OCO DEATH REVIEW
CONDUCTED BY PATRICIA H. DAVID MD MSPH CCHP,
DIRECTOR OF PATIENT SAFETY AND PERFORMANCE REVIEW

Summary of Complaint/Concern

On May 17, 2019 the Office of the Corrections Ombuds (OCO) received a complaint on behalf of a deceased incarcerated individual (I/I), which alleged the following:

- The complainant alleged that the I/I reported having a severe and persistent headache which did not resolve with medications. The complainant further alleged that the I/I continued to deteriorate, but received no medical care for her medical emergency until it was too late.

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 Review Process

As part of this review, OCO reviewed the medical chart, DOC Policies 600.000 Health Services Management, 610.040 Health Screenings and Assessments, 610.650 Outpatient Services, 890.620 Emergency Medical Treatment, and the Offender Health Plan. In addition, OCO also reviewed DOC internal correspondence, incident reports, and Incident Management Response System Report #16-42939.

Timeline

1/15/2016	I/I declared a medical emergency for sudden-onset neck and head pain after an altercation with another incarcerated individual. Blood pressure was 160/100 and headache severity was "8/10." Pain medicine was given. An hour later, blood pressure was 131/85, and she was released back to her unit. The nurse practitioner later prescribed Clonidine "for acute anxiety/agitation."
1/18/2016	I/I sent a Kite to the physician assistant reporting a "migraine" since Friday; "maybe see me." A response on 1/19/2016 was "Ok – watch callout please."

1/19/2016 I/I was seen by a nurse – not the physician assistant– for right-sided migraine; she also reported her leg and arm were going numb since the last medical emergency. The plan was to "flag for provider review." The nurse wrote, "Offender worried that something's wrong."

1/21/2016 I/I sent a Kite to mental health, reporting that she had an episode of high blood pressure on 1/15/2016 and continued to have a "migraine" on the right side. She had been weaning off Effexor, and requested an appointment. The nurse practitioner responded on 1/24/2016: "Does the clonidine help?"

1/22/2016 I/I was evaluated by a UW nurse practitioner student, under the supervision of the physician assistant. She gave history of sudden headache on 1/15/2016 that felt "like something broke in my neck;" she described a pulsating headache on the right side of the head, with lightheadedness, nausea, blurred vision in the right eye, weakness in the legs, and difficulty walking. On exam, there were no abnormalities noted, although no visual acuity is documented. The nurse practitioner student appeared to associate the headache with caffeine intake. She was to return for persistent or worsening symptoms.

3/6/2016 2101: I/I declared a medical emergency for a headache that was 10/10 in severity; she described a shooting pain on the right side of the head and neck. The MCCCW nurse noted a blood pressure of 168/108. She was seen by the nurse and treated with medications for pain and vomiting. The nurse cleared her for return to the unit despite documentation that the I/I stated "I can't walk, I need [a wheelchair], my head still hurts." There is also no evidence that a follow-up blood pressure reading was obtained before returning her to the unit.

2232: A correctional officer called the nurse stating that the I/I was having a hard time standing, and that she had fallen out of her lower bunk. According to an incident report, they had initially found the I/I unresponsive, but she eventually responded with incoherent sounds and grunts. The nurse replied that it was due to the medication, and instructed the officer "to keep an eye on her and that she was going to WCCW for medical in the morning."

2311: According to an incident report, another incarcerated individual reported to correctional officer that the I/I was having a seizure. The correctional officer observed the I/I as "making random squirmy full-body movements and smacking the side of her face and the side of her thigh." Two correctional officers entered the room and found the I/I to be slow to respond to questions. The physician assistant was notified; rather than sending her immediately to the ER, the physician assistant ordered the I/I to be transferred to WCCW.

At 2325, the WCCW nurse received a phone call from the physician assistant instructing the nurse to admit the I/I to IPU for observation, perform vitals with mental status and neuro check, and perform a urine toxicology screening. An incident report by the WCCW nurse indicates that the I/I arrived at WCCW IPU

at 0033 hours, and that the correctional officers reported the I/I as "thrashing" in the back of the car and vomiting. Vital signs were abnormal, and the I/I was found to be "extremely groggy and incoherent" and incontinent of bladder and bowel. The nurse called the physician assistant to request that the I/I be sent to the hospital. A 911 call from the IPU did not go through; a 911 call by Master Control also did not go through. 911 was finally contacted by cell phone. By the time EMT arrived, the I/I was completely unable to respond.

3/7/2016 At the emergency department, the chief complaint was "possible [overdose], decreased loss of consciousness." However, the ER physician was concerned about a possible brain injury, and obtained a CT which showed a large brain hemorrhage and an aneurysm. The I/I was transferred to St. Joseph's Hospital, where she underwent two intracranial surgical procedures to stop the bleeding and decrease the pressure on her brain. Despite these efforts, the I/I remained critically ill.

3/7/2016 A report by an IT staff indicates that phone routing was affected by an ongoing issue with the phone service. 911 service was restored, and both Control and IPU could once again dial 911. There was a plan for utilizing a cell phone as standard backup, in the event that 911 service became unavailable through the regular phones.

