STATE OF WASHINGTON

OFFICE OF THE CORRECTIONS OMBUDS

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

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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 suicide of an individual incarcerated at the Monroe Correctional Complex. We appreciate the opportunity to raise concerns regarding suicide prevention measures and staff actions. We look forward to working with DOC to amend current policies and practices to better ensure that all incarcerated persons' health, safety, 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. All concerns 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

Joanna Carns
Director

cc: Governor Inslee

OCO INVESTIGATION CONDUCTED BY

CAROL SMITH, FORMER ASSISTANT OMBUDS HEALTH CARE SPECIALIST
REPORT PREPARED BY
PATRICIA H. DAVID MD MSPH CCHP, DIRECTOR OF PATIENT SAFETY AND PERFORMANCE REVIEW

Summary of Complaint/Concern

On July 10, 2019, the Office of the Corrections Ombuds (OCO) received a complaint, on behalf of a deceased incarcerated individual, which alleged the following:

- An incarcerated person's death by suicide at the Monroe Correctional Complex on March 9, 2019 resulted from staff failures to appropriately respond to multiple warning signs that the person was at heightened risk for suicide.

OCO Statutory 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.

OCO Investigative Actions

OCO was able to verify facts through medical documentation, video surveillance and interviews with staff and other incarcerated individuals. The OCO investigator reviewed the following:

- DOC policy 630.550 Suicide Prevention and Response, and Suicide Risk Assessments
- DOC 890.620 Emergency Medical Treatment
- DOC 610.650 Outpatient Services
- Washington DOC (Offender) Health Plan
- DOC patient medical records
- DOC video surveillance of the event
- DOC Critical Incident Review (CIR) Report
- DOC Root Cause Analysis and the DOC Corrective Action Plan (CAP)

Summary of Incident

The Incarcerated Individual was 38 years old when he arrived at DOC under violator status on March 6, 2019. At intake, he reported to DOC staff that he had attempted suicide twice previously, with the most recent occurring within the last two months. The following day, he informed his correctional counselor that he attempted suicide the night before, and voiced his ongoing desire to kill himself. This critical information was not clearly communicated to the mental health staff assigned to him. Furthermore, the mental health staff failed to properly evaluate the Incarcerated Individual, opting to converse with him at cell front rather than moving him to a private interview room to perform a thorough evaluation and Suicide Risk Assessment.

He complained of right eye pain on March 8, 2019 and was taken to the emergency department where tests did not reveal a clear source of his pain. On March 9, 2019 medical staff noticed a change in the Incarcerated Individual's baseline behavior but did not notify others. Throughout the day, custody staff, medical staff, and other incarcerated individuals observed the Incarcerated Individual screaming out in pain and asking for help. The Incarcerated Individual pushed his emergency call button[1] multiple times throughout the day, calling for medical support. Because he had already been evaluated in the ER, the RN on duty believed that there was nothing else that could be done for the Incarcerated Individual, and attempted to dissuade him from using the emergency call button by threatening him with a $4.00 copay if he continued.

Finally, the Incarcerated Individual pulled the emergency cord[2] out of the wall, initiating both a light and a continuous alarm. The CNA on duty approached a correctional officer regarding the alarm, but was told it would be handled later since it was shift change. The CNA silenced the alarm. Seventeen minutes later, staff observed the Incarcerated Individual hanging from that emergency cord. DOC staff subsequently initiated the facility emergency medical response, and the Incarcerated Individual was taken to the hospital. After 11 days on a ventilator, the Incarcerated Individual's family made the decision to remove him from life support and he passed away. His death was ruled a suicide.

Based on the information as outlined, OCO concludes that the care the Incarcerated Individual received at Monroe Correctional Complex did not meet community healthcare standards, and his death by suicide on March 9, 2019 was possibly preventable.

Timeline of Events

March 6, 2019 — The Incarcerated Individual is placed into the Monroe Correctional Complex (MCC) under violator status on March 6, 2019. A Violator Intake Screening form indicates that the Incarcerated Individual reported two prior

[1] The emergency call button is a red button located at the end of the emergency call system cord, which is attached to the wall. When this button is pushed, the nurses' station is notified with a "beep" and nurses use the intercom to communicate with the patient.

[2] This cord for the emergency call system is attached to the wall; when detached from the wall, it sets off a continuous beeping alarm that is different from the emergency call button, and a red flashing light appears above the cell door. This alarm cannot be shut off until the cord is plugged back into the wall.

suicide attempts – once by overdose, and once by hanging. He additionally reports a prior psychiatric hospitalization at Sacred Heart Hospital, and current prescriptions for Risperdal and Sertraline. The nurse does not assign an "R" code for suicidal risk.

