STATE OF WASHINGTON

OFFICE OF THE CORRECTIONS OMBUDS

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May 4, 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 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
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Summary of Complaint/Concern

On January 31, 2020, the Office of the Corrections Ombuds (OCO) received a complaint, on behalf of a deceased Incarcerated Individual, which alleged the following:

- On September 21, 2019 an individual under the jurisdiction of DOC died by suicide at the Monroe Correctional Complex as a result of failure to appropriately respond to warning signs of heightened risk.

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 the following:

- DOC 320.145 Violator Confinement in Department Facilities
- DOC 630.550 Suicide Prevention and Response, and Suicide Risk Assessments
- DOC 640.020 Health Records Management
- DOC 890.620 Emergency Medical Treatment
- DOC 610.650 Outpatient Services
- Washington DOC (Offender) Health Plan
- Patient medical records
- Critical Incident Review Report CIR-083-19-P
- Interview of DOC Headquarters staff

Summary

The Incarcerated Individual had been in and out of a DOC facility numerous times since March 2018. Prior intake screenings documented a history of substance use disorder, attention deficit

disorder, and hallucinations. At an intake screening on 8/7/2019, he admitted to acts of self-harm and thoughts of suicide by hanging six months earlier; he also admitted that he had tried to provoke police officers to kill him. At that time, he was to be referred to mental health; however, there is no evidence that a mental health assessment was performed or that he was connected to community mental health providers upon release on 8/13/2019.

A little over a month later, he returned to the MCC Violator Unit on 9/20/2019. At this intake screening, he denied any mental health diagnoses and denied prior attempts of self-harm; as such, he was housed in general population. Unfortunately, due to the lack of definitive policies and processes in place for the violator population, his prior records were not readily available, and intake staff was unaware of the prior history of attempts at self-harm. The following day, the Incarcerated Individual was found unresponsive in his cell, with a ligature secured around his neck. DOC staff initiated the facility emergency medical response, and EMS was called. Despite resuscitative efforts, vital signs remained absent and death was pronounced at 1630 on 9/21/2019.

OCO concludes that the Incarcerated Individual's death by suicide was possibly preventable.

Timeline

3/5/2018	A Washington ONE Assessment indicates a history of suicidal thoughts and attempts in the past.[1]
3/30/2018	The Incarcerated Individual is admitted to the MCC Violator Unit. A Violator Intake Screening indicates the use of alcohol and methamphetamine. He denies any prior attempt at suicide or self-harm, and denied any current thoughts of suicide. A Mental Health Screening form indicates prior treatment for a mental health concern, and a diagnosis of ADD/ADHD as a child. He is housed in general population.
4/10/2018	He is released to CCP Bellingham.
5/9/2018	The Incarcerated Individual returns to the MCC Violator Unit. A Violator Intake Screening denies any prior attempt at suicide or self-harm. A Mental Health Screening form again reflects no prior history of suicide or self-harm, and he denies any prior mental health diagnoses. He reports the use of methamphetamine, alcohol and marijuana. He is housed in general population. A note by a physician assistant states that a full history and physical exam is unnecessary. On 5/14/2018, the Incarcerated Individual's mother leaves a voicemail stating that he might benefit from mental health treatment; she reports an assault six months earlier, with possible traumatic brain injury. A staff

[1] See CIR report, page 2.

