STATE OF WASHINGTON
OFFICE OF THE CORRECTIONS OMBUDS
PO Box 43113 • Olympia, Washington 98504-3113 • (360) 664-4749

November 15, 2019

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 death of an individual incarcerated at the Monroe Correctional Complex. We appreciate the opportunity to raise concerns regarding the medical treatment that the individual received, the lack of response to his grievances regarding his medical treatment, and the need for improved staff training. 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
Director

cc: Governor Inslee

OCO INVESTIGATION
INVESTIGATION CONDUCTED BY MATTHIAS GYDÉ, ASSISTANT OMBUDS – EASTERN DIVISION

Summary of Complaint/Concern

On March 18, 2019, the Office of the Corrections Ombuds (OCO) received a complaint, on behalf of the incarcerated individual involved, which alleged the following:

- The complainant alleged that his friend reported to medical at Monroe Correctional Complex (MCC) when he was feeling ill and a lump was discovered in his breast. He further alleged that it took months of pushback by his friend to get an appointment to address the lump, get a biopsy, or biopsy results. Further, when the incarcerated friend was finally seen by an oncologist he was told to he needed to start chemotherapy immediately. Two months later his friend collapsed in his cell and learned that the cancer had spread. No cancer care had been provided by DOC. The incarcerated person has since passed.

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 offenders, 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 inmates' health, safety, welfare, and rights.

OCO Investigative Actions

- As part of this investigation, OCO reviewed DOC policy outlining cancer care for incarcerated persons as outlined in the Offender Health Plan. OCO also reviewed related grievances, supporting documents and contacted incarcerated individuals, DOC staff, and external providers.

OCO Findings

This report will be broken into sections addressing the following concerns: (1) delay in medical care; (2) grievance procedure failures and issues with medical kites; (3) staff confusion regarding DOC policies and procedures; (4) poor documentation; and (5) staff accountability. OCO was able to verify, through documentation and interviews, the following:

Delay in Medical Care

The allegation of delayed treatment for the discovered lump was substantiated by OCO.

- When the lump was discovered by a Registered Nurse (RN) at an unrelated medical appointment in March 2018, no action was taken to address the lump past the notification of the discovery to higher level staff. Those individuals notified also took no action. The patient was not seen by medical staff to address the lump for two more months when he signed up to be seen for sick call and was evaluated by a Licensed Practical Nurse (LPN).

- Three months after the lump was discovered and one month after the patient was seen by an LPN to address the lump, the patient is seen for the first time by a Physician Assistant Certified (PA-C) regarding the lump in June 2018. The PA-C identifies urgent needs at this visit relating to mammography and ultrasound of the lump. It takes another month for these "urgent" needs to be satisfied. A recommendation for an ultrasound guided core biopsy is recommended as a result of these diagnostic procedures. It is another month before this biopsy is done.

- The guided core biopsy takes place in August 2018, and identifies an invasive carcinoma and recommends surgical and oncological follow-up. The report notes that DOC staff have been notified and DOC reports that they will arrange the surgical and oncological follow-up. This report is not signed as received by DOC medical staff for fifteen days. The surgical follow-up was never scheduled but the oncology consultation takes place twenty-seven days later.

- Following the guided core biopsy, an Emergency Consultation Request/Report is submitted asking for a CT scan with contrast of chest, abdomen, and pelvis in August 2018. This "emergency" request was not approved by the Facility Medical Director for ten days and it will be a further 60 days before the procedure is done.

- Thirteen days after the cancer has been identified through the biopsy in August, the patient reports to medical on an unrelated complaint. It is noted at this visit that the patient has not been informed that he has cancer. The attending provider informs him of his diagnosis at this visit.