March 7, 2019

The Incarcerated Individual meets with his classification counselor for a standard PREA (Prison Rape Elimination Act) screening. During this screening, he tells the classification counselor that he is "surprised he was awake," because he had tried to kill himself the night before. The Incarcerated Individual also expressed an ongoing desire to kill himself. This information is shared with the PhD Psychologist, who assigns a Psychology Associate to the Incarcerated Individual's case because the PhD Psychologist is busy with another incarcerated individual. (This Psychology Associate is not normally assigned to the violator unit, but is filling in due to a staff vacancy.)

The Psychology Associate approaches the Incarcerated Individual at cell front, where she finds him crying. They converse through the cuff port. The Incarcerated Individual reports that his wife (or girlfriend, by other reports) and daughter have left him, and he feels "hopeless." The Incarcerated Individual reportedly denies thoughts of self-harm, but reiterates the feeling of hopelessness. A Suicide Risk Assessment form is not completed. (The Psychology Associate would later state that she did not receive any information regarding the Incarcerated Individual's recent suicide attempt or ongoing desire to kill himself, and had never seen the Suicide Risk Assessment form until several weeks after his death.) The Psychology Associate believes that the Incarcerated Individual is "just a little sad," and makes no plan for further mental health follow-up. The Psychology Associate reports back to the PhD Psychologist that the Incarcerated Individual did not require close observation.

March 8, 2019

The Incarcerated Individual declares a medical emergency, complaining of right eye pain and describing it as "a balloon that wants to pop." He is initially sent to Providence-Everett, where he also gave a history of "blackouts" and described an episode prior to his incarceration when he "blacked out" while brushing his teeth and woke up on a stranger's front porch. CT of the head and neck were within normal limits.

He is subsequently sent to Harborview Medical Center for an ophthalmology evaluation. The ophthalmologist is unable to find a specific diagnosis for the right eye pain; medications are prescribed, and the Incarcerated Individual is instructed to return in two to four weeks for a repeat exam. Because the Incarcerated Individual was out of the facility for this evaluation, he is does not receive his evening dose of psychotropics.

March 9, 2019

The Incarcerated Individual returns to MCC in the very early hours and is admitted to the Inpatient Unit (IPU). Because other cells were full, the Incarcerated Individual is placed in a cell which has only a small observation window, and which contains an emergency call system cord and window blind cords (items not present in the other cells for violator patients). Around 0900, he reportedly makes some phone calls using a "rollaway" telephone. Around 1040, the Incarcerated Individual starts "screaming for [right] eye pain;" he was assessed by a RN who found no abnormalities on external observation. Toradol was given for pain relief. A correctional officer is told that the Incarcerated Individual was discharged from the IPU and would be returned to the violator unit during 3rd shift, but "not to tell him as he was causing issues."

Immediately after yard, the CNA notices that the Incarcerated Individual begins to make more frequent emergency calls using the call button. Throughout the day, correctional officers and other incarcerated individuals observe the Incarcerated Individual complaining of eye pain and asking for help. His complaints are relayed to nursing, but officers later describe the nursing staff as "annoyed" because the Incarcerated Individual had already gone to the ER "and he is fine." The RN tells the Incarcerated Individual that if he continues to push the emergency call button, he will be charged a $4.00 copay. Although a correctional officer reported that this RN performed a wellness check at 1300 in response to the Incarcerated Individual's call, there is no documentation of any wellness checks during the afternoon of 3/9/2019 in the records provided for review.

At 1400 the emergency call system cord is pulled from the wall, initiating a continuous alarm. The CNA on duty leaves the microphone open to silence the beeping, but the light remains on. At 1405 the CNA tells a correctional officer about the emergency alarm and says she needs to check on the Incarcerated Individual; the officer says he would take care of the light later because it is shift change. At 1414, two officers have a 20-second attempt to engage the Incarcerated Individual, who ignores them. At 1416 LPN walks down the hall with an officer who states, "We can't stop in the Incarcerated Individual's room." At 1417, on the way back, the LPN and officer find the Incarcerated Individual hanging by the emergency call cord.

DOC staff initiates the facility emergency medical response; a custody officer reports that that nursing "froze at first and they had to be asked by custody staff to move over so CPR could get started."

