STATE OF WASHINGTON

OFFICE OF THE CORRECTIONS OMBUDS

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July 27, 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 Peninsula Work Release Center. 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 REVIEW
CONDUCTED BY PATRICIA H. DAVID MD MSPH CCHP,
DIRECTOR OF PATIENT SAFETY AND PERFORMANCE REVIEW

Summary of Concern

On 10/30/2019, a 61-year-old incarcerated individual (I/I) under the jurisdiction of the Washington Department of Corrections (DOC) died by suicide, 21 days after arriving at the Peninsula Work Release. He had an earned release date of 3/8/2020.

This case was reviewed as part of the Office of the Corrections Ombuds (OCO) review of all DOC suicides that occurred within 2019.

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 reviewed 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 #19-75549. OCO also attempted to analyze patient records as part of this review; however, **OCO was unable to obtain mental health information, a critical component of any suicide review, due to the lack of a signed release from the I/I's next of kin.**

The following key findings are based on the limited information that was received and is not considered comprehensive due to the redactions.

Timeline

8/1/2019	An intersystem/restrictive housing mental health screening form was completed by DOC following the I/I's intake to DOC. DOC staff found him appropriate for general population, and there was no referral for mental health appraisal made.
8/2/2019	An intake nursing screening indicates that he had no teeth and had dental concerns. He reported the use of alcohol six months earlier, and drugs in 2008.
8/9/2019	A third intake form, the History and Physical form, indicates that his brother died of suicide. History of drug use was entered into the Problem List in the medical

chart. There are several labs ordered, but there was no referral for mental health appraisal made.

8/22/2019 He sent a Kite requesting hearing aids, and the provider who performed the History and Physical did not order any follow-up appointments; he was told to sign up for sick call.

8/29/2019 He sent another Kite requesting hearing aids, and was told that clinic staff was emailed to set up an appointment.

9/23/2019 An intrasystem intake screening indicated that he needed dentures and would send a Kite to dental.

10/3/2019 The I/I was seen by an advanced practitioner for difficulty hearing. Audiometry was ordered. A subsequent note dated 10/9/2019 indicates that audiometry could not be performed due to his transfer to work release.

10/9/2019 The I/I was transferred to Peninsula Work Release. He stated that he still needed dentures and hearing aids, and was told to follow-up in the community.

10/21/2019 0830: The I/I signed out on a job search pass. 1615: The I/I was discovered to be 15 minutes late returning from the job search. Several attempts to reach him via cell phone were unsuccessful. Calls to local jail facility and hospitals revealed the I/I was not at those locations. 1715: The I/I was placed on escape status, and a warrant was issued.

10/30/2019 1507: Police received notification that passers-by found a body hanging from a railing in the elevated parking lot of a motel.

10/31/2019 0825: DOC received a call from the coroner's office reporting that the I/I had committed suicide by hanging; the estimated time of death was 10/30/2019 at 0250.

Key Findings

Failure to recognize red flags

The I/I was identified as being over 60 years of age, having a history of substance abuse disorder, and having a family history of suicide. These, in addition to the I/I's incarceration, reflect **four** main risk factors for suicide.[1] However, because neither the psychology associate nor the physician who performed the History and Physical appear to have fully recognized these risk factors, the I/I was not identified as being at high risk for suicide.

Failure of communication between staff

The physician who performed the History and Physical indicated the I/I's family history of suicide which, again, is one of the main risk factors for suicide. However, the mental health screening and the History and Physical occur eight days apart, and there does not appear to be any

[1] National Institute of Mental Health, https://www.nimh.nih.gov/health/publications/suicide-faq/index.shtml#pub2.

multidisciplinary review of the I/I's assessments as a whole. Because of this, the information was not brought to the attention of mental health staff so that an appropriate referral could be made.

Delay in access to care

Because of the failure to recognize red flags and the failure of communication between medical and mental health, the I/I was not referred for a mental health appraisal. Further, the individual's basic needs of a hearing aid and dentures for adequate quality of life were not met by DOC staff and may have played a role in the I/I's mental state and decision to commit suicide. Last, due to prison staff's failure to recognize the red flags, as stated above, DOC staff also failed to provide community linkages for mental health care after he transferred to the Peninsula Work Release Center.

Recommendations

- **Improve OCO access to a deceased I/I's medical and mental health records.** Per OCO's statutory role in producing recommendations for the Governor and the Legislature to act upon, OCO recommends that it be given access to all records in DOC's possession related to an incarcerated individual.

- **Improve the existing Form 13-349 Intersystem/Restrictive Housing Mental Health Screening.** This form should include all of the risk factors for suicide, so that the provider can accurately determine which patients are at risk and need mental health assessments.

- **Increase the opportunity for cross-disciplinary communications.** For example, requiring the medical provider to review results of the initial mental health screening as part of the intake History and Physical would ensure that all available information regarding an I/Is health status is analyzed when making decisions on whether an I/I needs a mental health assessment.

- **Provide training to medical, mental health, and nursing providers on the risk factors for suicide.** It is important for staff to remember that **all** I/Is already have at least one of the major risk factors for suicide – being in prison or jail. Becoming more aware of the risk factors for suicide will enable staff to be more attentive to the incarcerated persons under their care.