	member returned the call and left a voicemail.[2] There is no further follow-up, and no indication of a mental health referral.
5/17/2018	He is released to Bellingham.
6/11/2018	The Incarcerated Individual again returns to the MCC Violator Unit. A Violator Intake Screening indicates no prior attempt at suicide or self-harm. A Mental Health Screening form does not indicate any prior mental health diagnoses, nor any attempts at suicide or self-harm. He is housed in general population. A note by a physician assistant on 6/12/2018 states that a full history and physical exam is unnecessary.
6/23/2018	He is transferred to Yakima.
7/11/2018	The Incarcerated Individual returns to the MCC Violator Unit. A Mental Health Screening form indicates no prior attempt at suicide or self-harm, and no prior mental health diagnoses. Prior use of methamphetamine and alcohol is reported. He is housed in general population. A note by the physician assistant indicates that a full history and physical exam is unnecessary.
7/19/2018	He is transferred to Yakima.
10/15/2018	The Incarcerated Individual returns to the MCC Violator Unit. A Mental Health Screening form indicates no prior mental health diagnoses, and no prior attempts at suicide or self-harm. A Violator Intake Screening form reflects a history of alcohol use, as well as a right shoulder dislocation that occurred three days earlier. He is housed in general population.
10/24/2018	He is transferred to Yakima.
1/23/2019	The Incarcerated Individual returns to the MCC Violator Unit. A Mental Health Screening form indicates a past treatment for mental health diagnosis; he states that he attended Alcoholics Anonymous and Narcotics Anonymous while "growing up." He reports a history of ADD/ADHD. He also reports seeing shadows, and a history of methamphetamine use. A Violator Intake Screening form provides similar information. He is housed in general population.
2/6/2019	He is transferred to Yakima.
3/1/2019	The Incarcerated Individual returns again to the MCC Violator Unit. A Mental Health Screening form indicates no prior history of mental health diagnoses. However, he admitted to seeing shadows. A Violator Intake

[2] See CIR report, page 2.

Screening indicates that he was seen at the hospital a week earlier for a black eye. He is housed in general population.

On 3/5/2019[3], the Incarcerated Individual sends a Kite to Mental Health, expressing concern about flashbacks and "different things like that I have no control over." He states that he is "ready to ask for some help." The response by a RN on 3/6/2019 is "I forwarded your kite to the people who can talk to you about these concerns."

On 3/8/2019, he is evaluated by a Psychology Associate. He discusses dreams that consist of events that had not yet happened, but later it seemed like real life events were reminiscent of his dreams. He denies thoughts of self-harm. He is encouraged to seek mental health services when he completed his sanction as a violator. There is no referral to a specific community mental health provider made.

3/11/2019 He is released to Bellingham.

3/26/2019 The Incarcerated Individual tells his community corrections officer that he feels "suicidal all the time."[4] There is no information regarding any additional actions in response to this information.

3/27/2019 The Incarcerated Individual returns to the MCC Violator Unit. A Mental Health Screening form indicates no prior attempts at suicide or self-harm, and no need for mental health services. A Violator Intake Screening indicates the use of methamphetamine. He is housed in general population.

4/6/2019 He is transferred to Yakima.

5/29/2019 The Incarcerated Individual's mother tells his community corrections officer of her concerns regarding his mental health. There is no information provided regarding any additional actions.[5]

8/7/2019 The Incarcerated Individual returns to the MCC Violator Unit. A Mental Health Screening form indicates that the Incarcerated Individual admits to hurting himself by head-banging, and states that approximately six months ago he considered killing himself by hanging. He also admits to attempting to provoke others (e.g. police officers) in an attempt to kill himself. The nurse note indicates that he would be housed in the observation unit and referred to mental health. There is no assessment by a mental health provider in the records provided for review.

8/13/2019 He is released to Bellingham.

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[3] The original Kite is dated by the Incarcerated Individual as "3/5/2018," but the response is dated 3/6/2019, therefore it is presumed that the 2018 date is an error.
[4] See CIR Report, page 10.
[5] See CIR Report, page 2.

9/20/2019	The Incarcerated Individual returns to the MCC Violator Unit. A Mental Health Screening form indicates that he denies any prior mental health diagnosis, and does not feel he needed mental health services. He also denies any prior suicide attempts or attempts at self-harm. He admits to daily methamphetamine use. He is housed in general population.
9/21/2019	A nursing note indicates that at approximately 1600, notification for an "unresponsive violator" was received. When nursing staff respond, they find the Incarcerated Individual in supine position with two officers performing CPR. EMS arrives at approximately 1610; the Incarcerated Individual is pronounced dead at approximately 1645. The Certificate of Death cites the time of death as 1630. The cause of death is asphyxia due to ligature tied around the neck.
11/4/2019	The DOC Critical Incident Review indicates that no information regarding any current or prior mental health concerns were relayed to the correctional unit supervisor. The report also indicates that the superintendent and his leadership team submitted a proposal for additional staffing in the Violator Unit.

