STATE OF WASHINGTON

OFFICE OF THE CORRECTIONS OMBUDS

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

April 15, 2020

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 incarcerated individual at Monroe Correctional Complex. We appreciate the opportunity to raise concerns regarding both medical and mental health provided to him, as well as concerns regarding the emergency response and critical incident review report. 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. 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 AND REPORT
BY
PATRICIA H. DAVID MD MSPH CCHP,
DIRECTOR OF PATIENT SAFETY AND PERFORMANCE REVIEW,
ELISABETH KINGSBURY, SPECIAL PROJECTS MANAGEMENT ANALYST, AND
CELESTE FOX KUMP, OCO INTERN

Summary of Complaint/Concern

On October 25, 2019, a 74-year-old incarcerated individual (I/I) committed suicide at the Monroe Correctional Complex Special Offender Unit A. He had a number of severe medical issues, and had previously attempted suicide on multiple occasions. This was his first incarceration; his earned release date had been planned for December 18, 2032.

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 Process

As part of this investigation, OCO conducted interviews and reviewed the medical chart, video footage, radio recordings, logbook entries, and witness statements. In addition, OCO reviewed multiple DOC Policies including 600.000 Health Services Management, 610.040 Health Screenings and Assessments, 610.650 Outpatient Services, 630.550 Suicide Prevention and Response and Suicide Risk Assessment Protocol, 890.620 Emergency Medical Treatment, the Suicide/Attempted Suicide Response Emergency Checklist, and the Offender Health Plan.

Summary

The I/I was incarcerated for the first time at the age of 73. He had multiple significant chronic medical conditions, including Parkinson's disease and a cardiac pacemaker implantation. A Mental Health Appraisal in October 2018 identified the I/I as being high risk for suicide, and the records noted multiple attempts at self-harm. Despite this information, there was only **one** Suicide Risk Assessment performed on the I/I during his entire time under DOC jurisdiction, even though the records reflect many COA admissions as well as multiple documented incidents where the I/I was clearly exhibiting symptoms that demonstrated increased risk for suicide.

In addition, the records demonstrate a substantial delay in care for the I/I's Parkinson's disease. This is a chronic, progressive disease associated with depression, anxiety, psychotic symptoms, and other neuropsychiatric manifestations; suicidal ideation is present in up to 33% of patient with Parkinson's disease. At no time did the I/I receive a comprehensive evaluation of his

Parkinson's disease or the medications that he was taking for this condition. The I/I himself suspected that his symptoms were related to his Parkinson's disease or the medications to treat it, and tried multiple times to ask for help – sending kites, asking the nursing staff, asking the psychologists, asking the psychiatrist – but no one took the time to bring the issue to the medical team or make the I/I an appointment, even when his tremors grew so significant that he had problems walking without help from other incarcerated individuals. On two instances, correctional officers attempted to bring the I/I's motor issues to the attention of nursing staff, but again no appointments were made.

In the days leading to his death, a unit sergeant took note of the I/I's difficulty walking and gave him a walker even though one had not been prescribed (since he was never evaluated). Unfortunately, another sergeant removed the walker from the I/I since there was no HSR for it. The DOC psychologist who reviewed this case believed that this action was the "last straw" for the I/I, and was the reason he committed suicide.

Finally, once the I/I was found hanging in his cell, there was a delay of approximately three minutes before the cell was entered; part of the delay was because an officer had to return to the unit booth to retrieve a noose tool for rescue. Then, after the I/I was declared dead, the body and surrounding crime scene were not appropriately secured per policy. Discrepancies were found between the timeline recorded by video and the timeline documented in the log book. Photos taken of the crime scene were of poor quality, and some evidence (a presumed suicide letter) was missing.

Based on the information as outlined, OCO concludes that the care the I/I received at Monroe Correctional Complex did not meet community healthcare standards, and his death by suicide on 10/25/2019 was possibly preventable.

