



STATE OF WASHINGTON

OFFICE OF THE CORRECTIONS OMBUDS

2700 Evergreen Parkway NW • Olympia, Washington 98505 • (360) 664-4749

April 9, 2021

Steve Sinclair, Secretary
Department of Corrections (DOC)

Office of the Corrections Ombuds (OCO) Investigative Report

Attached is the official report regarding the OCO investigation into the two suicides that occurred in DOC custody in 2020. We consider this report and its findings to be a continuation of our earlier report on the 2019 suicides in DOC custody. We look forward to working with DOC to amend current policies and practices to better ensure that all incarcerated persons' health, safety, welfare, and rights are protected while they are within state confinement.

Any member of the public who wishes to report a concern to OCO is welcome to contact the office at (360) 664-4749 or at the address above. Complaints can be made by non-incarcerated persons through OCO's online complaint form at oco.wa.gov or incarcerated persons can utilize OCO's paper form that should be available on each housing unit. All complaints are logged into the OCO database and used as part of its overall reporting to policymakers and analysis of issues within DOC.

Sincerely,

Joanna Carns
Director

cc: Governor Inslee

**OCO INVESTIGATION OF
2020 SUICIDE DEATHS IN WASHINGTON DEPARTMENT OF CORRECTIONS
CONDUCTED BY PATRICIA H. DAVID MD MSPH CCHP,
DIRECTOR OF PATIENT SAFETY AND PERFORMANCE REVIEW**

SUMMARY OF CONCERN

In 2019, five suicide deaths occurred within the Department of Corrections (DOC), representing a dramatic increase from prior years. In response, the Office of the Corrections Ombuds (OCO) initiated an investigation of the cases and published a report of the analysis of the 2019 suicide deaths in August 2020. Prior to report publication, the OCO forwarded the confidential preliminary investigative report to DOC and hosted a consultation with DOC leadership to discuss the preliminary findings and proposed recommendations. As of this date, OCO has not received a formal response to the recommendations in that report.

Although the number of suicide deaths in 2020 returned to DOC's average baseline of two per year, the OCO proceeded with an investigation into both cases to determine whether there were findings similar to those put forth in the prior report which potentially contributed to these two deaths.

RELEVANT STATUTORY AND REGULATORY AUTHORITY

- Per RCW 43.06C.005, OCO was created to assist in strengthening procedures and practices that lessen the possibility of actions occurring within DOC that may adversely impact the health, safety, welfare, and rehabilitation of incarcerated individuals, and that will effectively reduce the exposure of DOC to litigation.
- Per RCW 43.06C.040, OCO has the authority to receive, investigate, and resolve complaints related to incarcerated individuals' health, safety, welfare, and rights.

INVESTIGATION PROCESS

In the preparation of this report, OCO reviewed the following information:

- Patient charts
- (2017) DOC 320.265 Close Observation Areas (COA)
- (2018) DOC 610.040 Health Screenings and Assessments
- (2017) DOC 630.500 Mental Health Services
- (2017) DOC 630.550 Suicide Prevention and Response
- (2014) DOC 890.620 Emergency Medical Treatment
- (undated) DOC Suicide Risk Assessment Protocol

DOC staff were not interviewed due to concurrent COVID19 outbreaks at the involved facilities.

At the conclusion of this investigation, the OCO forwarded the confidential preliminary investigative report to DOC in March 2021. The OCO then hosted a consultation with DOC medical and mental health leadership in April 2021 to discuss the OCO's preliminary findings. Information and feedback provided by DOC during this consultation was considered by the OCO prior to publication of the final report.

CASE SUMMARIES

Patient A¹

Patient A was a 25-year-old White person who entered the DOC system in June 2019 because of a Drug Offender Sentencing Alternative (DOSA) revocation. Patient A was initially housed in a county violator facility prior to transferring into a DOC facility. PULHES S code² was initially assigned as 3 but was later upgraded to 4 after a mental health appraisal was performed at the request of a correctional officer who observed “strange behaviors.” Patient A was admitted to a facility Residential Treatment Unit.

¹ See Appendix A for case timeline.

² DOC's PULHES code is meant to reflect a person's mental health service utilization. Any number greater than 1 (no identified mental health need) indicates that the person is on DOC's mental health caseload. S codes 2, 3, 4, and 5 (most significant) reflect increasing mental health services use and needs.