- Upon seeing an oncologist for consultation in August 2018, almost six months after the lump was discovered, the patient is diagnosed with advanced breast cancer and makes the following recommendations for follow-up and treatment:

    - Complete staging work-up, CT scan of chest, abdomen, pelvis, a brain MRI, and a bone scan.
    - Port-placement for chemotherapy
    - Refer to surgeon and radiation oncologist
    - Genetic counseling
    - Start chemotherapy ASAP

- DOC took the following actions on the oncologist's recommendations:
    - The staging work-up was done
    - The CT and bone scan were done two months after the consultation recommendation.

- DOC did not take action on the following recommendations:
  - Brain MRI
  - Port-placement
  - Surgical and radiation oncologist consult
  - Genetic counseling
  - Chemotherapy

  Upon interviewing the external oncologist who assessed the patient, OCO learned that if the patient had been treated promptly and prior to the oncological consultation almost six months after discovery of the lump, his life expectancy would likely have been extended. This incarcerated individual had an earned release date of December 2020.

- Eight months after the lump was discovered, and almost three months after the oncologist recommends treatment ASAP, no treatment has been done. At this time the patient signs a Do Not Attempt Resuscitation order and requests comfort measures only.

- The patient expires in June 2019, fifteen months after the lump was discovered having never been treated.

Grievance Procedure Failures and Issues with Medical Kites

The following section quotes grievances and kites that were sent by the patient to the grievance coordinator and medical, respectively. No action was taken on any of the grievances or the kite other than they were all returned to the patient and subsequently administratively withdrawn.

- Two months after the discovery of the lump, the incarcerated individual filed a grievance stating: "I need to see a provider. I have signed up 5 times, wrote one kite, went to sick call where the nurse felt the lump in my breast and told me that I would surely see a provider but still nothing on the call outs. This has been going on for 6 months now and I feel that I have been very patient, could you please help me. Thank you." The grievance coordinator's response was, "The grievance program has a 20 working day timeline for this, dates are required. When (date) did you sign up to be seen? Did you sign up right outside medical on the clipboard?" The grievance was returned to the incarcerated individual to be rewritten and the grievance was administratively withdrawn when a rewrite was not received within the requested timeframe of 7 days.

- Three months after filing the above grievance the patient sends a kite to medical on an unrelated complaint. This kite is signed and returned, with no action taken, by a medical assistant.

- Seven months after the discovery of the lump, the incarcerated individual files a grievance stating: "Have not received or heard any results from the taking of water off my knee, in order to find out if I have an infection or start chemo immediately. I do not have long to live according to an outside specialist who is the fourth leading cancer doctor in the world. He told me I needed to start chemo aggressively right away or would

not live nine months. This was 2 months ago. What is taking so long?" The grievance coordinator's response was, "When (date) did you last request this info? "2 months" ago is past established grievance timeline of 20 working days. Did you talk to your provider recently or request info? Who/when, please." This grievance was sent back to the incarcerated individual to be rewritten and was administratively withdrawn when no rewrite was received within the allotted timeframe of 7 days.

- At the end of the same month as the grievance above, the incarcerated individual files another grievance stating: "The oncologist told me on Aug. 22nd, 2018 that I needed to start aggressive chemotherapy ASAP and said he would schedule me for the following week. This was now seven weeks ago, almost two months and I have not been given any reasons for the delay. I am dying, what is holding up my treatment that will save my life?" The grievance coordinator replied with, "You must date and sign complaints. Rewrite requested-sign and date. Also this appears to be past timelines of past 20 work days. Have you attempted to contact medical via kite, kiosk, or in person for an appointment scheduling? If not, please do so, then if no response or you disagree with response, send new complaint." This grievance was sent back for a rewrite and was administratively withdrawn when a rewrite wasn't received within the allotted timeframe of 7 days.

OCO views the above communications with DOC staff to be failures of the established process by which incarcerated individuals may reach out for help. DOC staff rejected these communications and none of the recipients took any action to indicate that the content of the communications was important.

Staff Confusion Regarding DOC Policies and Procedures

Throughout the interviews conducted by OCO, staff were asked about the policies and procedures governing certain issues. It became clear to OCO that there is confusion about these amongst staff, as the same questions about the same issues would solicit conflicting answers. Below are the areas on which OCO identified confusion.

