Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-007

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 June 12, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Ryan Quirk, Director – Mental Health
- Dr. Bhinna Park, Chief of Psychiatry
- Dr. Zainab Ghazal, Administrator
- Dr. Rae Simpson, Director – Quality Systems
- Mark Eliason, Deputy Assistant Secretary
- 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)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

Health Care Authority (HCA)

- Dr. Heather Schultz, 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: May 2022

Date of Death: March 2024

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

His cause of death was severe traumatic brain injury. The manner of his death was homicide.

A brief timeline of events prior to the incarcerated individual's death.

Days Prior to Death		Event
7 days prior	2016 hours	• After incident review of security video, showed the incarcerated individual walking with a second incarcerated individual into the unit recreation yard.
	2032 hours - 2040 hours	• The recreation period ends, and the yard began to clear. • Custody staff observed the second incarcerated individual with blood on clothing as he was exiting the yard, and he was detained for questioning. • Custody staff began searching the yard for anyone that may be injured.
	2044 hours	• The incarcerated individual was found unresponsive. • Medical emergency response was requested, and first aid provided.
	2049 hours - 2122 hours	• Facility medical staff arrived and rendered aid. • Community Emergency Medical Services (EMS) were requested. • EMS arrived, assumed care, and transported him to the hospital.
6 days prior	0732 hours	• He was placed on DOC seriously ill status.
Day of Death		**Event**
Day 0	0234 hours	• He was pronounced deceased by the community hospital.

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:

      a. The medical emergency response was appropriate.

      b. He was diagnosed with autism spectrum disorder with attention deficit hyperactivity disorder. Neuro-psychological testing documented an approximate IQ of 81.

      c. He was coded correctly in the DOC electronic case management system for developmental disability support needs based on the current criteria.

   2. The committee recommended:

      a. Referring to the UFR committee for review.

      b. Exploring updating the Health Services coding to accurately reflect the definition of developmental disability in accordance with RCW 71A.10.020.

      c. Exploring opportunities for Health Services to actively engage in housing/placement decisions for incarcerated individuals with identified intellectual and developmental disabilities.

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. Custody staff were not present in the recreation yard at the time of the incident.

      b. There was limited visibility in the corner of the recreation yard where the incident took place.

      c. Staff experienced limited and broken radio communication during the incident response.

   2. The CIR recommended:

a. Increase recreation yard walkthroughs and visibility of custody staff.

b. Install additional lighting to assist with visibility in the recreation yard.

c. Implement planned upgrades to the radio system to ensure access is adequate for daily and emergency operations.

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

1. Housing decisions and classification levels.

   The committee discussed whether the diagnosis of an intellectual or developmental disability would have impacted this incarcerated individual's housing placement and custody level. DOC stated that if an individual had a diagnosis of developmental disability this may have triggered heightened case management and may have impacted the adjudication of infractions he received. The committee discussed the resources available in close custody or more restrictive settings for individuals needing skill building supports including the Sky River Unit at Monroe Correctional Center and the Specialized Housing units at the Washington State Penitentiary.

   The committee discussed the classification review which triggered the move of this individual to a general close custody housing unit rather than being placed in protective custody or other specialized housing unit. The Ombuds expressed concerns about safety related to the incarcerated individual's placement in a general close custody unit with known violence. DOC indicated that staff members had interviewed him on multiple occasions, and he stated he was okay living there.

2. Structural and equipment issues.

   The committee discussed the technical issues related to the incident, specifically focusing on the radio system, lighting, and cameras. DOC shared that updates are currently underway for each of these systems. Specifically:

   a. Radio system updates: The radio system upgrade was funded in 2023. The project was initiated in May of 2023 and installation of new equipment and shelter initiated on April 23, 2024. The new radio system went live on June 29th, 2024. This was a major upgrade to the system requiring extensive multi-year planning and implementation.

   b. Additional lighting: A capital project was initiated in the 19-21 biennium budget. However, the agency is allocated limited funding for capital projects as designated through legislative process. Typically, priority requests are usually more urgent deferred maintenance issues as compared to new programmatic requests. This would be categorized and prioritized as a new programmatic request.

   c. The initial lighting in the area was designed and installed per contractor specifications. On the Northeast corner of the recreation yard, there were two additional cobra heads lights installed on the rack to provide lighting. The light models initially installed per the contract's specifications were within specifications of the city's permitting

requirements regulating the amount of light emitted to prevent light pollution.

On the Northeast side of the cemetery, 2 additional cobra head lights were installed. The additional new installation does enhance the field of view for surveillance area wide. New lights have also been installed to enhance visibility in other locations. On the south side of a unit, facility staff installed two additional flood lights that are aimed at the three tables that were near the incident site.

d. Camera adjustments: The existing cameras have been adjusted to cover specific areas of the yard. In the NE corner of the yard. There were blind spots in the cameras view. Those cameras have been adjusted minimizing the blind spots.

e. Capital project: There is a capital project underway to install new cameras and construct an additional tower to improve overall security and surveillance to enhance monitoring capabilities. This request is subject to the agency and legislative prioritization and approval process.

3. Monitoring of the yard.

   The committee discussed safety protocols for custody staff. DOC is piloting changes to yard patrols, assigning four (4) officers to patrol the yard twice during each recreation period. These updated patrols aim to enhance security and will be reviewed to evaluate effectiveness.

Committee Findings

The incarcerated individual died as a result of severe traumatic brain injury. The manner of death was homicide.

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 review and update their classification and health services support needs coding processes to better support individuals with developmental disabilities.

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

1. DOC should continue to pursue an electronic health record when full legislative funding becomes available.