Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-005

Report to the Legislature

As required by RCW 72.09.770

September 14, 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 10, 2023:

DOC Office of the Deputy Secretary

- Sean Murphy, Deputy Secretary

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 – Health Services
- Rae Simpson, Quality Systems Director
- Mary Beth Flygare, Project Manager
- Deborah Roberts, Program Manager
- Danielle Moe, Director of Nursing

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Jack Warner, Superintendent A -MCC/SOU/IMU
- Lorne Spooner, Correctional Operations Program Manager
- Jason Bennett, Superintendent SCCC

DOC Risk Mitigation

- Michael Pettersen, Director

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)

- Brittany Tybo, Director – 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

Date of Birth: 1968 (55-years-old)

Date of Incarceration: March 2011

Date of Death: May 2023

At the time of his death, this incarcerated individual was housed in a residential treatment unit. The cause of death was blunt force injury to the head and torso. The manner of death was suicide.

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

Day of Injury	Event
20:25 hours	• Incarcerated individual (I/I) walked upstairs to the 2nd tier, walked past showers, approached the railing on the 2nd tier, stood on the railing and jumped.
20:26 hours	• Medical emergency called.
20:27 hours	• Head/Neck supported by custody officer.
20:28 hours	• 911 was notified.
20:29 hours	• Medical staff arrive on unit.
20:30 hours	• C- Collar attempted by RN2.
20:35 hours	• IV placed by RN2.
20:37 hours	• Emergency Medical Services (EMS) arrived on grounds.
20:38 hours	• C-Collar placed by RN2.
20:41 hours	• Emergency Medical Services (EMS) arrived in unit.
21:03 hours	• I/I was transported to hospital by ambulance.
Day of Death	**Event**
04:06 hours	• I/I was pronounced deceased by 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 care delivered and provided the following findings and recommendations:

   1. The committee found that the incarcerated individual did not choose to engage with the primary care team significantly in his life. His last primary care visit was in 2021. The committee members felt that having an established primary care rapport may have added to his protective factors.

   2. The committee recommended DOC Health Services (HS) work to make an annual primary care visit standard for each resident in prisons.

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.

   1. The Critical Incident Review found no deviations from policy or operational procedures and determined the medical emergency response to be appropriate for both the custody and health services staff.

   2. The CIR had the following recommendations:

      a. DOC should install linear barriers that continue to the ceiling on the 2nd tier in the residential treatment units to prevent the opportunity of jumping. Additional barriers should be put on the stairs.

      b. DOC should explore options for peer programming support groups to educate incarcerated individuals in suicide prevention.

C. The Department of Health (DOH) representative supported the Department's recommendations regarding annual primary care visits, peer support and training, and extended barriers on the tiers.

   1. DOH also offered to support the recommendations by providing resources on Adverse Childhood Experiences (ACES), trauma informed care, and peer support groups.

   2. The DOH representative inquired about the post care for staff that witnessed the incident. *Note: DOC's Director of Behavioral Health shared that services were provided and are continuing to be provided. In addition, information and check ins were provided to incarcerated individuals.*

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

1. The OCO asked for information on the wellness checks for incarcerated individuals on the tier after the suicide. The OCO asked that the wellness checks happen quickly after a significant event.
2. The OCO recommends DOC advertise the 988-suicide prevention hotline in prisons and have a memorandum of understanding with the 988 program to communicate emergent situations in need of DOC follow-up.
3. The OCO encouraged DOC to highlight the difficulty locating housing and treatment to support the community reentry of hard-to-place individuals. The OCO asked that DOC consider adding a trigger point for case management staff to request additional support when appropriate post-release housing cannot be located.

E. The Health Care Authority (HCA) representative supported the Department's recommendations regarding annual visits, peer training and support, and extended bars on the tiers.

Committee Findings

The incarcerated individual died as a result of suicide. The cause of death was blunt force injury to the head and torso after jumping from the 2nd tier railing.

Committee Recommendations

Table 1. UFR Committee Recommendations
1. DOC should install linear barriers that continue to the ceiling on the 2nd tier in the residential treatment units and the stairs.

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

1. The OCO highlighted the need for greater awareness of the lack of statewide post-prison housing and treatment resources for hard-to-place individuals which may impact release date. OCO requested DOC consider including a trigger for case managers to ask for additional supports in locating housing.

2. DOC should explore options for peer programming support groups to educate incarcerated individuals in suicide prevention**.**

3. DOC Health Services should explore proactively offering annual primary care visits for each incarcerated individual that has not been seen in the last calendar year.

4. DOC should explore options for utilization of the 988-suicide prevention hotline.