Additional Information

Interview of DOC Headquarters staff revealed that medical records for the violator population are placed in "red folders" to distinguish them from blue binders which house records for the regular incarcerated individuals. Each time an incarcerated individual arrives at the facility on a violation, a new red folder is generated; once the individual is released or transferred, the red folder is placed into a drawer. If the same incarcerated individual returns to the facility on another violation, another new red folder is generated; the DOC HQ staff reported that the records from prior stays are not incorporated into the new folder, so any information from prior stays is not carried forward.

Key Findings

- Delay in access to care
    - On 8/7/2019, the Incarcerated Individual admitted to a prior attempt at self-harm by head banging, and that he was thinking of hanging himself six months earlier. He also admitted to provoking police officers in an attempt to kill himself. Although a nurse note indicates he would be referred to mental health, the records did not include an assessment by a mental health provider.[6]

[6] Per DOC 630.550 II A., "Employees/contract staff who suspect an offender may be suicidal or self-injurious should immediately alert his/her supervisor and take precautions to prevent any attempt at self-injury, including continuous observation of the offender until further steps are taken."

- Failure of communication between staff
    - Prior records show that the Incarcerated Individual had either attempted or considered self-harm several times; however, because of the lack of policy and procedure specifically for the violator population, his past records were not available to the staff who were caring for him when he returned on 9/20/2019. As a result, they were unaware of his prior history of attempts at suicide or self-harm.

- Failure to assume responsibility for the incarcerated individual's care
    - The Incarcerated Individual's mother reached out to DOC on 5/14/2018 to inform them of his need for mental health treatment. Although a DOC staff member returned the call and left a voicemail, there was no additional attempt at follow-up and no referral made to a mental health provider.[7]
    - On 3/26/2019, the Incarcerated Individual reported to his community corrections officer that "he felt suicidal all the time." However, there is no indication that a referral to mental health or any other action was taken.[8]
    - On 5/29/2019, the Incarcerated Individual's mother again reached out to his community corrections officer to express concerns regarding his mental health. Again, there is no information regarding what action, if any, was taken.[9]

Recommendations

- **Strengthen the processes for identifying those at risk of self-harm.** Existing intake forms should be reviewed and updated to include multiple ways of eliciting mental health histories, intellectual disabilities, and feelings of depression or suicidality. In addition, staff should be required to ask suicide screening questions each time they come in contact with an incarcerated individual on the violator unit, rather than only on intake.

- **Give staff clear guidance on how to respond when history or risk of self-harm is elicited.** Since stays in the violator unit are typically short, rapid referral for mental health assessment is critical. Nursing staff responsible for intake must have very specific instructions on how to respond to answers that suggest suicide risk; the current process – which requires staff to report to a supervisor – should be streamlined to allow staff to directly notify the mental health and/or medical provider. Community corrections officers also need clear guidelines on how to protect those on community supervision when they express a desire to self-harm, including a process for connecting them to a mental health provider who can assist with securing their safety.

[7] See footnote 6.
[8] See footnote 6.
[9] See footnote 6.

- **Promote continuity of care by developing policies and processes unique to the violator population.** Medical records for the violator population should be maintained in a single folder or binder, so that information from prior incarcerations is readily available for assigned staff. In addition, a dedicated medical practitioner and mental health provider should be assigned to the Violator Unit, and they should be responsible for collaborating in the care of each patient – from intake through transfer or discharge.

- **Connect violator patients to mental health providers after release.** Linkages to mental health care after release is one of the key strategies to reduce recidivism. DOC should develop referral relationships with community health practitioners so that the violator patients who are at risk for suicide have a definitive place to seek help after release. Reentry staff should also assist those in the violator unit with pre-release Medicaid enrollment to avoid interruptions in treatment.