Timeline

6/2018	The records indicate that the I/I attempted suicide by cutting his wrist with a broken denture. A week after that incident, he tore a Velcro strip from his jumpsuit and wrapped it around his neck.
7/2018	The records indicate that the I/I attempted to choke himself sometime during this month, but no other details are provided.
10/11/2018	DOC's intrasystem intake screening indicates a history of attempted suicide, with last attempt in July 2018. The report also notes a diagnosis of Parkinson's disease since 1995.
10/8/2018	The I/I was admitted to Close Observation Area (COA) after fashioning a noose. A Mental Health Appraisal indicates that his suicide risk was high because he was 73 years old with a 16-year sentence, he had a diagnosis of Parkinson's disease, and it was his first incarceration.
4/24/2019	A Mental Health Treatment Plan was outlined.

7/1/2019 This was reportedly the I/I's wedding anniversary. A mental health note indicates that he was observed crying throughout the day in his cell, and he refused medications. **There was no Suicide Risk Detection form completed.**

7/2/2019 The I/I did not show for a medical appointment. A subsequent Emergency Response Record indicates that the I/I was found in bed with a sock tied around his neck. He had been refusing food, drink, and all medications and was noted to be actively crying/weeping; "states that we should just let him die." He attempted to fight with custody when they were securing the scene. He was admitted to COA. A psychologist note indicates that the I/I was "tired of all his suffering;" he cried during the interview, and was shaking due to Parkinson's symptoms. **There was no Suicide Risk Assessment form completed.**

7/3/2019 A nurse note indicates that the I/I was lying on his side and having "gross tremors." He was seen by a psychiatric practitioner, and was described to be shaking and crying; he would not respond when his name was called, and he refused to engage with staff. At 1245, nursing called by correctional officers stating that the I/I was not breathing. He was found lying on his bunk with "slowed respirations and foaming out of mouth;" he did not follow commands and was completely limp. At the clinic, he began responding to some verbal stimuli; he unhooked his restraints and attempted to sit up, resisting the correctional officers. The medical practitioner consulted with mental health, and the I/I was taken back to COA. The I/I was noted to be intermittently shaking his head, upper torso, right arm; he began to sob for several minutes. **There was no Suicide Risk Assessment form completed; in addition, given his initial presentation (slowed respirations, foaming of mouth, unresponsiveness) he should have been sent to the ER rather than COA.**

7/4/2019 A psychiatrist note indicates that the I/I asked to return to his unit. He stated that he attempted to suffocate himself because "it was all those meds." He reiterated this complaint about his medications several times. **No referral was made to a medical practitioner for an evaluation of his Parkinson's disease.**

7/5/2019 A psychologist note indicates that the I/I attributed COA placement to "being stupid." Another note by a different psychologist is mostly illegible due to poor handwriting, but indicates that the I/I's personality disorder could be magnified by Parkinson's and its treatment. **No referral was made to a medical practitioner for an evaluation of his Parkinson's disease.**

7/10/2019 A psychiatry practitioner note indicates that the I/I was doing well; affect was bright and he denied thoughts of harming himself. He was reportedly working on his safety plan. He was to return to his unit. Plan was to increase his antidepressant dose. **There was no Suicide Risk Assessment form completed**, but a Mental Health Safety Plan was developed.

8/5/2019 A nurse note indicates that the I/I had a witnessed fall in the courtyard while returning to his unit. There was superficial skin injury to the left elbow, which was bleeding; bruising was noted. He also reportedly bumped his head when he fell, but "no visible lumps or injury." Right hand tremor was reportedly baseline. He was returned to cell. **There was no referral made to a medical practitioner for an evaluation to determine the reason for this fall.**

8/7/2019 A nurse note indicates that a correctional officer requested an assessment regarding the I/I's shakiness. The only assessment was vital signs. "Offender stated that shakiness is due to Parkinson's attack" and that this was a normal occurrence. The nurse accepted this report, and **there was no referral made to a medical practitioner for a more detailed evaluation of his Parkinson's disease.**

8/17/2019 A nurse note indicates that the I/I's cellmate raised a concern of possible nitroglycerin overdose. The I/I was found mumbling incoherently and not responding to pain stimuli or directives. An open bottle was found on the desk with only four pills remaining. The I/I was sent to ER via 911.