Patient A filed an emergency grievance in September 2019, expressing concern that it was unlikely Patient A would survive until Patient A's release date. The grievance was returned for a rewrite, and later administratively withdrawn. Patient A subsequently submitted the rewrite, asking "why should I have to die in jail if I'm not convicted of a death penalty crime?" This was again returned for a second rewrite but none was received, and the grievance was administratively withdrawn in October 2019. There is no indication that the grievance coordinator notified or consulted with mental health staff regarding the statements Patient A made in the grievances.

Over the course of five months, Patient A was placed in COA four times due to self-harm events. However, the Suicide Risk Assessments that should have been completed prior to releases from COA were not found in the medical record. In addition, there is insufficient documentation that an evaluation by a mental health provider was performed to determine whether Patient A presented "minimal imminent risk for self-injury³" prior to the releases from COA. In addition, Patient A incurred multiple serious infractions. Each involved behaviors attributable to mental illness, such as using personal clothing to clean following a bowel movement and subsequently wearing the soiled clothing, failing to maintain the cell, indecent exposure and public self-stimulation, and failure to comply with cell confinement. There is no indication that mental health staff were consulted in any disciplinary hearings. Because of these infractions, Patient A was not released on the earned release date.

On 1/25/2020, two days after the last release from COA, Patient A was found lying on the cell floor with two strips of cloth around Patient A's neck; the strips were crafted from a towel. Resuscitation was attempted by DOC staff; the resuscitative efforts were hindered by some difficulties with the AED as well as the nursing staff's apparent lack of knowledge regarding how to properly administer respirations. Once the emergency responders arrived, additional resuscitative efforts were administered and there was return of spontaneous circulation. Patient A was transported to the hospital, and later died on 1/28/2020.

DOC's Critical Incident Review (CIR) report found several suicide risk assessments – which policy requires to "be completed to demonstrate readiness for discharge, before the person is approved for return to their regular living unit⁴" – were absent from the medical chart. Safety

³ DOC 320.265, Section V.A. and B.

⁴ DOC Suicide Risk Assessment Protocol.

Plans – also required by policy “to address the patient’s suicide/self-harm risk⁵” – were similarly absent.

Patient B⁶

Patient B was a 42-year-old Latinx⁷ male who entered the DOC system on 2/20/2020. On the day he arrived, the medical department received documents from the county jail confirming two recent suicide attempts (August and September 2019); in addition, Patient B was noted to be taking two psychotropic medications. His mental health screening form described having “received therapy or medication for a mental health concern and/or suicide attempt” two weeks earlier, but it is not clear whether this response refers to therapy, medication, or suicide attempt. He appeared heavily sedated, disheveled, and withdrawn. The mental health staff responsible for performing Patient B’s mental health screening did not sufficiently review the documentation regarding Patient B’s two recent suicide attempts, and only skimmed the diagnostic section and medications. Patient B was assigned a PULHES S code of 2⁸ and R code of 1.⁹ On 3/1/2020, Patient B was found hanging in his cell for an unknown amount of time.

On the day that Patient B arrived at the DOC facility, the mental health staff responsible for performing mental health screenings processed 46 people; because of the need to screen this high volume of people, the staff did not review the documentation regarding Patient B’s two previous suicide attempts, and only skimmed the diagnostic section and medications. Thus, the staff was unaware of Patient B’s relevant prior history.

DOC’s CIR report revealed that the mental health staff assigned to do new intake screenings performs 40 to 70 screenings in one day. The staff felt that the intake screening was very rushed, with the “mindset of get them in and get them out,” and that it was “not the best for patient care.”

⁵ DOC Suicide Risk Assessment Protocol.

⁶ See Appendix B for case timeline.

⁷ Listed in OMNI as White Chicano.

⁸ PULHES S2 = Mild symptoms of mental illness; may have some mild deficits in functioning or mood but is able to be maintained in general population with minimal mental health treatment.

⁹ PULHES R1 = There is no history of self-harm or suicide attempt in the past 10 years.

