Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-008

Report to the Legislature

As required by RCW 72.09.770

October 10, 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. 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 August 24, 2023, or the follow-up meeting on September 11, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Karie Rainer, Director – Behavioral Health
- Dr. Zainab Ghazal, Administrator
- Dr Frank Longano, Chief Medical Information Officer
- Mark Eliason, Deputy Assistant Secretary
- Dr. Tracy Drake, Chief of Psychology
- Danielle Moe, DNP Director of Nursing
- Patty Paterson, MSN Director of Nursing
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Jeremy Turner, Associate Superintendent CRCC
- Melissa Moore, Correctional Program Manager CRCC
- Lorne Spooner, Correctional Operations Program Manager

DOC Community Corrections Division

- Kristine Skipworth, Regional Administrator – E. Region
- Kelly Miller, Administrator – Graduated Reentry

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. Dan Lessler, Associate Medical Director

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

Fatality Summary

Year of Birth: 1988 (35-years-old)

Date of Incarceration: July 2022

Date of Death: June 2023

At the time of his death, this incarcerated individual was housed in a residential mental health treatment unit. The cause of death was ligature strangulation resulting in an anoxic brain injury incompatible with life. The manner of death was suicide.

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

2 Days Prior to Death	Event
14:34 hours	• Routine tier check conducted.
14:36 – 14:39 hours	• Incarcerated individual's door slightly opens and closes several times.
15:11 hours	• Routine tier check conducted. • Officer discovered individual unresponsive after self-harm and radioed for help.
15:13 – 15:15 hours	• 911 was called. • Two other incarcerated individuals assisted the officer to support his body. • Second officer arrived with a noose cutter and ligature is removed. • Additional custody and nursing staff respond initiating lifesaving efforts.
15:28 hours	• Community Emergency Medical Services (EMS) arrived on unit.
15:54 hours	• Incarcerated individual is transported to the hospital by community EMS.
Day of Death	**Event**
17:01 hours	• Individual was pronounced deceased by community 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 considered the information from both reviews in formulating recommendations for corrective action.

A. The DOC Mortality Review Committee (MRC) reviewed the medical record, the psychological autopsy, the care delivered, and provided the following findings. They did not identify any additional

recommendations to prevent a similar fatality in the future.

1. The incarcerated individual had been diagnosed with anxiety and schizophrenia with psychosis for which he was appropriately treated by his mental health team with only episodic follow up in primary care.
2. Throughout his incarceration, he consistently denied being suicidal or depressed and had no previous history of suicide attempts.
3. While staff and EMS were able to return spontaneous circulation at the facility, he died because of his injuries.

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 pill line nurse did not follow Medication Administration Nursing Protocol N-306 when they failed to notify the psychiatric provider after the first medication dose that the individual had missed prior to his death.
2. DOC does not have an electronic health record or electronic medication administration system (E-MAR) which would automate these provider notifications.
3. The CIR recommendations were related to administrative changes or upgrades to current infrastructure and did not directly correlate to the cause of death. These recommendations will be remediated per DOC Policy 400.110 Reporting and Reviewing Critical Incidents.

C. The Department of Health (DOH) representative supported the recommendations for administrative improvement.

D. The Health Care Authority (HCA) representative inquired about DOC suicide prevention protocols and support available for individuals expressing suicidal ideation and experiencing anxiety about the pending transfer into the community. They supported the recommendations for improvement.

Note: DOC provides annual suicide prevention training for staff. Incarcerated individuals receive information regarding suicide risk factors and prevention in the DOC Orientation Handbook. There are suicide prevention posters in all living units and healthcare locations. More information can be found here News Spotlight: Humanity in Corrections - Suicide Prevention in Prisons | Washington State Department of Corrections

E. The Office of the Corrections Ombuds (OCO) offered the following information and input:

1. The OCO requested DOC provide incarcerated individuals information on the 988-Suicide prevention hotline resource.
2. The OCO had questions regarding the review of medications, medication changes made prior to the incarcerated individual's death and the side effects of those medications.

Note: DOC clinical staff reviewed the medication records and found no correlation to the death.

Committee Findings

The incarcerated individual died as a result of suicide. The cause of death was anoxic brain injury secondary to ligature strangulation.

Committee Recommendations

The UFR committee members did not offer any recommendations for corrective actions.

Consultative Remarks

A. DOC should continue working toward implementation of an electronic medication administration record (E-MAR) system.

B. DOC HS should work toward making an annual primary care visit standard for each resident in prisons.

C. DOC should continue to pursue an EHR when legislative funding becomes available which would support automatic notifications if an individual has not had a routine primary care visit in the last year.

D. DOC should continue to pursue options for utilization of the 988-Suicide prevention hotline.