8/18/2019 Upon return from ER, the I/I was to be admitted to the COA for risk of suicide. He was temporarily placed in another room for count; within minutes of placement, he attempted strangulation with his jumpsuit. He was placed in COA. **No Suicide Risk Assessment form was completed.**

8/20/2019 The I/I refused to take medications until he was released to his regular cell. Later, he was found crying in his cell after the mental health counselor informed him he would not be released to his unit. That afternoon, a nursing note indicates that a correctional officer reported the I/I not responding; there were no signs of fall. Upon arrival, the I/I was not responding to name or sternal rub; ammonia given twice until finally the I/I reacted and was very agitated and upset. He was fighting with the correctional officers, **who then placed the I/I in a restraint chair.** The mental health provider was contacted. He was removed from the restraint chair that evening; later, he was found to have a urinary tract infection, and antibiotics were started. **There was no referral made to a medical practitioner to evaluate the reason for his unresponsiveness.**

8/21/2019 The I/I had refused medications and breakfast, and was crying. He felt that his pacemaker wires had broken after being placed in the restraint chair. Electrocardiogram demonstrated pacer spikes indicating normal function. A note by a psychology provider is very difficult to read due to poor handwriting, but appears to indicate that his symptoms had a "possible component of Parkinsonism." **There is no referral made to a medical practitioner for an evaluation of Parkinson's disease.**

8/22/2019 The I/I was adamant that he did not take all of the nitroglycerin pills at once, and denied attempting to kill himself. The psychologist noted that, per medical, he

did not demonstrate a drop in blood pressure that would have been expected with an overdose of nitroglycerin. "It appears that the concern that the pt. overdosed on nitro may have been unwarranted." **Again, there was no referral made to a medical practitioner for an evaluation of the reason for his unresponsiveness on 8/17/2019.**

8/23/2019 The I/I was seen by psychologist, who noted that the I/I felt he had been "tormented by DOC staff over the past week." He was released from COA back to his unit. A Suicide Risk Assessment – the only one performed – indicates that the overall estimate of risk of suicide was "High" for "Chronic/Static" and "Moderate" for "Acute/Dynamic;" "Protective Factors" were "Low Moderate." A Mental Health Safety Plan was prepared and signed.

8/24/2019 There is another psychology provider note that is entirely illegible.

8/27/2019 Seen by outside surgeon for abdominal pain. CT of the abdomen and pelvis was recommended to assess abdominal pain. **There is no report of CT of the abdomen/pelvis in the records provided to OCO.**

9/3/2019 Seen by outside cardiologist for syncope. No clear etiology was found, and the cardiologist recommended decreasing dose of metoprolol to see if his symptoms improved. Back at the facility, the I/I's medical practitioner reduced the dose of metoprolol on 9/4/2019, but **there was no follow-up appointment made to monitor for improvement or deterioration.**

9/26/2019 The I/I walked to pill line; he appeared to stumble at the window and was caught by another incarcerated individual. He was brought to the infirmary where he complained of having a "Parkinson's attack." He stated that he was supposed to have his medications checked every six months, but he had not been seen for two years. The right hand and arm were "tremoring heavily." "Offender appears to be in emotional distress." After being assessed by mental health, he was admitted to COA. **No Suicide Risk Assessment form was completed.** A nursing note indicates that the I/I arrived in COA via wheelchair, "hysterical, crying and screaming." He was concerned that his Parkinson's medication had not been changed; he had already expressed his concern to his provider. "Email sent to [medical practitioner] for follow up." **An appointment should have been made with a medical practitioner for an assessment of his Parkinson's disease.**

9/27/2019 He was seen by a psychology provider, but the handwritten note is entirely illegible. Another handwritten note from a different psychologist is more legible; this note stated that the I/I was unsure why he was admitted to COA, reporting that he had a "Parkinson's attack" as well as "claustrophobia" due to being in his cell. He focused on the need to have his Parkinson's medication adjusted, indicating that this was supposed to be done every six months. He planned to ask his medical provider for a referral to a neurologist. The I/I was noted to have some difficulty with balance while he was standing up to talk to the psychologist.

A nursing note indicates that he was requesting to speak with his provider about his Parkinson's disease. **However, there was no appointment made with a medical practitioner for an assessment of his Parkinson's.** He was discharged from COA.