The CIR report concluded that Patient B should have been assigned a PULHES S code of 3¹⁰ and R code of 2.¹¹

ANALYSIS

Patient A's case revealed the following findings:

- Several Suicide Risk Assessments and Mental Health Safety Plans were missing from the medical file. Although providers responsible for completing these forms produced them when being interviewed by the CIR team after Patient A's death, the reason why those forms were not placed in the medical file could not be determined. Potential reasons for the missing assessments included the lack of a suitably confidential area for interviewing patients in COA, and a delay in supervisory review / cosigning of documents when a supervisor is absent from work.
- Patient A incurred multiple serious infractions associated with behaviors that most would identify as being related to mental illness. There does not appear to be any consultation with mental health in any of the disciplinary hearings; although it is not clear what the impact of these disciplinary hearings and infractions may have had on Patient A, the incidents point to Patient A as being a person in crisis. It seems significant to note that, if not for these infractions, Patient A would have been released and already out in the community on 1/25/2020 – the day of the self-harm act which ultimately led to death.
- Medical grievances submitted by Patient A were returned for rewrite¹²; the grievance coordinator explained to the CIR investigators that the grievances “didn't make sense.” Despite the references to dying and Patient A's mental health condition, there is no indication that the information was relayed to mental health staff.
- The AED used in resuscitation attempts initially malfunctioned.

¹⁰ PULHES S3 = Current, active symptoms of mental illness; moderate severity with some noted problems with functioning (e.g. school, work, interpersonal); can be managed in general population with appropriate mental health treatment.

¹¹ PULHES R2 = There is a history of self-harm or suicide attempt in the past 10 years.

¹² DOC has since made improvements to their grievance process. The newly renamed Resolution Program now includes a process for escalating rewrites to DOC Headquarters for review, so that serious concerns can be identified and redirected as appropriate.

- Nursing staff reportedly lacked the knowledge regarding proper resuscitative technique and required redirection by custody staff.

Patient B's case revealed the following findings:

- A single mental health staff member is responsible for processing an astonishingly high number of mental health screenings in one day. Because of this high daily caseload, the staff member reportedly did not have sufficient time to review documents from the county jail which outlined Patient B's recent suicide attempts.
 - Although a member of the psychiatry staff later reviewed the documents and sent an email regarding the suicide attempts, an assessment (per the Suicide Risk Assessment Protocol) did not take place, and Patient B was not relocated to COA for his protection.
- Although Patient B had been assigned a PULHES S code of 2 by the staff member performing the initial screening, another staff member felt that Patient B should have been assigned a S code of 3 based on his appearance and history of medications. The S3 code reportedly would have resulted in an expedited mental health evaluation.
- As with Patient A, there was an AED malfunction during this resuscitation; in Patient B's case, the AED pads did not provide a firm connection with his torso and were sliding during CPR delivery.

DISCUSSION

These cases demonstrate the following opportunities for improvement, identified by DOC's Critical Incident Review process:

1. Ensuring that Suicide Risk Assessments and Mental Health Safety Plans are always completed per policy.¹³ To assist this process, some needs include:
 - a. A confidential location¹⁴ where mental health staff can complete in-person assessments;

¹³ This recommendation was previously noted in the OCO [Analysis of 2019 Suicide Deaths in Washington DOC](#).

¹⁴ This need appears to be limited to one facility location; other DOC facilities have a sufficiently confidential space for these types of assessments.

- b. Coverage for staff supervisors when they are out of the office, so that important patient care documents are reviewed and cosigned quickly; and
 - c. A more robust oversight process by the responsible providers to confirm that these assessments are being completed as required by policy.
2. Reviewing and revising the current mental health screening process to achieve a staffing level that allows for a more reasonable daily caseload, so that staff can perform a thorough review of medical documents accompanying new intakes;
3. Improving nursing staff knowledge and comfort level regarding the use of resuscitative equipment.
4. Confirming that all AED pads used throughout the system maintain adequate adhesion during resuscitation efforts.

The following additional opportunities for improvement were identified by this investigation:

1. Improving the communication between custody and health services staff who interact with people with mental health disorders, so that
 - a. An individual's mental health status is considered throughout the disciplinary process¹⁵, since many behaviors may be linked to a disability; and
 - b. Mental health staff are promptly notified when people with significant disabilities are being infraacted and sanctioned, losing privileges, and/or being confined.
2. Clarifying the process of assigning PULHES S codes, for the benefit of staff responsible for making those assignments. Routine supervisory review and feedback to staff can ensure consistency and appropriateness of S code assignments.
3. Clarifying DOC 890.620 (Emergency Medical Treatment) so that AEDs are inspected at specific regular intervals.