- When asked what the procedure for notifying the on-call provider on weekends and afterhours was, OCO received varying answers. Some staff thought it was to be done through a chart note, others thought it was to be done through a phone call, and others thought it was to be done via email.

- When asked whose responsibility it was to take action when a suspicious lump or lesion is discovered, the answers were just as varied. Some staff thought it was the patient's responsibility to sign up for sick call to address it, some staff thought it was the staff's responsibility to ask the medical assistant to schedule a follow-up appointment, while other staff thought they were to notify the provider above them and it was then that provider's responsibility to follow-up.

- There appears to be a general lack of knowledge amongst DOC staff as to how follow-up appointments are made. Several medical staff stated that a "scheduler" sets all

appointments. When asked what that process entails, no staff could give an answer past notifying the medical assistant that a follow-up is needed.

Poor Documentation

- It was noted by OCO that throughout the medical record when orders were received by outside providers they receive a signature and/or an initial from a DOC staff member to signify the receipt of these orders. There does not appear to be any system in place whereby the reviewing provider actually makes a note that they have received, reviewed, or acted upon the orders. In fact, at least two staff members interviewed stated that they are often asked to initial something and they do so as a matter of routine, as the policy requires a signature or initial, but they do not necessarily read and or respond to what they are signing. This has led to a system wherein it is not possible to look at orders or reports from outside providers and know if anything has been done with them beyond them being signed or initialed.

- As noted earlier, a medical assistant responded to the complainant's kite without taking action and without any indication that a higher level medical provider reviewed the concern or was otherwise made aware of it.

- There is a note in the patients chart stating "the patient is expected to start chemotherapy this week." OCO could find no documentation to support this statement in the medical record. A port was never placed as recommended by the oncologist, and OCO could find nowhere in the patient record where he was offered chemotherapy by DOC. When asked where this conclusion came from, the staff member could not recall why they had written that, other than to say if they wrote it then it must have been scheduled.

- In the medical note from the patient's visit to address the lump, the nurse writes, "…appointment made to see provider." Upon interviewing the nurse they stated that they had no idea if an appointment was actually made or not, only that they asked the medical assistant to make one. If no appointment had been scheduled when the nurse made the chart entry, the chart should not reflect that an appointment was made.

- On the report that was generated from the guided core biopsy, the provider recommends surgical and oncologic follow-up and notes that no follow-up consultations have been arranged. As mentioned earlier, these types of documents require nothing more than a signature so there is no way of knowing if these were acted upon other than looking back on what did and did not eventually take place.

- OCO learned from the oncologist that he was notified four months after his consultation with the patient that the patient had refused chemotherapy. There is no note anywhere in the patient chart that indicates the oncologist was ever contacted again after the initial consultation, nor is there anything in the record indicating that the patient was offered chemotherapy. There is a note stating that the patient asks for comfort measures only, but this is not the same thing. Medical records are legal documents and are not intended to be left up to interpretation or inference.

Staff Accountability

- At the time of OCO's meeting with DOC to review the contents of this report, no DOC staff had been investigated or disciplined for their part in the complainant's lack of care and subsequent death. Further, no reports had been made to any external entities, such as the Department of Health or the Medical Commission. Last, the DOC mortality review of the complainant's case did not identify any areas for investigation or discipline.

Outcomes

- DOC implemented a policy by which no grievance that pertains to a medical complaint can be sent back to the incarcerated individual for a re-write or other clarification without the approval of an Associate Superintendent.

Recommendations

- DOC should implement a clear policy and procedure regarding how staff are to follow-up with a patient when a suspicious lump or lesion is discovered or otherwise brought to their attention.

- DOC should implement a clear policy and procedure that addresses specifically how and in what timeframe urgent and emergency requests are to be addressed and acted upon.