9/29/2019 The I/I declared a medical emergency for a headache. He told the nurse that he had Parkinson's and had not been sent to the neurologist. The nurse advised the I/I that this was not a medical emergency, and he was given Tylenol for his headache. **There was no appointment made with a medical practitioner for an assessment of Parkinson's.**

10/5/2019 A nursing note indicates that, right before pill line began, a correctional officer called to notify the clinic that they were sending the I/I first because "he's shaky again." The nurse observed him being walked over by other offenders; his hands were "extremely shaking." The nurse told him to sign up to see a provider, and to go lie down in bed. "Walked back to F unit w/ help from other offenders." **Despite witnessing firsthand how difficult it was for the I/I to ambulate, he was not sent to the clinic for an evaluation with a medical practitioner, and no appointment was made for a future visit.**

10/9/2019 The I/I submitted a Kite requesting an appointment to adjust his Parkinson's medications "so I can function without shaking so much." Five days later, the medical assistant wrote, "Please sign up to see provider to discuss." **An appointment with a medical practitioner should have been made for an assessment of Parkinson's.**

10/10/2019 The I/I was seen by a psychologist for a therapy session. He complained primarily about medical issues; he insisted that he needed to be seen by a neurologist, and that three of the four wires in his pacemaker were broken. He felt that no one cared, and pondered why he should continue to care as well. The provider felt that he had regressed to pessimistic thinking in response to exacerbation of his Parkinson's symptoms. **A referral to the medical practitioner should have been made given the worsening of his Parkinson's symptoms.**

10/14/2019 A medical emergency was declared when a correctional officer found the I/I face down on the floor and unresponsive. When the medical practitioner arrived, she found the I/I on his bed shaking; he had a reddened area on the right forehead with a small amount of swelling. The medical practitioner "suggested that he lay down to rest." The plan was to have the third shift nurse check on him later. **The I/I should have been sent to the ER for a more comprehensive medical evaluation, particularly given the history of multiple episodes of unresponsiveness.**

10/15/2019 The I/I apparently had been given a walker by a Unit Sergeant, but later that same day another Unit Sergeant took the walker away because he did not have a HSR

for it. Nurse note indicates that during pill line, he threw water in the air, stated "I don't want to go to the COA," and then started running towards his unit. He fell in the grass a few times. He was seen by a provider, but the handwritten note is difficult to read. He was subsequently admitted to COA for "psychiatric decompensation;" the I/I was noted to be refusing a medical assessment and yelling at staff. **No Suicide Risk Assessment form was completed.**

10/15/2019 The I/I sent a Kite requesting to see his medical practitioner about his Parkinson's medications. The medical assistant responded two days later, "Sign up to see provider." **An appointment with a medical practitioner should have been made for the I/I regarding his Parkinson's disease.**

10/16/2019 Another mostly illegible note by a psychology provider.

10/17/2019 The I/I was seen by psychologist. The I/I believed he was placed in COA because of his Parkinson's disease. He stated that his walker was taken away, and then he ran after attending pill line because he was afraid they would put him in COA. He was noted to be sobbing during the interaction; custody reported he had been crying/sobbing off and on. **No Suicide Risk Assessment form was completed.**

10/18/2019 A psychology provider note indicates that the I/I was insistent that he did not need to be in COA, but the provider noted that the I/I was not interested in discussing his behavioral plan. A note by another psychologist indicates that the I/I was upset no one would research Parkinson's disease to learn about his symptoms. Later on this date, he declared a medical emergency for chest pain; this was deemed likely to be "tissue pain or bone and non-cardiac" per a nursing note.

10/21/2019 A psychiatrist note indicates that the I/I was medication-compliant and had no behavioral issues. The psychiatrist planned to have the psychologist decide whether to release the I/I back to his unit. A Conditions of Confinement form indicates that the I/I had become upset when his walker was taken away; he refused evening medications, became extremely agitated, and refused directives from staff. "He does not believe his medical condition is being cared for and he is stressed by this greatly." **Although this was documented in the chart, the information was not verbally relayed to any medical staff, and no referral to a medical practitioner was made.**

10/22/2019 There is a psychology provider note which is illegible.

10/23/2019 There is a psychology provider note which is illegible. A nurse note indicates that nursing was summoned by correctional officers who found the I/I lying on the floor. It was unclear how he got on the floor. The correctional officer stated that when the I/I was offered lunch, he cursed and started spinning around fast. The I/I was later found on the floor in the corner, wailing with shoulders moving up and down rhythmically. He was seen by a psychology provider, but **no Suicide Risk Assessment form was completed and there was no assessment**

by a medical practitioner to determine if there was a medical reason for the I/I's behavior.