OCO welcomes the opportunity to assist and collaborate with DOC in developing solutions to address the opportunities for improvement identified in this report.

¹⁵ See OCO systemic report regarding Mental Health Access & Services (pending publication) for additional information and recommendations.



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May 7, 2021

Joanna Carns
Office of Corrections Ombuds
2700 Evergreen Parkway NW
Olympia, WA 98505

Dear Ms. Carns:

The Washington Department of Corrections appreciates the opportunity to respond to the OCO Investigation Report on the 'two suicides that occurred in DOC custody in 2020' completed by the Office of Corrections Ombuds.

Recommendation	Response
<p>Ensuring that Suicide Risk Assessments and Mental Health Safety Plans are always completed per policy. To assist this process, some needs include:</p> <ul style="list-style-type: none">a. A confidential location where mental health staff can complete in-person assessments;b. Coverage for staff supervisors when they are out of the office, so that important patient care documents are reviewed and cosigned quickly; andc. A more robust oversight process by the responsible providers to confirm that these assessments are being completed as required by policy.	<ul style="list-style-type: none">a. The chiefs of psychology along with facility administrators will be asked to survey the physical plant of each close observation area (COA) location to identify the confidential space adjacent to the COA where interviews and assessments may occur. The survey will be completed by May 30, 2021. Any areas that do not have confidential interview spaces identified nearby, will be required to establish a formal process, place and time to complete that activity. Staff responsible for performing this task will be trained to the updated processb. The chiefs will establish the coverage plans for each location to insure there is no delay in the review of documents and discharge of patients. The plans will be established by May 30, 2021.c. Active monitoring of all COA admissions and discharges by the chiefs of psychology started March 23, 2021. The monitoring includes insuring that discharge suicide risk assessment (SRA) evaluations are conducted, and the safety plans completed and placed into the patient's chart before a person is

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	<p>released from the COA, per protocol. The chiefs of psychology are monitoring the work completed by primary therapists (primarily psychology associates and psychologist 4s).</p>
<p>Reviewing and revising the current mental health screening process to achieve a staffing level that allows for a more reasonable daily caseload, so that staff can perform a thorough review of medical documents accompanying new intakes.</p>	<p>The sense of urgency during the reception process is not exclusively about the number of staff at the Washington Corrections Center (WCC) in Shelton but is also driven by the intake process itself and the expectations of the process. An example includes finishing in a brief period of time to get the individuals to their living units or because another bus is soon to arrive as the department must accept new incarcerated individuals within seven days of sentencing by the courts, per state law.</p> <p>To best achieve a reasonable caseload, a comprehensive review of the intake process is needed and will be conducted by July 1, 2021. The department recognizes that greater efficiencies and increased safety would be likely with the addition of two more full-time psychology associates to better address the workload at WCC. These additional staff would be in addition to the necessary changes in the workflow/physical plant.</p>
<p>Improving nursing staff knowledge and comfort level regarding the use of resuscitative equipment.</p>	<ul style="list-style-type: none"> • The department has contracted with Newcastle Training to provide cardiopulmonary resuscitation (CPR)/ basic life support (BLS) training for staff out of compliance with their CPR certification and to train new CPR certified instructors across the agency. As of May 1, 2021, the training has been initiated. • The department has developed emergency drills that include the use of emergency equipment and a debrief session afterward to review the drills

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	<p>and discuss potential training opportunities needed for staff.</p> <ul style="list-style-type: none"> • Conduct after action incident debriefs to help staff identify conformance to policy, physical plant issues, exemplary recognition or opportunity for improvement. Ensure the debrief performed is captured in the institution shift log. • The department has developed a competency review process for all nursing staff that will allow the department to review nursing procedures, including emergency response and the use of emergency equipment, on an annual basis. • Re-educate staff on the process that emergency equipment is to be checked on a routine basis to ensure equipment is in proper working condition when needed.
<p>Confirming that all AED pads used throughout the system maintain adequate adhesion during resuscitation efforts.</p>	<p>Per policy 890.000 Safety Program and its corresponding form 16-347 Monthly Safety & Sanitation Inspection, AEDs are inspected monthly by trained inspectors and local safety committee members. The status of the AED, to include maintenance of adequate adhesion during resuscitation efforts, is to be noted on the checklist and reported to the Health Services senior supervising nurse for those located in Health Services and/or inpatient units. Area supervisors are to be informed of any deficiencies noted during the inspections to ensure they are corrected and will be tracked until the correction occurs. Reviews, findings and completed actions will be documented in the meeting minutes, and routinely audited by local Health Services administration to ensure compliance.</p>
<p>Improving the communication between custody and health services staff who interact with people with mental health disorders, so</p>	<p>The department is presently piloting a new disciplinary process at Washington Corrections Center for Women (WCCW) in</p>

