Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-026

Report to the Legislature

As required by RCW 72.09.770

December 9, 2022

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 meetings held virtually on November 10 and November 29, 2022:

DOC Health Services

- Dr. Mary Ann Curl, Chief Medical Officer
- Dr. Frank Longano, Deputy Chief Medical Officer
- Dr. Alonso Pezo-Salazar, Director Infection and Prevention Control
- Dr. Karie Rainer, Director of Mental Health
- Mark Eliason, Deputy Director Health Services
- Dr. Kasey Gregory, Facility Medical Director, CBCC
- Paul Clark, Administrator
- Rae Simpson, Director Quality Systems
- Mary Beth Flygare, Program Manager
- Keith Parris, Health Services Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- Eric Jackson, Deputy Director
- Jeri Boe, Superintendent, CBCC

DOC Risk Management

- Michael Pettersen, Risk Mitigation Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Policy Advisor

Department of Health (DOH)

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

Health Care Authority (HCA)

- Dr. Charissa Fotinos, Medicaid Director

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

Fatality Summary

Date of Birth: June 1988 (34-years-old)

Date of Incarceration: May 2018

Date of Death: August 2022

The incarcerated individual was a 34-year-old man who was first incarcerated by WA DOC in May 2018 after serving a six-year prison sentence in Oregon related to the same crime. English was his second language, and use of language interpretation services were needed at times to ensure clear communication with this individual. At the time of his death, he had been housed in medical isolation for 37 days to rule out active tuberculosis disease. Ten days were spent in a negative pressure room in the facility infirmary and 27 days in an alternative housing unit used for medical isolation during infectious disease outbreaks when there was not capacity in a DOC infirmary. His death was the result of lack of oxygen to his brain secondary to ligature hanging. The manner of his death was suicide.

His risk and needs assessments were completed correctly. He had been housed in the same prison facility for three years where he was employed as a food preparation worker and was pursuing his general education diploma (GED) and English courses. During his annual facility review, he requested a facility move to be closer to family for visitation. He transferred to the new facility in July 2021. In January 2022, there was an outbreak of tuberculosis (TB) at his facility. He was identified through Department of Health contact tracing to potentially have been exposed.

In March 2022, he tested positive for TB. He was initially asymptomatic and not contagious. He was offered treatment that would prevent active TB infection, which he declined after stating he was concerned the antibiotics would impact the effectiveness of his antidepressant medication. He was reassured that his medications would be monitored and could be adjusted if needed. He was counselled about the need for treatment and provided written educational materials in his native language. In July 2022, he developed symptoms of active TB disease, including a cough and fever. He was moved into a negative pressure room in the infirmary to prevent further spread of TB in the facility.

A brief timeline of events prior to his death beginning with day 36 of being in medical isolation:

Day 36	Event
1000 hours	Medical check by nurse in alternate housing location.
2307 hours	Formal count by custody officers – the incarcerated individual was watching TV.
Day 37	**Event**
0634 hours	Formal count by custody officers who discover the incarcerated individual hanging by a sheet from a closet door.
0635 hours	Medical emergency response activated including call for 911 – community Emergency Medical Services (EMS).

Day 37 (cont.)	Event
0636 hours	Radio call requesting cut-down knife – two additional custody officers arrive on the scene and assist in lowering the incarcerated individual to the floor.
0637 hours	Facility nursing staff arrive on scene.
0638 hours	Ligature successfully removed, incarcerated individual moved to the living room for better access, and CPR initiated by a nurse.
0640 hours	AED applied – advises no shockable rhythm. CPR continued.
0641 hours	CPR resumed and Narcan administered per DOC protocol.
0643 hours	IV line established by a nurse.
0645 hours	Second dose of Narcan administered.
0649 hours	AED check advised no shockable rhythm. CPR continued.
0651 hours	AED check advised no shockable rhythm. CPR continued. Community EMS & ambulance arrive on scene.
0653 hours	The incarcerated individual is pronounced deceased by a Fire Department Paramedic.

Committee Discussion

A. The DOC mortality review committee reviewed his health record, the circumstances of his death and presented the following for discussion:

1. The incarcerated individual had a medical history of major depressive disorder without suicidality, latent tuberculosis infection (LTBI), gastroesophageal reflux, and social phobia.
2. From the time he was incarcerated in Washington State, during Health Services interactions he consistently denied any past suicide attempts and stated he "was not suicidal."
3. There were signs that he felt despair and hopelessness early during his incarceration in Washington State. That situation changed when he was able to obtain work in the kitchen and was taking classes. He also reported being engaged in exercise, playing soccer, playing games, and reading.
4. After he was transferred to the new facility in July 2021, he reported struggling with depressed mood and felt despondent after not being able to become employed and reestablish a social network since his transfer.
5. While he was housed at the new facility, they were on COVID outbreak status 8/19/21-9/30/21, 1/2/22-6/21/22, and 8/1/22-8/23/22 which impacted job and programming opportunities.
6. He was under treatment for depression with a psychiatrist prior to being placed in medical isolation.
7. His condition required medical isolation in a negative pressure environment related to positive TB testing to distinguish between LTBI and active TB.
8. Initially he was housed in the only negative pressure room in the facility infirmary. Plumbing issues necessitated him to be relocated.
9. When alternative housing options were being considered, the infection prevention physician was informed that there were no pressurized medical isolation rooms available in any facility.