March 10, 2019

The Incarcerated Individual is resuscitated and sent to the ER. Upon arrival to the ER, the Incarcerated Individual is found to have a heartbeat but CT of the head shows diffuse brain swelling and evidence of other organ damage related to lack of oxygen. His prognosis is very poor.

March 21, 2020 The Incarcerated Individual's family decides to remove him from life support. He is pronounced dead at 1346.

Key Findings

- *Failure to recognize, evaluate, and manage clinical "red flags"*
    - Prior suicide attempts while in custody, previous psychiatric hospitalization, and use of psychotropics are potential indicators of suicide risk.[3] However, although the RN performing the Incarcerated Individual's intake documented his recent history of attempted suicide while in jail, history of previous psychiatric hospitalization, and current use of psychotropic medications, the RN did not take any further action such as notifying a mental health provider or assigning the Incarcerated Individual an "R" code that would have indicated a higher suicide risk and prompted a more comprehensive assessment.
    - On March 7, 2019 the Incarcerated Individual told his classification counselor that he was "surprised he was awake" because he had attempted suicide the prior evening. Despite knowing this information, the classification counselor did not ensure that the Incarcerated Individual was properly secured and under continuous observation.[4]
    - Upon arriving at cell front on March 7, 2019 the Psychology Associate found the Incarcerated Individual crying; the Incarcerated Individual explained that his wife and daughter had left him, and he described feeling "hopeless" on more than one occasion. Despite knowing this information, the Psychology Associate perform a thorough mental health assessment, and did not complete a Suicide Risk Assessment form.
    - On March 9, 2019, the CNA noticed a difference in the individual's behavior after his yard time and after making phone calls.[5] The CNA stated, "He was visually more upset and started making more emergency calls." No documentation exists that indicates that she notified additional staff regarding this change in his baseline behavior.[6]

[3] Marzano, Lisa, et. al. Prevention of Suicidal Behavior in Prison. Accessed at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5120691/.
[4] DOC Policy 630.550 states, "Employees/contractors who suspect that an offender may be suicidal or self-injurious should immediately alert his/her supervisor and take precautions to prevent any attempt at self-injury, including continuous observation of the offender until further steps are taken."
[5] DOC staff later reviewed all phone calls and could not find that the individual had made any calls to his wife on this day. However, multiple staff believed that he had made these calls and received distressing information and therefore that information should have factored into their assessment and actions.
[6] The CNA asserts that she verbally notified both the RN and mental health staff. She reportedly was not aware and was not trained on a more formal method of documenting such issues other than verbal notification.

- *Failure of communication between staff*
    - Although the classification counselor stated that he immediately shared the Incarcerated Individual's very recent suicide attempt and ongoing desire to end his life with the PhD Psychologist on March 7, 2019, this information was allegedly not relayed to the Psychology Associate assigned to the Incarcerated Individual's case.
    - In addition, the information regarding the Incarcerated Individual's very recent suicide attempt and his ongoing desire to end his life was not relayed to the medical or custody staff taking care of the Incarcerated Individual.
    - Medical documents for the violator population are maintained in red folders (in contrast to the large blue binders that contain medical information for those incarcerated in the prison). Every time a violator enters the facility, a new red folder is created, and information from prior violations is not always included in the new folder. In addition, the red folders remain in the violator unit, so the Incarcerated Individual's red folder did not follow him to the IPU. Therefore, the mental health intake screening that contained information about the Incarcerated Individual's prior suicide attempt was not available to IPU staff.

- *Failure of communication between patient and staff*
    - The Psychology Associate assessed the Incarcerated Individual through a cell front window on March 7, 2019. A cell front meeting through the glass is not considered a proper screening for suicide risk, nor is it supported or recognized as a standard of care by correctional mental health professionals.
    - In response to the Incarcerated Individual's repeated emergency calls on March 9, 2019, the RN on duty threatened to charge him a $4.00 copay if he continued. The RN's rationale was that the Incarcerated Individual had already been evaluated at the hospital for eye pain. However, since eye pain can be a manifestation of a variety of diagnoses, and since diagnoses can change over time, the more appropriate response for a nurse would be to contact the practitioner on call and allow them to determine whether an additional evaluation was indicated or, at the very least, to provide the Incarcerated Individual with adequate pain relief.[7]
    - Custody staff described the Incarcerated Individual as "complaining," and nursing staff were "annoyed" at the Incarcerated Individual's repeated requests for help. There was also a plan to release the Incarcerated Individual from IPU back to the violator unit, but custody staff were instructed "not to tell him as he was causing issues." This lack of compassion and purposeful withholding of information reflects a culture that may have contributed to the cursory responses to the Incarcerated Individual's emergency calls.

