STATE OF WASHINGTON

OFFICE OF CORRECTIONS OMBUDS

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July 9, 2019

Steve Sinclair, Secretary
Department of Corrections (DOC)

Office of Corrections Ombuds (OCO) Investigative Report

Attached is the official report regarding the OCO investigation into the response to an accident injury suffered by an incarcerated person at Airway Heights Correctional Center (AHCC) while on a work crew outside the facility. We appreciate the opportunity to work collaboratively with DOC to amend current policies and practices to better ensure that the health and safety of incarcerated persons 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
INVESTIGATION CONDUCTED BY SHELLEY ALDEN, ASSISTANT OMBUDS – HEALTHCARE SPECIALIST
REPORT PREPARED BY SIGMA CHANG, INTERIM ASSISTANT OMBUDS – EASTERN DIVISION

Summary of Complaint/Concern

On November 29, 2018, Office of Corrections Ombuds (OCO) received a complaint that alleged the following:

- The complainant was working on an offsite work crew for the City of Airway Heights. He was directed to pick up a small area of trash by the escorting correctional officer, which included hundreds of hypodermic needles. The escorting officer reportedly was aware of the needles and told the inmates to be 'very careful' but still wanted the complainant to pick up the trash, despite the complainant not having appropriate protective gear. The complainant was subsequently stuck in his finger with the needle. He immediately reported the injury and was escorted back to the facility for medical evaluation, where he was provided with a dose of prophylactic medication to prevent HIV. The complainant's lab tests later indicated that he contracted Hepatitis C as a result of the finger stick. Further, he was informed by medical staff that he had been given the wrong prophylactic medication. The complainant reported both physical and mental distress as a result of this occurrence.

- The complainant filed a grievance regarding the original work site incident. He alleges it was assigned to a biased investigator. The grievance received multiple time extensions and the complainant alleged that it was being "swept under the rug" until the complainant was released.

- The complainant filed a separate grievance regarding the provision of the wrong prophylactic medication. This grievance was lost and had to be re-filed, resulting in additional time delays.

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 in regard to the "Offender Grievance Program," "Blood-Borne Pathogen Protection and Exposure Response," "HIV Infection and AIDS," and "Job Safety Analysis, Hazard Assessments and Personal Protective Equipment;" OCO also reviewed related grievances and supporting documents and contacted inmates and DOC staff.

OCO Findings

- OCO substantiated the complainant's allegations that he was working on an offsite work crew, was stuck by a needle, and subsequently contracted Hepatitis C. OCO also substantiated that the inmate was provided only gardening gloves, which were inadequate for the task.

- OCO could not substantiate the allegation that the escorting officer knew of the needles' presence due to the fact that the officer went on leave immediately after the incident and was unavailable for interview.

- OCO found that the facility took immediate action to prescribe corrective action including the use of cut proof gloves, handheld grabbers, easily available sharps containers, and ensuring proper notification procedures.

- OCO substantiated that medical staff provided the wrong dosage for the HIV prophylactic, as documented in a medication incident report.

- OCO found the following concerns with the worksite assessment, both pre and post incident, and training:

    - AHCC staff did not complete the Job Safety Analysis (JSA) for the worksite required by DOC Policy 890.130, which may have assisted in the identification of potential hazards and the need for additional personal protective equipment (PPE). Further discussions with DOC staff found that in fact JSAs were not in practice at all but two facilities, in contravention of policy.

    - The "Offender Off-Site Crew Rules" signed by the complainant states, "While assigned to an outside work crew, you are under the direct supervision of the Crew Supervisor and will be expected to comply with all directions…Your Crew Supervisor will conduct a Tailgate Muster and inform you of all safety rules in the area in which you will be working and ensure you have appropriate safety equipment for your job. Report all accidents and near misses to the Crew Supervisor immediately. If you see an unsafe act, stop the action and direct/inform the Crew Supervisor immediately." The form does not address what a work crew incarcerated person should do if ordered by the Crew Supervisor to handle hazardous material for which they are not equipped.

- OCO could not obtain documentation regarding what training was given to the escorting officer for the incident regarding handling hazardous and/or unexpected materials.

- After the incident occurred, the prisoners and escorting officer were brought back to the facility and the escorting officer filed an accident injury report. However, it is not clear what additional actions were taken to properly assess the worksite location. The complainant alleged that photos were taken of the worksite by DOC staff the following day, but these photos were reportedly not provided to staff investigating the grievance and cannot be verified. OCO found no documentation or testimony that witnesses were interviewed prior to the grievance to attain a better understanding of the events.

- OCO found the following concerns with the grievance investigation regarding the original incident:

    - In the original grievance, the incarcerated person relayed that "at a dumpsite littered with hypodermic needles we were instructed to be 'very careful' by C/O [redacted]" and that subsequently he was poked by a "very dirty hypodermic needle" leading to emotional distress and fear of contracting HIV. The only response to this grievance was "Per our conversation this issue has been resolved." However, this response referred only to the corrective action and improvement in protective gear provided to work crew members moving forward, and did not address the incident, staff actions, and whether the incident could have been prevented.

    - The Level II grievance investigator did not interview all potential witnesses. In the incarcerated person's statement, he identified the contractor, the escorting officer, and one other incarcerated person. The named incarcerated person witness was interviewed; however, neither the escorting officer who oversaw the work crew nor the contractor was interviewed as both were unavailable, nor were other members of the work crew interviewed to determine whether they had any knowledge.