10. The incarcerated individual's symptoms had improved, and he was medically stable. The decision was made to keep him in at the facility in an alternative housing unit to prevent possible spread of TB.
11. After the plumbing issue was repaired, an individual with higher nursing care needs and a requirement for isolation in a negative pressure environment was moved into the room.
12. DOC has insufficient capacity for medical isolation requiring a pressurized environment.
13. DOC has no centralized tracking for the availability of pressurized medical isolation rooms leading to missed infirmary housing opportunities for individuals requiring medical isolation.
14. An opportunity for mental health support was missed when his psychiatry appointment was cancelled the day he was moved into medical isolation. The psychiatrist's note documents that he was placed in medical isolation but did not include a plan for psychiatric follow-up and mental health well-being checks while he was isolated.
15. Medical providers and nursing staff conducted wellness checks but did not notify the Mental Health Team when the incarcerated individual exhibited signs of emotional distress while in medical isolation (i.e., wanting to prolong contact with staff, expressing boredom, looking sad and being concerned with the isolation period being extended).
16. Per the psychological autopsy review, it does not appear that other members of the Mental Health Team were made aware by custody, psychiatry, primary care, or nursing that this patient might require mental health well-being checks.
17. DOC policy requires weekly mental health well-being checks for persons on medical isolation. The TB medical isolation protocol at this facility did not have a standard operating plan or clear communication expectations for ensuring mental health well-being checks occurred.
18. The members of the mortality review committee agreed that receiving ongoing mental health support during the medical isolation period may have been meaningful to the incarcerated individual and improved his chance of survival.

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. Custody wellness/tier checks in the alternative housing unit were not consistently completed as required in the Security Inspection Matrix attached to DOC Policy 420.370 Security Inspections.
2. The incarcerated individual did not receive wellness checks by mental health staff while housed in solitary medical isolation.
3. Mental health staff were not notified that he was placed in alternative housing for medical isolation.
4. Staff did not utilize DOC Form 13-420 "Request for Mental Health Assessment" when they noticed the incarcerated individual had behavior changes and/or was in emotional distress.
5. Custody staff responding to the medical emergency did not have direct access to personal protective equipment.
6. Custody staff who found the incarcerated individual did not have access to a cut down tool in the alternative housing unit.
7. Custody supervisory log reviews for the alternative housing unit were not completed as required by DOC policy.

8. Custody post orders were not consistently reviewed by officers as required by DOC policy.

C. The Office of the Corrections Ombuds (OCO) discussed their analysis of the case and submitted the following recommendations for UFR committee discussion:

1. When an incarcerated individual is placed in an alternative housing for medical isolation, a multidisciplinary team meeting should be conducted at a minimum weekly to ensure that the continued placement in alternative housing is appropriate and that the individual's medical, mental health, and safety needs are being met. The team will include representatives from medical, mental health, classification, and custody.

D. DOC should explore options to expand capacity of medical isolation space in facilities. The Health Care Authority (HCA) discussed their analysis of the case and submitted the following for UFR committee discussion:

1. When an individual is not a native English speaker and has a complex medical condition, an interpreter should always be used to insure understanding. DOC staff should not just assume a patient will understand. In this instance, the medical and mental health staff did not always utilize an interpreter to facilitate communication.

E. Department of Health (DOH) representative participated in the discussion and concurred with UFR committee findings and recommendations.

Committee Findings

1. DOC has inadequate housing space for managing medical isolation patients during an infectious disease outbreak and there is no capacity in the community to absorb DOC patients.

2. The Mental Health team was not aware of the incarcerated individual's placement in medical isolation and the need for wellness checks.

3. The incarcerated individual was not referred to mental health services when staff noticed behavior changes.

4. Custody wellness/tier checks in the alternative housing were not consistently completed as required in the Security Inspection Matrix attached to DOC Policy 420.370.

5. There was inadequate mental health planning and support for the incarcerated individual due to an absence of communication across multiple teams regarding this at-risk person housed in solitary medical isolation.

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. Explore options for expanding medical isolation capacity in DOC facilities.
2. Ensure incarcerated individuals on medical isolation/quarantine status have access to mental health services.
3. Improve staff awareness of suicide risk and the need for a referral to the Mental Health Team when an incarcerated individual displays concerning behavior changes.
4. Establish written procedures to ensure alternate housing units are managed and operated with the same security expectations as established housing units as defined by the security matrix.
5. Consider amendment of DOC Policy 630.500 Mental Health Services to be more descriptive of the role of mental health staff, including psychiatrists, in the care and well-being of persons admitted to an alternate house unit or on medical isolation/quarantine status.
6. Establish a process for multidisciplinary care planning (MDT) for the management of complex cases or situations (i.e., medical isolation, mental health concerns, alternative housing placement).
7. DOC should begin tracking the availability of pressurized medical isolation rooms.