3/8/2016 There is an email written by a headquarters nurse to the physician assistant, in reference to the Incident Management Response System (IMRS) report regarding the I/I. The email states, "This sounds a little off to me with regards to the nursing response and role. Am I being too suspicious or just missing important additional information?" The physician assistant replied, "She did call me initially but I was unaware of the rest of it until Sgt. Everitt called me."

3/9/2016 Email from the assistant secretary indicates that there were "some concerns with the initial medical response so we have coordinated a medical fact finding with HQ Health Services who is reviewing the situation." OCO requested a copy of this report on 6/25/2019 but a response was not received.

3/14/2016 The I/I was taken off life support in the presence of family, and was pronounced dead at 2045. She died eight days short of her 47th birthday.

4/3/2016 In a memo to the superintendent, a sergeant documented a conversation with one of the correctional officers, who was "genuinely concerned when this incident happened at the response" by the nurse at MCCCW. The correctional officer felt as though she took the lead in administering first aid to the I/I. The correctional officer also reported that the nurse did not want "to break the seal on the medical kit during a medical emergency," and that the nurse told EMTs "under normal circumstances, she would not have called 911." The correctional officer expressed concerns that "if a staff member has health issues on shift they will not

be appropriately taken care of" and that "she did not want [the MCCCW nurse] to respond to her if she was in medical trouble."

Summary

The I/I developed a severe headache on 1/15/2016, which was severe enough that she declared a medical emergency. According to the records, the headache persisted and evolved to include numbness and weakness in the extremities, blurred vision, and difficulty walking; however, she never underwent a comprehensive evaluation by a physician or advanced practitioner. When she declared another medical emergency for headache on 3/6/2016, she should have been immediately sent to the emergency room, given the elevated blood pressure and reports of her being minimally responsive after falling out of bed. The I/I ultimately was found to have a subarachnoid hemorrhage (bleeding in the brain) from a ruptured aneurysm (localized enlargement of an artery). She died on 3/14/2016.

OCO concludes that the care the I/I received at the MCCCW did not meet community healthcare standards, and her death could have been prevented.

Key Findings

- *Delayed access to care*
    - The I/I should have had an evaluation by a physician or advanced practitioner the next business day after the 1/15/2016 declared medical emergency.
    - The I/I should have been sent to the emergency department on 1/19/2016, when she presented with an ongoing headache and leg/arm numbness. Instead, the nurse planned to "flag for provider review."
    - The I/I should have been immediately referred for a medical evaluation by a physician or advanced practitioner when, in a Kite dated 1/21/2016, she reported an episode of high blood pressure and ongoing headache since 1/15/2016 and requested to be seen. Instead, after the mental health advanced practitioner simply asked, "Is the Clonidine helping?"

- *Inadequate evaluation*
    - The I/I should have been evaluated by the advanced practitioner on 1/19/2016 when she requested one via Kite on 1/18/2016, particularly since she did not get an evaluation immediately following the medical emergency on 1/15/2016. However, she was only seen by a nurse, who documented several very concerning symptoms but did not refer her for an evaluation.
    - The I/I should have been evaluated by the advanced practitioner or physician at the 1/22/2016 appointment, given the symptoms she was reporting. Instead, she was evaluated by a nursing student, and although the physician assistant cosigned the note, there is no indication that the physician assistant actually performed a separate examination.

- *Poor emergency response*
    - The I/I should have had a comprehensive evaluation by a physician or advanced practitioner after declaring the medical emergency on 1/15/2016. Instead, she was never evaluated again until 1/22/2016, and that evaluation was performed by a nursing student.
    - The I/I should have been immediately sent to the emergency department after she declared a second medical emergency on 3/6/2016 for severe headache and was found to have a dangerously elevated blood pressure. Instead, she was given medications and returned to her cell, without ensuring normalization of her blood pressure.
    - The I/I should have been sent directly to the emergency department when she was noted to be slow to respond and possibly exhibiting seizure activity on 3/6/2016. Instead, she was sent to the WCCW clinic – approximately 40 minutes away – via state car.
    - The 911 calls made from the WCCW IPU and WCCW Master Control did not go through, due to an issue with the phone service. The call to 911 had to be made using a cell phone.

- *Inappropriate level of decision making*
    - While nurses are a valuable part of the healthcare team, developing diagnoses is beyond their scope of licensure. Therefore, the MCCCW nurse should not have diagnosed the I/I's symptoms (fell out of bunk; initially unresponsive; responding incoherently) as being a medication side effect. Rather, the nurse should have contacted the practitioner on call to make the diagnosis.

- *Lack of staff accountability*
    - The MCCCW physician assistant involved in this case is no longer employed by DOC. However, the MCCCW nurse continues to work for DOC, and is currently placed at another facility.

Recommendations:

- **Ensure oversight of the physician assistants and nursing staff at camps.** DOC should implement a clear policy and procedure requiring recurring, documented oversight of physician assistants (10% of the physician assistant's working time, per Department of Health) and nursing staff at the camps.