[7] WAC 137-91-010 and the Washington DOC Health Plan (Offender Health Plan) outlines medically necessary care, and includes reduction of intractable pain.

- This investigation also revealed that staff was instructing the incarcerated population to use the emergency call button for non-emergent needs such as needing toilet paper. This directive is not an appropriate use of the emergency call system, and may contribute to alarms not being taken seriously.

- *Additional concerns*
  - The CIR report indicates that one sergeant reviews all incident reports and has sentences removed from the report because he wanted to make sure that the incident report "does not shed negative light on the Department of Corrections." OCO does not have any evidence of this action occurring in this case, but it is important to note since it was documented in the CIR report. This practice of editing of incident reports risks the integrity of the information reported.
  - The CIR report indicated that the rescue tool was not available on the floor of the unit where the Incarcerated Individual was housed. DOC staff indicated that this did not negatively impact or extend the amount of time that it took staff to release the noose from the Incarcerated Individual, but it is important to note as it may have caused a delay in other circumstances.

Outcomes

- On March 27, 2019, the WSRU Captain issued a memo to require the following:
  - If an incarcerated individual housed on the IPU pushes the call button, it will initiate an alert in the nurses station and the nurse will immediately contact the patient via the intercom.
  - When the call cord is pulled, nursing staff and custody must respond to the room immediately to assess the situation. When the situation is under control, staff will reattach the call cord into the wall and press the cancel button to reset the alarm. At no time will the alarm be silenced from the nursing station.

Recommendations

- **Develop formal policies and protocols specific to the care for those entering DOC on violations.** These will help eliminate gaps in the delivery of quality care and clinical oversight. Include enhanced suicide prevention measures found in jail settings,[8] such as implementing a brief suicide screening at each point where the violator comes in contact with a staff member. In addition, developing and maintaining an organized record-keeping process is necessary to ensure clear communication and continuity of care across disciplines.

[8] See work of Chief Corrections Deputy Ric Bishop, Clark County Sheriff's Office, Vancouver WA.

- **Consider adopting a collaborative care approach for patients with medical and mental health diagnoses.** There is substantial evidence base for the effectiveness of a collaborative care model in improving outcomes. Holding multidisciplinary conferences involving medical, mental health, and nursing staff will require an innovative approach for the violator population, since some violators leave the system within a matter of days.

- **Combat compassion fatigue.** OCO believes this is an **urgent** need at DOC. The Incarcerated Individual's case demonstrates a recurring finding from other OCO investigations and incident reviews: a diminished ability of many DOC staff – at the facilities and at the Headquarters level – to empathize or feel compassion for the incarcerated individuals in their care. DOC should provide training for staff on ways to manage compassion fatigue. DOC should also prioritize the filling of all vacant positions with qualified employee or contract staff, to avoid excessive overtime or the need to use less experienced staff for cross-coverage.

- **Develop additional methods and resources to reduce the risk of suicide in the incarcerated population.** DOC should review the overall therapeutic environment for all patients, particularly those at risk for suicide. Suicidal patients need to be surrounded by caring, empathetic staff who respond in a trauma-informed manner. DOC should consider using other incarcerated individuals as peer support to help with feelings of isolation. Providing books, a tablet, or other mentally-distracting activities may assist in redirecting a person's thoughts.

- **Provide training to mental health, medical, nursing, and custody staff to understand suicide risk.** Include refresher training on DOC 630.550 Suicide Prevention Response and Suicide Risk Assessments. Intake nursing staff should also be educated on the assignment of initial mental health PULHES "S" codes and suicidal risk "R" codes per DOC 610.640 Health Screenings and Assessments[9]. "S" codes must no longer be down-coded due to housing limitations.

- **Revise DOC policy to require the elevation of persistent declaration of medical emergencies by the incarcerated individual to the facility medical practitioner on duty for additional accountability and oversight.**

- **Change the emergency call system to modify or eliminate cords**. More than 70% of inpatient suicides occur by hanging[10], which increases the potential danger posed by emergency pull cords.

- **Ensure ready access to rescue tools in the officer booth on each floor.**

[9] Per DOC 610.640, "initial mental health PULHES "S" and suicidal risk "R" codes will be assigned. Patients with emergent needs will receive clinical follow-up."
[10] Williams SC, Schmaltz SP, Castro GM, Baker DW. (2018) Incidence and Method of Suicide in Hospitals in the United States. *The Joint Commission Journal on Quality and Patient Safety*, *44,* 11, 643-650.