10/25/2019 Early in the morning, the I/I was informed that he was receiving an infraction for having a walker without a HSR. A nursing note indicates that the I/I was found in his cell at 0832, hanging from a ligature made from a strip of cloth. CPR commenced at 0835; EMTs arrived on the scene at 0847 and provided additional advanced life support measures. The I/I was pronounced dead at 0911.

Key Findings

- *Delayed access to care*
    - Despite multiple requests to be seen by a medical practitioner or an outside neurologist regarding his Parkinson's disease and medications, the I/I was not given an appointment for a full evaluation.
    - Despite requests for an assessment regarding Parkinson's by correctional officers, the I/I was not given an appointment for a full evaluation by a medical practitioner.

- *Failure to recognize, evaluate, and manage clinical "red flags"*
    - The I/I was found unresponsive or minimally responsive on several occasions, with other signs of injury (bruising on head, skin abrasions), but he was not sent to the ER for an evaluation.
    - Despite having several documented falls and evidence of difficulty ambulating without assistance, the I/I did not receive an appointment with a medical practitioner for a full evaluation.

- *Failure of communication between providers*
    - The I/I relayed to nursing staff several times his concern about his Parkinson's medication and need for adjustment. However, no referral was made.
    - The I/I complained to his psychiatrist that his medications were the reason that he attempted to commit suicide. However, there was no referral made to medical for an evaluation.
    - Several psychology notes reflect the opinion that the I/I's psychological symptoms were magnified by his Parkinson's diagnosis and the associated treatment, but there was no referral made for a medical evaluation.
    - The medical record contains multiple notes by one psychologist which are mostly, if not entirely illegible. This lack of clarity results in suboptimal care for the patient.

- *Failure of assigned clinician to assume responsibility for patient's care*
    - When medications were decreased per a cardiologist's recommendations, there was no set follow-up to evaluate for improvement or continued symptoms of dizziness or fainting. Given that the I/I had two additional episodes of being

found unresponsive or found on the ground after this medication change, a follow-up clearly was warranted.
    - When an outside surgeon recommended CT of the abdomen and pelvis, the recommendation was not followed; there is no documentation explaining the rationale for not following this recommendation, and there is no indication that alternatives were considered.
    - The medical assistant assigned to respond to two of the I/I's kites instructed him to sign up for sick call for his Parkinson's complaints, rather than sending the request to the scheduler for an appointment to be made.

- *Delay or failure of emergency response and review*
    - In one instance when the I/I was found unresponsive, attempts to arouse him via verbal stimuli and physical stimuli were unsuccessful; when he finally awoke after two ammonia capsules, he was placed in a restraint chair rather than being sent for a medical evaluation.
    - When the I/I was found hanging in his cell, the correctional officer stated that he was immediately able to notice the noose when he looked into the I/I's cell, but there was a nearly three-minute delay before entering the cell to perform rescue; part of this delay was related to an officer having to return to the unit booth to retrieve a tool needed for rescue.
    - After the I/I was pronounced deceased, the body and crime scene were not secured indicating that policy was not followed. Video demonstrates the body was left alone for long periods of time. Since the area was not secured initially and no one was assigned to remain with the body, the integrity of the crime scene could not have been maintained for that nearly two-hour time frame.

- *Discrepancies in document review and failures in evidence preservation*
    - Significant discrepancies – between 4 and 40 minutes – were found between the timeline noted by video and the timeline entered into the log book.
    - Digital photos taken of the crime scene were of poor quality. One photo depicted what could have been a suicide letter, but it is not of high enough resolution to read.
    - While placing the body in a body bag, a correctional officer reportedly found a card belonging to the I/I that had implications of suicide. However, there is no record of this piece of evidence.

Recommendations

- **Eliminate barriers to medical appointments.** DOC should implement a clear policy and procedure that ensures an appointment for every patient who requests one.

- **Require an evaluation by a medical practitioner after every declared medical emergency.** DOC should implement a clear policy and procedure that requires an evaluation by a physician or advanced practitioner within a week after a declared medical emergency, to ensure that adequate treatment has been provided and appropriate referrals have been made.