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<p>that:</p> <ul style="list-style-type: none"> a. An individual’s mental health status is considered throughout the disciplinary process, since many behaviors may be linked to a disability; and b. Mental health staff are promptly notified when people with significant disabilities are being infringed and sanctioned, losing privileges, and/or being confined. 	<p>Gig Harbor and the Monroe Correctional Complex-Special Offender Unit (MCC-SOU) for those people with a serious mental illness. The pilot includes review of all serious infractions by a person’s primary therapist. When indicated, the primary therapist will develop alternative sanction recommendations to address the behavior of concern. This pilot is modeled after a similar program in Oregon Department of Corrections.</p> <p>In addition, each hearings officer will receive additional training on identification of mental health symptoms that would prompt the hearings officer to make an immediate referral for services to a mental health provider.</p> <p>Interventions for these individuals are developed collaboratively between mental health, custody and classification staff. The collaboration includes modified sanction recommendations as well as interventions necessary if the infractions are dismissed. The Residential Treatment Units (RTU) each utilize a multidisciplinary team to review all patient needs. These teams include the correctional unit supervisor (CUS), classification counselors, sergeants and officers as available.</p>
<p>Clarifying the process of assigning PULHES S codes, for the benefit of staff responsible for making those assignments. Routine supervisory review and feedback to staff can ensure consistency and appropriateness of S code assignments.</p>	<p>The department’s mental health leadership team will develop a plan to address training and supervision of the assignment of S codes by May 30, 2021. Only trained mental health and psychiatry staff can assign S codes. Part of the onboarding of a new mental health staff person is to learn about the how to make determinations of S codes. The determination relies on professional judgement of a person’s functioning. The department’s mental health leadership will be reviewing the S Code thresholds to see if there are any updates needed and then have a refresher training with psychologist 4’s who will then refresh their</p>

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	staff. The department is working to put together a plan that will improve the reliability of S code assignments across the system.
Clarifying DOC 890.620 (Emergency Medical Treatment) so that AEDs are inspected at specific regular intervals.	Per policy 890.000 Safety Program and its corresponding form 16-347 Monthly Safety & Sanitation Inspection, AEDs are inspected monthly by trained inspectors and local safety committee members. At the next scheduled updating of policy 890.620 Emergency Medical Treatment, the department can consider whether the regular monthly interval should also be stated in policy 890.620.

The department recognizes that in person interviews with staff was impractical for this event due to COVID, but encourages the Office of the Corrections Ombudsman interview staff by alternative means when serious events occur to give a full picture of the department’s opportunities for growth or exemplary action that may occur.

In any case, suicide prevention is a top priority for the Washington Department of Corrections. The rate of suicide among incarcerated individuals in the Washington state correctional system in the three calendar years prior to 2019 as well as in calendar year 2020 are less than half the national rates, and Washington is among the states with the lowest suicide rates in state correctional facilities, according to the federal Bureau of Justice Statistics (BJS). Nonetheless, one death by suicide is too many. The Department continues to strive to implement new efforts and activities to further reduce the number with a target rate of zero. The information provided by the OCO was useful to ensure the Department of Corrections is doing everything it can to ensure an incarcerated person’s time in the agency’s facilities is a safe space for all incarcerated individuals.

We also appreciate your team’s understanding of the unique processes across the correctional system and the addition of policies and procedures being put in place to address them. We are working proactively to improving quality standards throughout the department. Moving forward, the Washington Department of Corrections will continue to collaborate with the Office of the Corrections Ombuds to strengthen procedures and practices that positively impact individuals’ health, safety and welfare.