- DOC should establish a practice and policy on notifying patients about diagnostic and test results in a timely manner.

- DOC should re-examine their policies as they pertain to acting upon external providers and specialists recommendations for care. If recommendations for care are going to be ignored or altered, an explanation of why the recommendations are not being acted upon should be put into the patient's chart.

- DOC should clearly define and document what issues medical assistants are allowed to review in kites, under what circumstances a medical assistant must confer with a more qualified provider, and a system by which it is clearly documented that a medical assistant has consulted with a provider before responding.

- DOC should immediately begin a re-training program for medical staff to refresh them on the policies and procedures that govern their work. Specifically, how on-call providers are to be notified when needed, how follow-up appointments are made and who is responsible for making them, and what their responsibilities are regarding addressing suspicious lumps and lesions.

- DOC should implement a policy whereby every interaction with a patient is noted in the patient chart with a narrative, every outside consultation and/or recommendation for

treatment is noted in the patient chart with a narrative, and every action or inaction on external recommendations is noted in the patient chart with a narrative.

- DOC should provide ultrasounds on site at their facilities as they do x-rays, to expedite the evaluation of soft tissue.

- DOC should reevaluate whether any staff involved in the chain of care for the complainant should be investigated for failure to provide care or appropriately respond in a timely manner.

DOC RESPONSE*

*The full DOC response with attachments is provided on OCO's website.

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
P.O. Box 41100 • Olympia, Washington 98504-1110

December 13, 2019

Joanna Carns
Office of Corrections Ombuds
PO Box 43113
Olympia, WA 98504

Dear Ms. Carns:

The Washington Department of Corrections appreciates the opportunity to respond to the investigation into the 'death of an individual incarcerated at the Monroe Correctional Complex' completed by the Office of Corrections Ombuds on November 15, 2019.

Recommendations	Response
DOC should implement a clear policy and procedure regarding how staff are to follow-up with a patient when a suspicious lump or lesion is discovered or otherwise brought to their attention.	The Department of Corrections (DOC) Health Services Division has conducted training for nursing staff to ensure patient(s) with a suspicious lump or lesion (or other concerning condition) are referred to the patient's assigned practitioner by completing an electronic patient encounter (OMNI-HS) with an urgent internal referral as part of their nursing assessment documentation. This expectation was reinforced on 9/18/19 at the statewide Nursing meeting. The DOC Chief Nursing Officer has been assigned the task to reinforce this 'internal referral' expectation through nursing educator training and facility site visits by 2/1/20. DOC HS is developing an ongoing "checks and balances" system whereby the scheduler, clinic manager and clinical leadership review all urgent referrals to ensure timely appointments. In support of practitioners, the HS Division maintains a contract with UpToDate, an electronic clinical resource tool for physicians and clinical staff, and has recently expanded that subscription to include UpToDate *Advanced*. This expanded access provides an interactive clinical decision making resource,

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	including an extensive library of evidence based clinical pathways for treating health conditions, including suspicious masses or lesions.
DOC should implement a clear policy and procedure that addresses specifically how and in what timeframe urgent and emergency requests are to be addressed and acted upon.	DOC is revising policy 610.650 Outpatient Services to include definitions to the words emergent, urgent and routine to include time frames modeled after NCCHC best practices. A memo from the Health Services Assistant Secretary detailing these procedural and policy changes has been distributed to staff on December 13, 2019.
DOC should establish a practice and policy on notifying patients about diagnostic and test results in a timely manner.	DOC is revising policy 610.650 Outpatient Services to reflect time lines and reporting requirements for diagnostic testing results. A PER note is required for actions taken and initialed or signed by the practitioner to be included in the patient's medical record. The Offender Health Plan (OHP) has also been revised to require diagnostic and test results be addressed in a specified time frame and notification to the patient about diagnostic test results in-person and in a timely manner. Once these revisions have been adopted the OHP will be distributed by the Health Services Assistant Secretary and training implemented during the DOC Health Services spring 2020 conference. A memo from the Health Services Assistant Secretary detailing the policy changes has been distributed to all health services staff on December 13, 2019.
DOC should re-examine their policies as they pertain to acting upon external providers and specialists recommendations for care. If recommendations for care are going to be ignored or altered, an explanation of why the recommendations are not being acted upon should be put into the patient's chart.	DOC has revised the Offender Health Plan (OHP) to reflect the requirement of documentation when a medical practitioner reviews documents related to the care of an incarcerated individual. If the practitioner decides to pursue a specific treatment plan over another, the OHP has been revised to include the expectation that the provider will explain the reasoning in person to the incarcerated individual and document the