- **Adopt a collaborative care approach for patients with medical and mental health diagnoses.** DOC should require weekly multidisciplinary team meetings for these patients to ensure that their health needs are communicated and coordinated across disciplines**.**

- **Develop a process that ensures a follow-up appointment any time a medication is prescribed or dosage is adjusted.** A follow-up after medication changes is simply good medicine. It enables the provider to assess for improvement or to make adjustments as needed.

- **Develop a process that ensures documentation in the chart is legible.** Clear communication among all providers involved in a patient's care is imperative for good clinical outcomes. DOC should eliminate handwritten practitioner notes and require notes to be either dictation or typed. DOC should also ensure practitioner documentation quality via clinical oversight at appropriate intervals.

- **Ensure timeliness of Kite responses.** In particular, DOC should implement a clear policy and procedure that requires response within 24 business hours for all Kites containing appointment requests.

- **Review with custody and medical staff the proper use of emergency restraint chairs.** Patients who are found unconscious may be disoriented and instinctively defend themselves when finally aroused; they should not be placed in restraint chairs, but instead should undergo a medical evaluation.

- **Strengthen current policies and procedures so that rescue occurs promptly.** A three-minute delay prior to rescue – such as that which occurred in the I/I's case – is not likely to result in a life saved. In addition, accessibility to tools needed for rescue should be improved; this is particularly important in multi-tiered units, where precious minutes are lost while the officer is running back to the unit booth to find rescue tools.

- **Provide training on the manifestations and treatment of Parkinson's disease.** DOC should extend this training to Medical, Mental Health, and Nursing providers. Consider including Custody staff on appropriate sections so they are familiar with the signs and symptoms of Parkinson's and other dementias, so as not to misread these symptoms as willful aggression.

- **Provide training on the evaluation and management of falls and syncope.** DOC should extend this training to Medical, Mental Health, and Nursing providers.

- **Provide training on the risk factors, evaluation, initial management, and follow-up of suicidal patients.** DOC should extend this training to Medical, Mental Health, and Nursing providers. DOC should also include refresher training on DOC Policy 630.550 Suicide Prevention and Response, the Suicide Risk Assessment Protocol, and the Suicide/Attempted Suicide Response Emergency Checklist, to ensure that these policies are followed.

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

- **Provide better quality assurance for critical incident review reports and ensure better preservation of evidence.**

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

July 30, 2020

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 OCO Report on the 'the OCO investigation into the suicide of an incarcerated individual at Monroe Correctional Complex' completed by the Office of Corrections Ombuds.

Recommendation	Response
Eliminate barriers to medical appointments. DOC should implement a clear policy and procedure that ensures an appointment for every patient who requests one.	The Department of Corrections is reviewing the triage appointment request process and will ensure that the process is being utilized effectively. The agency has a standing process in place where incarcerated individuals can sign up to be seen for walk-in services during sick call hours if an appointment was scheduled at a later date than desired. Additionally, mental health and medical staff are always available to respond to emergent situations upon notification of the situation.
Require an evaluation by a medical practitioner after every medical emergency. DOC should implement a clear policy and procedure that requires an evaluation by a physician or advanced practitioner within a week after a declared medical emergency, to ensure that adequate treatment has been provided and appropriate referrals have been made.	The Department of Corrections is continuing to work on nurse training to ensure that appropriate follow-up appointments are scheduled with a medical practitioner following a substantiated medical or urgent emergency.
Adopt a collaborative care approach for patients with medical and mental health diagnoses. DOC should require weekly multidisciplinary team meetings for these patients to ensure that their health needs are	The Department of Corrections began discussions pertaining to the coordination of care of the incarcerated population, to include seriously mentally ill and chronic care patients. These discussions will resume post