Sincerely,

Julie Martin, Acting Secretary
 Washington Department of Corrections

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APPENDIX 1. Case Timeline, Patient A

- 7/26/2019 Intersystem/Restrictive Housing Mental Health Screening
- Form reflects “yes” response to question of whether Patient A had ever received therapy or medication for a mental health concern and/or suicide attempt. Reported 4-5 inpatient hospitalizations, with most recent one occurring three weeks earlier. Currently taking two psychotropic medications. Admitted to prior history of self-harm or suicidality, as recently as two weeks prior. Acknowledged a history of emotional, physical, and sexual abuse, and a history of methamphetamine use six months ago. PULHES S3 assigned.
- 7/28/2019 Request for Mental Health Assessment
- A correctional officer described “strange behaviors” as the reason for requesting a mental health assessment.
- 7/30/2019 Mental Health Appraisal
- PULHES code was upgraded to S4. Current suicide potential marked as moderate risk. Case was presented at Mental Health Transfer Teleconference, and approved for admission to a residential treatment unit.
- 7/30/2019 Negative Behavior Observation
- Told custody officer Patient A found a shampoo bottle with “snot in it.” The following day, Patient A was moved to COA and while packing up property the officer saw a shoe that held a shampoo bottle with something that looked like bodily fluid.
- 7/31/2019 History and Physical
- Exam indicates presence of suicidal thoughts, suicidal tendency, depression, anxiety, PTSD/trauma, and psychosis. There was a prior suicide attempt in 2017. Use of methamphetamine and alcohol was noted, with date of last use 5-7 months earlier. Currently taking two psychotropics. Routine labs were performed. Told to sign up for sick call and periodic physicals as needed and released to general population.
- 8/1/2019 Suicide Risk Assessment
- I/I was placed in COA on 8/1/2019 for “odd behavior.” Suicide Risk Assessment identified an overall estimate of suicide risk as being moderate. Case was discussed with treatment team; “at this time, [Patient A] is not presenting as a risk of self-harm or suicide.”
- 8/8/2019 Transferred to another facility COA. Released from COA on 8/12/2019.

- 8/20/2019 Negative Behavior Observation
Found with a rubber band around neck; the rubber band held the cell door key. Patient A was directed to remove it.
- 8/20/2019 Mental Health Safety Plan
Returned to COA after a self-harm event and exhibiting “bizarre behavior” on the unit. Released back to the unit on 8/27/2019.
- 8/27/2019 Infraction
During formal count, was found to be exposing genitalia and performing self-stimulation. Infraction issued for sexual harassment.
- 8/31/2019 Infraction
During random tier check, was found to be exposing genitalia and performing self-stimulation. Infraction issued for indecent exposure.
- 9/3/2019 Negative Behavior Observation
Found to have pants unzipped while on the way to medline; instructed to zip pants, and complied.
- 9/3/2019 Negative Behavior Observation
Found walking down the stairs and holding pants up with both hands; had not worn state-issued belt. The correctional officer indicated that this same circumstance was previously addressed, and Patient A was informed that an infraction would be issued if found not to be wearing a belt.
- 9/10/2019 Emergency Grievance
Filed an emergency grievance (dated 8/4/2019, but date has question mark above it) stating the following: “I have poor health and it is very unlikely I will live until my release date or if I do I would die the next week. How the (expletive) am I expected to just serve the program as if I’m on death row. This is ridiculous. I have guards telling me this is how I die or lying saying I should make it until my release date. This is unacceptable.” A response dated 9/16/2019 indicates that the emergency grievance was received on 9/10/2019; a rewrite was requested. ERD is noted to be 1/19/2020.
- 9/11/2019 Negative Behavior Observation
During formal count, found with genitals exposed. Directed to discontinue and get dressed, and complied. Informed that if the behavior continued, would be infracted.