- **Require a practitioner evaluation after every declared medical emergency.** DOC should implement a clear policy and procedure that requires an evaluation by a physician or advanced practitioner after a declared medical emergency.

- **Revise Outpatient Services policy to clarify that transfer from camp to major facility clinic is not required in a medical emergency.** DOC should implement a policy and procedure that clearly instructs the direct transfer from a camp to the emergency room in cases of medical emergency.

- **Improve kite responses.** DOC should implement a clear policy and procedure that ensures an appointment for every patient who requests one.

- **Provide training on the evaluation of the adult with a non-traumatic headache.** Training should be required for all medical and nursing staff.

- **Ensure regular testing of 911 emergency call system.** The system should have a regular testing schedule, with documented plan for backup with cell phone in the event the regular call system fails.

- **Reassess whether the remaining staff involved in the patient's care should be investigated for failure to provide care or appropriately respond in a timely manner.**

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June 18, 2020

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 Report on the 'the OCO investigation into the death of an incarcerated individual at Mission Creek Correction Center for Women' completed by the Office of Corrections Ombuds.

Recommendation	Response
Ensure oversight of the physician assistants and nursing staff at camps. DOC should implement a clear policy and procedure requiring recurring, documented oversight of physician assistants (10% of the physician assistant's working time, per Department of Health) and nursing staff at the camps.	The Department of Corrections adheres to the medical oversight process that is approved by the Department of Health on continuing education and oversight of medical staff. Additionally, the department created a Coordinated Quality Improvement Program (CQIP) that was built to review current processes for recommendations on updating current practices. This program was tasked to review oversight of the nursing staff and a plan was created by the Health Services 2020 effort for implementation of nursing staff oversight. Please see Attachment A and B
Require a practitioner evaluation after every declared medical emergency. DOC should implement a clear policy and procedure that requires an evaluation by a physician or advanced practitioner after a declared medical emergency.	Nursing staff can perform the referral function in OMNI-HS by creating a nursing encounter and referring the patient to the medical practitioner. One of the department's health service administrators and health services managers are working on a training curriculum for nursing staff to train/update them, through Skype training sessions, on creating Internal Referrals to the practitioner after a patient has returned to the Emergency Room (ER). The referral will be to see the patient within 24-48 hours after an ER visit.
Revise Outpatient Services policy to clarify that transfer from camp to major facility	This protocol was revised in the Offender Health Care Plan under *Authorization for*

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clinic is not required in a medical emergency. DOC should implement a policy and procedure that clearly instructs the direct transfer from a camp to the emergency room in cases of medical emergency.	*Medically Necessary Care.* The Chief Medical Officer distributed a memo to Health Services Staff on June 9, 2020, noting of this update and new procedure that was implemented.
Improve kite responses. DOC should implement a clear policy and procedure that ensures an appointment for every patient who requests one.	Health services has fully implemented a new medical kite tracking protocol at all major facilities. The process update includes a detailed tracking tool, daily retrieval, daily clinical triage and daily follow up. All triaged emergent or urgent kites are immediately addressed for follow up by health services staff with the reporting patients. All routine requests are forwarded to the appropriate discipline for response and action. The agency expectation is that all routine kites will be responded to within five business days. Each facility specific leadership is tasked to conduct periodic audits to ensure time lines are met, clinical triage is appropriate, and the quality of responses, and to ensure staff are attempting to remedy at the lowest level as appropriate. The goal is to provide a rapid response and remediation of issues to avoid delays where possible and avoid a protracted grievance process. This allows critical staff to spend more time on patient care and support and lessens excessive administrative activities. In an effort to utilize the resources as effectively as possible, not all medical kites require an appointment and will be addressed per the new tracking protocol and routinely reviewed for quality assurance.
Provide training on the evaluation of the adult with a non-traumatic headache. Training should be required for all medical and nursing staff.	This specific case was added to the cases used for continuing education of health care staff pertaining to responding to non-traumatic headache concerns at future morbidity and mortality conferences. All medically licensed staff are required, per the Department of Health, to participate in continuing education to remain compliant with practicing medical

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	services. The Department of Corrections has a policy for continuing education cost reimbursement to encourage staff to continue with their education.
Ensure regular testing of 911 emergency call system. The system should have a regular testing schedule, with documented plan for backup with cell phone in the event the regular call system fails.	In the year of 2018, the Department of Corrections updated the telephone security compliance process which allowed for 911 dedicated phones to be placed throughout all DOC facilities and requires regular routine maintenance and testing.
Reassess whether the remaining staff involved in the patient's care should be investigated for failure to provide care or appropriately respond in a timely manner.	The Department of Corrections reviewed this case and has ensured that individuals involved in the care of this incarcerated individual were evaluated for accountability and received training on proper responses to the incident. In addition, all nursing staff that are employed through the Department of Corrections are now receiving annual competency reviews by supervising 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 a fair and safe space 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

"Working Together for SAFER Communities"

****Full DOC response with attachments provided on OCO website****