed sheet tied around his neck. • Resuscitation efforts were unsuccessful, and he was declared dead by community emergency medical services.

Committee Discussion

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

1. The incarcerated individual had a history of substance use disorder (methamphetamines), diabetes, high blood pressure, high cholesterol, and low thyroid.
2. During a previous incarceration he had been treated for latent tuberculosis infection (2020), and gunshot wounds to his chest, arm and leg that required a prolonged recovery (2021).
3. During his nursing intake screening exam, he was noted to be on duloxetine (generic Cymbalta) to treat chronic pain. The medication can also be used to treat depression.
    a) Three weeks later the incarcerated individual chose to discontinue the medication and the prescription was discontinued.
4. He answered negatively to all questions on the self-report opioid screening questionnaire scoring 0/8 possible points indicating a low risk for opioid dependence.
5. During his initial physical exam, he was started on medication to treat his elevated blood pressure, referred to the optometrist for an eye exam and to the lab for baseline screening tests.
6. After transferring to his parent facility, an x-ray of his left leg was done and a HSR was issued to document the presence of metal fragments in his leg.
7. An appointment to meet with his primary care provider was scheduled.
8. The psychological autopsy found:
    a) He was screened by mental health staff at the appropriate times and there were no referrals to mental health from staff.
    b) He did not have any notable mental health conditions and was coded as S-1 (no need for on-going mental health services).
    c) He had not requested mental health services during his present or past incarcerations.
    d) He had several risk factors for suicide, most of which were static including:
        i. Male gender
        ii. Over 35 years of age
        iii. Lengthy incarceration (26 years)

iv. Being housed without a cell mate (which is not in itself predictive of suicidality). (*It is by no means a certainty that his death by suicide would have been avoided if another individual had been assigned to his cell)*

v. Lack of programming (which is not unusual for a recent transfer)

vi. Chronic medical conditions and a history of substance abuse

e) While it is possible to speculate that closer monitoring might have been possible if he had been assessed further by a mental health clinician, there was no viable reason to initiate such a meeting, and even if such a meeting had occurred, there is no evidence that the incarcerated individual would have divulged any information about suicidal thoughts or plans.

9. The mortality review committee members discussed the potential mood impacts of the incarcerated individual stopping duloxetine.

a) They were unable to draw a clear correlation between the discontinuance of the medication and his suicidal actions.

b) The mortality review committee members did not identify any recommendations to prevent a similar fatality in the future.

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. On the day of the incident, tier checks were logged as being completed per policy.

2. Custody officers were notified there was a problem in the incarcerated individual's cell.

a) When they check the incarcerated individual's cell they immediately radioed for a medical emergency and started resuscitation efforts.

b) Nursing arrived on the scene with an AED.

i. Staff had difficulty getting the AED pads to properly adhere and there was no hair removal device readily available.

ii. A second set of pads was brought to the scene.

c) Medical emergency response and treatment was appropriate for the situation.

i. Community emergency response personnel arrived and assumed resuscitation efforts.

ii. Resuscitation efforts were unsuccessful, and the incarcerated individual was pronounced deceased.

iii. Recommend DOC explore adding an extra set of pads to each AED and hair removal devices that could be included in the emergency response bags.

d) Facility custody staff were out of compliance with First Aid/CPR training.

i. This is a known training issue post COVID-19 pandemic. The Department and facility have scheduled trainings to ensure that all DOC employees are current with AED/CPR training requirements.

ii. The CIR recommendations did not directly correlate to the cause of death and will be remediated per DOC Policy 400.100 Reporting and Reviewing Critical Incidents.

C. 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 a full psychological review (similar to the psychological autopsy) is not conducted after a suicide attempt.

a) Only the Chiefs of Psychology are trained to conduct the review.

i. A Psychologist 4 is assigned to the CIR team and reviews the mental health history and care.

ii. There is a clinical review conducted by the mental health team.

b) DOC has consulted with Lindsay Hayes, a correctional suicide prevention specialist, and is evaluating his recommendations.

c) The mental health director has created suicide prevention materials for the housing units and is working on funding for a dedicated suicide prevention specialist.

i. Suicide Prevention Poster 2/1/2023 (wa.gov)

2. The OCO asked why he was housed in a cell without a cell mate.

a) There is no documentation that he was intentionally housed by himself. It is most likely that there was space at the time of his transfer, and he would have been assigned a cell mate when more individuals transferred to the unit.

b) The OCO expressed a concern that there is a pattern of individuals who are housed alone who have completed suicide.

3. The OCO inquired if DOC has plans to provide mental health support/check-ins for incarcerated individuals impacted by a traumatic event.

a) DOC is exploring options to have the mental health duty officer come to the facility after hours to respond to an event.

b) There is an expectation for mental health staff to round on the impacted units when they are scheduled to work.

c) The OCO again recommended that both facility staff and incarcerated individuals receive mental health follow up after they are impacted by an event.

D. The Department of Health (DOH) representative requested additional information, discussed the case, and offered the following:

a) There is a stigma for men related to mental health issues. What are DOC's current practices to offer education and support to minimize the stigma?

i. Each person who arrives participates in a mental health screening. The screening consists of a brief set of questions related to their mental health history, current concerns, and past suicidal thoughts or behavior.

ii. During orientation they are educated on how to request mental health services.

iii. DOC provides annual staff training to recognize and intervene when they see concerning behaviors.

iv. DOC has developed four different educational posters to address the stigma and normalize mental health concerns which are available for posting.

b) The DOH representative offered suicide prevention training resources and recommends DOC explore the possibility of making suicide education materials available to incarcerated individuals via their assigned Securus tablets.

E. The Health Care Authority (HCA) representative concurred with the committee discussion and had no additional recommendations.

Committee Findings

1. Despite resuscitation efforts, the incarcerated individual died from self-inflicted hanging.

Committee Recommendations

1. The UFR Committee members 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. The OCO offered to partner with the Department of Health to upload DOH educational material to the incarcerated individuals' Securus tablets.