- 9/14/2019 Infraction
- During a tier check, was found to be performing self-stimulation. Received an infraction for sexual harassment.
- 9/21/2019 Submitted a rewritten grievance: “My body is shutting down. Health issues are [illegible] all the time [illegible]. Please do not pretend you don’t understand. We are all dying. Even you are dying. But why should I have to die in jail if I’m not convicted of a death penalty crime.” Additional information was requested by the grievance coordinator in a response dated 9/24/2019.
- 9/22/2019 Declared medical emergency for nausea, abdominal pain, throat pain, and back pain. Nurse evaluated and felt it was not a medical emergency; told to sign up for sick call if symptoms increased or worsened.
- 9/25/2019 An injection of fluphenazine was administered.
- 10/2/2019 Declared a medical emergency for bleeding from rectum. Nurse evaluation did not find any abnormalities. Instructed to sign up for sick call to establish care with a provider.
- 10/3/2019 Sent a Kite noting that Patient A was supposed to go to sick call after the medical emergency the day prior. Tried to do this at 0835 on this date but was told it was too late. In a response dated 10/7/2019, instructed to request sick call at AM Medline.
- 10/4/2019 Infraction
- During a tier check, was found to be performing self-stimulation. Received an infraction for sexual harassment.
- 10/17/2019 Infraction
- Cell was found to be dirty; instructed to clean the cell, but the following day the cell continued to be dirty and in disarray.
- 10/23/2019 Negative Behavior Observation
- Did not attend chemical dependency treatment. Was informed to check the callout daily. The note indicates that multiple staff had previously spoken to Patient A on several occasions about importance of attending chemical dependency treatment and all callouts.
- 10/29/2019 Infraction
- During tier check, was found to be performing self-stimulation. When ordered to stop, Patient A threatened to kill the correctional officer. Was moved to administrative segregation for threatening and sexual harassment toward staff; released on 12/3/2019.

- 11/28/2019 There is a note referencing discussion with poison control regarding a recent injection, but the records provided by DOC did not include any additional information to explain the situation. Patient A was to have daily vital signs for thirty days; an EKG was ordered.
- 12/4/2019 Infraction
Found to have used sweatshirt to wipe feces. Received an infraction for placing feces in an unauthorized location, failing to maintain hygiene, and misusing property.
- 12/17/2019 Medical emergency was declared for self-harm. Found to have tied shoelaces around neck. Placed in COA and released on 12/23/2019.
- 12/30/2019 Infraction
Found in the dayroom while on a sanction for fifteen days of cell confinement. Received infraction for failing to comply with the sanction.
Received a second infraction when found in gym during sanction period; also found to have feces on sweatshirt.
- 1/1/2020 Found with a piece of towel in cell; admitted to have obtained the towel two days earlier, with the intention of self-harm. However, denied suicidality at the time, and remained on the unit.
- 1/10/2020 Attempted to strangle oneself with linens. Was described as presenting with psychiatric decline; noted to be playing with and eating feces. Moved to COA due to suicide attempt.
- 1/19/2020 Earned Release Date passed without release, due to several infractions.
- 1/22/2020 Released from COA.
- 1/23/2020 Attended a release planning group.
- 1/25/2020 Found lying on cell floor during formal count; two strips of cloth crafted from a towel were around neck. Code for non-responsive inmate was called at 2109. CPR was initiated by correctional officers, and resuscitative efforts were assisted by nursing staff when they arrived. 911 was initiated. Nursing staff initially said that the AED was not working properly, but later stated that it was functioning properly.¹⁶ Nurses who responded also did not seem to be aware of how to properly administer respirations, and required repositioning by custody staff.¹⁷ Once EMTs arrived (2123 per log), additional resuscitative efforts were administered and there

¹⁶ 2/26/2020 interview with custody staff.

¹⁷ 2/25/2020 interview with custody staff.

was return of spontaneous circulation. Patient A transported to the ER at 2139. Died on 1/28/2020.

3/10/2020 Critical Incident Review Report

Several suicide risk assessments were found to be absent from the medical chart. When asked about their absence, staff identified process issues including not being uploaded to SharePoint, not being placed into chart, and no consistent process for coverage when the staff supervisor was unavailable which resulted in delayed review/cosigning of documents. Staff was also unclear regarding the expectations for what to include in a PER note.

Although the typical process was to not release someone from COA back to the unit without a confidential in-person interview, CIR noted that there were no truly confidential settings in the COA to achieve this. Staffing issues also made it “nearly impossible” to get someone out of their cell for an assessment at certain times of the day.

CIR investigation determined that several policies were only partially followed. Although there was an initial treatment plan in the chart shortly after Patient A’s arrival on E-unit, there were no other treatment plans found, disrupting coordination of care. In addition, Suicide Risk Detection forms, Suicide Risk Assessment forms, and Mental Health Safety Plans were not reliably in the medical record.