	rationale and the patient encounter in the patient's medical record. A memo from the Health Services Assistant Secretary detailing these procedural and policy changes and the OHP revisions has been distributed to all health services staff on December 13, 2019.
DOC should clearly define and document what issues medical assistants are allowed to review in kites, under what circumstances a medical assistant must confer with a more qualified provider, and a system by which it is clearly documented that a medical assistant has consulted with a provider before responding.	DOC is revising policy 610.650 Outpatient Services to reflect verbiage that medical kites are sent to "appropriate Health Services Staff for review and response". A memo from the Health Services Assistant Secretary detailing these procedural and policy changes has been distributed to all health services staff on December 13, 2019.
DOC should immediately begin a re-training program for medical staff to refresh them on the policies and procedures that govern their work. Specifically, how on-call providers are to be notified when needed, how follow-up appointments are made and who is responsible for making them, and what their responsibilities are regarding addressing suspicious lumps and lesions.	The Chief Medical Officer (CMO) is providing training to all medical practitioners on the Offender Health Plan and all policy updates at their scheduled training in March 2020.
DOC should implement a policy whereby every interaction with a patient is noted in the patient chart with a narrative, every outside consultation and/or recommendation for treatment is noted in the patient chart with a narrative, and every action or inaction on external recommendations is noted in the patient chart with a narrative.	DOC Clinical Providers shall follow policy 640.020 Section II., A. and C. which identifies patient-specific clinical information required, including provider orders, following any patient interaction. The CMO has forwarded a reminder to the facility medical directors to reinforce this policy requirement on December 13, 2019.
DOC should provide ultrasounds on site at their facilities as they do x-rays, to expedite the evaluation of soft tissue.	As an agency our practice is to send emergent and urgent ultrasound needs immediately out for ultrasound services at a hospital facility in the surrounding area. For needs that are not emergent or urgent, we have contracted with a statewide ultrasound vendor service who are available to come into the facility to perform routine ultrasound services. Notification to all health services staff informing them of this onsite service was issued via email on 11/20/19.
DOC should reevaluate whether any staff involved in the chain of care for the	The Facility Medical Director has enhanced clinical oversight of all advanced care

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complainant should be investigated for failure to provide care or appropriately respond in a timely manner.	practitioners at MCC and has formulated corrective action plans for those involved in this case. Also, the Mortality Review identified significant process failures that are under immediate address with the HS team at MCC under the direction of the new Health Services Administrator over MCC. The primary provider for this patient has resigned from state employment. Health Services administrative staff are engaged in Patient Safety Review Committees, both at Headquarters and at the facility level. The Mortality Review Committee (MRC) also will engage the Headquarter Administrator regarding the concerned facility. Administrators will determine if extreme departure of care warrants an investigation into DOC Staff.

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 safe and supports the health and wellbeing for all incarcerated individuals.

We also appreciate your team's understanding of the unique processes across facilities and the addition of policies and procedures being put in place to address them. We are working towards proactivity and improving quality assurance processes throughout the department. Moving forward, Washington Department of Corrections will continue to collaborate with the Office of the Corrections Ombuds to implement additional policies, procedures, and security measures to continue to improve the facility operations.

Sincerely,

Steve Sinclair, Secretary
Washington Department of Corrections