Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-011

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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Table of Contents

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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. Federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying substance use 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 December 5, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Patricia Paterson, Chief of Nursing
- Mark Eliason, Deputy Assistant Secretary
- Dr. Ryan Quirk, Director – Behavioral Health
- Dr. Zainab Ghazal, Administrator
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Program Manager
- Rochelle Stephens, Men's Prisons project Manager

DOC Risk Mitigation

- Mick Pettersen, Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Deputy Director
- EV Webb, Assistant Corrections Ombuds – Investigations
- Madison Vinson, Assistant Corrections Ombuds - Policy

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Christopher Chen, Associate Medical Director

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

Fatality Summary

Year of Birth: 1994 (29-years-old)

Date of Incarceration: November 2022

Date of Death: June 2024

At the time of death, this incarcerated individual was housed in a DOC prison facility.

The cause of death was hanging. The manner of death was suicide.

A brief timeline of events on the day of the incarcerated individual's death:

Events on the Day of Death
• A custody officer was informed by an incarcerated individual that the deceased incarcerated individual was actively self-harming. • Emergency radio call made. • Custody officers entered the cell and began rendering aid. • Medical staff arrived and assumed care. • Community emergency medical services arrived and assumed care. • Community emergency medical services pronounced the incarcerated individual deceased.

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 the incarcerated individual:

        a. Received both 1:1 and group mental health treatment and support including medication.

        b. Had several suicidal attempts throughout their lifetime and openly discussed their suicidal desire, rationale and plans.

c. Consistently denied feeling suicidal in 2024.

d. Requested a Do Not Resuscitate (DNR) status* in the event of having no pulse and not breathing, in accordance with their religious beliefs.

e. Requested their DOC identification badge be updated to include their DNR status.

*Per DOC Policy 620.010 Advance Directives, individuals may, at any time, sign a health care directive outlining their wishes with regard to treatment, including life sustaining treatment. Policy states the health care directive would not apply in the event of self-harm.

2. The committee recommended:

a. The DOC identification badge DNR flag language be updated to include "Does not apply in instances of self-harm."

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.

1. The CIR found:

a. Responding officers stopped and resumed life saving measures because of confusion caused by the do not resuscitate (DNR) flag on the ID badge.

b. Exterior cell window coverings created a safety and security concern, making it difficult for staff to observe the individual.

2. The CIR recommended:

a. Message DOC staff to clarify that the DNR request does not apply to self-harm events per Policy 620.010 Advance Directives.

b. Distribute directive to prevent full coverage of windows that block all light out of the cells.

C. The committee reviewed the unexpected fatality, and the following topics were discussed.

1. Emergency Response:

During this event, DOC responders stopped and then resumed life saving measures due to confusion caused by a Do Not Resuscitate (DNR) flag on the incarcerated individual's identification (ID) badge. The DOC Chief Medical Officer followed-up immediately to ensure staff are trained to provide life saving measures after a self-harm event. The committee appreciated that the DNR flag language will be added to the badges.

The committee discussed the location and availability of equipment used to remove ligatures. The DOC standard equipment is kept in every living unit's control booth and is only accessible by staff for safety reasons. The location within the control booth is determined at the facility level. The committee recommends a refresher to custody staff on appropriate use and location of the equipment to ensure functionality and ready access during emergencies.

2. Suicide Risk Assessment:

   DOC provided a summary of the suicide risk assessment process which determines the level of risk of self-harm/suicide for the individual and the necessary response to that risk including housing assignments. If an incarcerated individual is determined to be at imminent risk, they would be placed under close observation in a highly restrictive close observation area (COA) environment which may be perceived as punitive. Residential treatment units (RTU) are housing options for individuals who need additional mental health support and are determined to not be at imminent risk of self-harm. The committee discussed opportunities for RTU versus COA units and the efficacy of the current suicide risk assessment tool.

   The committee discussed the incarcerated individual periodically discontinuing their medications, the follow-up and support provided by clinical staff. They had a medication management appointment five days prior to their death and weekly meetings with their counselor.

3. Incident Follow-up:

   The committee discussed the mental health staff offered immediate and ongoing support to incarcerated individuals following the death.

Committee Findings

The incarcerated individual died as a result of hanging. The manner of death was suicide.

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. DOC should remind custody staff of appropriate use and location of the ligature removal tool.
2. DOC should provide clarification to staff that the DNR request does not apply to self-harm events per Policy 620.010 Advance Directives.

3. DOC should direct staff to ensure cell windows are not fully covered.
4. DOC should update the identification badge DNR flag language to include “Does not apply in instances of self-harm.”