APPENDIX 2. Case Timeline, Patient B

- 2/20/2020 Entered DOC system. On the day of intake, the medical department received information from the county jail confirming two previous suicide attempts in August and September 2019.
- 2/20/2020 Intersystem Intake Screening
Form indicates that he was on two psychotropic medications, one of which was DOC non-formulary. History of alcohol and drug use was reported.
- 2/20/2020 Intersystem/Restrictive Housing Mental Health Screening
Form indicates that he had received therapy or medication for a mental health concern and/or suicide attempt two weeks earlier. A history of 10 inpatient hospitalizations was reported, with the most recent in 2019. Denied prior suicide attempt; however, reported that voices had told him to hurt himself or someone else. Substance of choice was methamphetamine; reported last use of substances was in 2019. Appeared heavily sedated, disheveled, withdrawn/with flat affect. Assigned S code of 2 and R code of 1. Referred for routine mental health appraisal.
- 3/1/2020 Date of death
Found hanging in cell for an unknown amount of time. Pronounced deceased at 14:03.
- 3/3/2020 OMNI Medical Reporting of Offender Death
Unexpected death due to suicide by hanging. Although patient was prescribed psychiatric medications that were continued on admission to the facility, he had not been seen by a psychiatric or medical provider (other than the initial medical and MH screening by DOC nurses).
- 3/6/2020 Critical Incident Review report
Custody staff notified by another incarcerated individual who found him hanging from the cell door at 1327 on 3/1/2020; sheet knotted around neck.
Psychiatry staff indicates that an email notified him of I/I's suicide attempts. Felt that staffing is an issue due to volume of I/Is coming in as new admits.
Psychology staff indicates that based on his appearance (heavily sedated, disheveled, withdrawn) at intake, S code should have been a 3 which would have resulted in an evaluation sooner than 14 days, especially given that he was on two psychotropic medications. Summary from county jail was not read fully, so a Suicide Risk Detection form (13-526) was not completed. In addition, an appointment for a mental health assessment was scheduled for 2/28/2020 but was moved to 3/3/2020 due to scheduling conflicts with other staff.

Another Psychology staff member stated that he must process 40-70 intakes daily, and therefore only has time to scan jail summaries and check medications. He felt that the intake screening process was very rushed, with “the mindset of get them in and get them out.” He stated that the process was “not the best for patient care.” He felt it would be better if the intake screening could be completed after he was able to review the jail summaries in his office, so that he would not be rushed and forced to skim for information. At the time he completed the 13-349, he had information that highlighted two previous suicide attempts in the past four months but admitted that he did not review the document; he only reviewed the diagnostic section and looked at medications. He noted that the I/I was on psychiatric medications and wondered if he might be over-medicated because he seemed somewhat lethargic.

Psychiatry staff member reported having reviewed the summary sheet provided by the county jail, and sent an email referencing the I/Is medication management and two suicide attempts; asked for I/I to be scheduled for a brief assessment to negate one of his medications or whether he needed to have a mental health assessment first.

One incarcerated witness who lived in the cell next to the I/I stated that the I/I appeared “heavily medicated but ok overall.” When he noticed the body hanging, he called for help, but it took a few minutes for officers to arrive; “one officer come to the cell and said ‘ohh’ and left to get help.” Staff also could not figure out how to cut the I/I down; once they got him down, staff only performed chest compressions but were unwilling to provide mouth-to-mouth resuscitation, so the I/I did not receive any respirations until the nurses found an air bag.

Nursing staff spoke to other incarcerated individuals who had witnessed the suicide. One of them stated that he was there for 40 minutes and that he had reported it but “no one listened.” Pads for the AED came loose and were sliding down the patient during CPR. Staff did not feel they had support from other fellow nurses after the incident; no one asked if they were ok, and no one restocked the red emergency bag. Staff stated that medical did not hold an internal debrief after the incident.

Another nursing staff member felt that radio traffic during the emergency was not clear, and “staff were stepping on each other.” She acknowledged administering the wrong medication during the resuscitation attempt.

The CIR report stated that the I/I should have been assigned a PULHES S3 code (rather than S2) and a R2 code (rather than R1). Recommendations for improvement included review of the intake medical / mental health assessment and screening process; revision of a question in the 13-349 to be more clear regarding prior suicide attempt; changing consistency of tier checks (which appeared regimented based on movement times); and replacing the AED that had malfunctioning pads.