communicated and coordinated across disciplines.	COVID-19 response, as many of the individuals required to further these conversations are fully invested in the agency's current pandemic response.
Develop a process that ensures a follow-up appointment any time a medication is prescribed or dosage is adjusted. A follow-up after medication changes is simply good medicine. It enables the provider to assess for improvement or to make adjustments as needed.	The Department of Corrections mental health unit currently requires an evaluation every 90 days with patients prescribed psychiatric medications to evaluate their care, to include medications, and their mental health state. Psychiatric providers will schedule follow-up appointments if needed within the required 90 day time period.
Develop a process that ensures documentation in the chart is legible. Clear communication among all providers involved in a patient's care is imperative for good clinical outcomes. DOC should eliminate handwritten practitioner notes and require notes to be either dictation or typed. DOC should also ensure practitioner documentation quality via clinical oversight at appropriate intervals.	The Department of Corrections Health Services Administrator for Command B sent an email to all health services staff reminding them of the important of medical records and medical documentation being presented in a legible way for review of others who may need to evaluate the medical records. Additionally, Health Services will be conducting a cost benefit analysis to determine efficacy of providing clinical staff with a speech recognition program on their computers. Once this analysis is completed, Health Services leadership will determine next steps for the department. Please see the attachment A.
Ensure timeliness of Kite responses. In particular, DOC should implement a clear policy and procedure that requires response within 24 business hours for all Kites containing appointment requests.	The Department of Corrections is analyzing the current response time to kites, specifically health service related kites. Upon completion of the analysis and if the determination is made, the department will look to process improvements to ensure that kites are being responded to in an acceptable time frame. Additionally, at any time an incarcerated individual can declare a medical emergency through the grievance process.
Review with custody and medical staff the proper use of emergency restraint chairs. Patients who are found unconscious may be disoriented and instinctively defend themselves	Per policy 420.255 Emergency Restraint Chair, staff are now trained on the proper use of emergency restraint chairs, to include manufacturer's training, Department

when finally aroused; they should not be placed in restraint chairs, but instead should undergo a medical evaluation.	procedures and practical application.
Strengthen current policies and procedures so that rescue occurs promptly. A three-minute delay prior to rescue – such as that which occurred in Mr. Brown's case – is not likely to result in a life saved. In addition, accessibility to tools needed for rescue should be improved; this is particularly important in multi-tiered units, where precious minutes are lost while the officer is running back to the unit booth to find rescue tools.	Per policy 630.550 Suicide Prevention and Response, calls for assistance and lifesaving efforts are to be immediately made by responding staff.
Provide training on the manifestations and treatment of Parkinson's disease. DOC should extend this training to Medical, Mental Health, and Nursing providers. Consider including Custody staff on appropriate sections so they are familiar with the signs and symptoms of Parkinson's and other dementias, so as not to misread these symptoms as willful aggression.	At the Continuing Medical Education (CME) conference held in September 2019, attended by departmental health service providers, there was a specific course held titled "Older Incarcerated Individuals with Memory Loss and Dementia", along with other courses related to caring for geriatric incarcerated individuals. The department will continue to research, learn, and educate about signs and symptoms of dementia and other diseases. Please see Attachment B
Provide training on the evaluation and management of falls and syncope. DOC should extend this training to Medical, Mental Health, and Nursing providers.	At the Continuing Medical Education (CME) conference held in September 2019, attended by departmental health service providers, there was a keynote course held titled "Deprescribing to Reduce Fall Risk" followed by a course titled "Fall Risk Assessment". The department will continue to research, learn, and educate about evaluation and management of falls and syncope. Please see Attachment B
Provide training on the risk factors, evaluation, initial management, and follow-up of suicidal patients. DOC should extend	The Department of Health requires that all individuals who hold a medical license adhere to their requirement of completing a required number of suicide prevention continuing

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

this training to Medical, Mental Health, and Nursing providers. DOC should also include refresher training on DOC Policy 630.550 Suicide Prevention and Response, the Suicide Risk Assessment Protocol, and the Suicide/Attempted Suicide Response Emergency Checklist, to ensure that these policies are followed.	education hours to remain in good status with their medical license. Additionally, the department's Training and Development Unit projects this curriculum specific to a prison setting could be incorporated in a year's time to future required annual in-service learning for health service professionals.
Assess whether the staff involved in the patient's care should be investigated for failure to provide care or appropriately respond in a timely manner.	Staff involved in the patient's care have been assessed and the case investigated. Action items suggested by the assessment and the investigation have been completed.
Provide better quality assurance for critical incident review reports and ensure better preservation of evidence.	DOC policy 400.110 Reporting and Reviewing Critical Incidents is scheduled for review. The Department has recently hired a new risk manager, who will consider increased quality assurance standards that may be incorporated into both the policy and practice of completing critical incident review reports.

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"