    - Although the Level II investigation did not include interviewing the officer in question and although the only interview of a witness included a statement that the officer "told the crew they needed to be very careful due to the amount of needles that typically is seen while on trash detail," the Level II grievance response found that "no misconduct occurred during this incident…the officer escorting you did not know a needle was present under the bag of trash." There is no evidence to support this statement of the officer's knowledge.

    - Further, the Level II response appears to place the blame on the complainant for not notifying his supervisor of the safety concern, when the complainant's allegation is that the supervisor was aware of the needles and directed the

incarcerated person to pick it up anyway. The Level II response is signed by the Superintendent.

- The timeliness of the grievance response was lacking. Six months passed between the submission of the original grievance to the Level III response and coincided closely with the inmate's release date. The Level I investigation was extended once and, due to the investigator's unavailability, was elevated to a Level II investigation. After the grievance went to headquarters for Level III response, that deadline was missed as well.

- The Level III response did not identify any of the above concerns OCO found in the Level I and II grievance investigations and responses, again addressing only the corrective action that DOC took.

- OCO found the following concerns with the administration of the incorrect prophylactic:

  - Per the grievance investigation, the administration of the incorrect dosage of prophylactic medication resulted from a chain of disorganized communication and poor Post Exposure Prophylaxis (PEP) protocols in place. After seeing the complainant, an AHCC Licensed Practical Nurse (LPN) first called a Registered Nurse (RN) for treatment direction. The RN told the LPN treating the complainant to "follow PEP protocol." The standard PEP protocol reportedly listed the medication but not the dosage amount.

    - When interviewed later, the RN stated that her direction to the LPN to "follow PEP protocol" included the resource of antiretroviral drug information that she presented in a July 2018 statewide Infection Prevention Nurse meeting, which the LPN had attended. The information referenced is a PowerPoint titled, "Beginners Understanding of Antiretroviral Drugs." However, it is reportedly not part of DOC's normal medical practice for staff to consult conference materials in making dosage determinations.

  - The LPN next contacted the AHCC doctor via email and asked, "Raltegravir & Truvada x28 days is this ok for PEP tx." The AHCC doctor confirmed this order. Neither communication included the dosage amount and the LPN ordered a dosage for half the necessary amount. The prescription for the incorrect dosage was signed by yet another person, the Advanced Registered Nurse (ARN), who also did not catch the error.

  - Upon discovering the error almost the full month of treatment later after the complainant reported severe physical side effects, the RN filed a medication incident report, stating that she felt that the pharmacy should have caught the error.

- In the grievance investigation documentation, the RN recommended an update of the PEP protocol to include dosages. Following discussion with medical staff, it became clear that neither the medication error report, nor the substantiated grievance, nor this recommendation for an updated PEP protocol ever made it to headquarters health services staff to be able to take action on it, nor is there a process in place to enable such corrective action.

- OCO found the following concerns with the grievance regarding the administration of the incorrect dosage of the prophylactic:

  - The tone of the Level I grievance response could be interpreted, and in fact was interpreted by the complainant, as diminishing his concern. The response stated, "your level of exposure risk was considered negligible. Because of this, medication was not required at all…The only reason you were provided any prophylactic medications was because you voiced such a strong desire to be treated. Due to your voiced concerns, medication was approved by the Infection Control Doctor despite it not being medically necessary. Therefore, any medication prescribed would more than cover your already negligible risk." Once again, the grievance response appears to put the onus on the complainant rather than making any acknowledgement of staff failures, taking responsibility for them, or recommending corrective action. It did not address the side effects that the complainant experienced, nor did it address any effect that an improper dose may have had.

  - The Level II response was returned to the inmate over a month after it was submitted with no extensions filed. DOC staff reported to OCO that the grievance had been "lost."

  - The response to the Level II appeal acknowledged the improper medication and the tone issue. However, it too minimized the complainant's concern by stating, "It is understood that you experienced side effects from the prescribed medication and ask you to consider that if you had received it twice per day [i.e. the correct dose], which would have meant twice as much, your side effects may have worsened." The fact that the side effects may have been worse is not sufficient reason to not receive the correct dosage of a medication to prevent HIV, and the implication is that the complainant was better off by not receiving a correct dose. The response goes on to state that "At any rate I am glad to learn that you turned out to be negative for the disease for which the medication was prescribed." This could be perceived as taking a "no harm, no foul" approach that minimizes what happened to the inmate and also does not recommend any corrective action for the medical staff.

  - There is no mechanism for DOC health services staff at higher levels to become aware of substantiated claims of medical error and take corrective action if they are not appealed by the inmate.

- Regarding the medical treatment provided to the complainant pertaining to Hepatitis C, DOC staff determined beginning Hepatitis C treatment at the facility was not appropriate because the treatment requires a strict regimen and the treatment could not have been completed prior to the complainant's release. Interrupting the treatment regimen could have a greater negative impact on the complainant later. Instead, DOC staff provided the complainant with information on how to have Labor and Industries (L&I) cover the cost of treatment once he was released. However, DOC staff did not make an appointment with an outside health provider for the complainant's post-release care[1] and it was ultimately left to the complainant to find care post-release.

- In addition to the above cited issues, OCO found the following concerns with DOC policy:

    - OCO could not find language in DOC policy preventing escorting officers from ordering incarcerated work crew individuals to perform hazardous tasks for which they are not equipped and ensuring that PPE is utilized. There may be language in the facility-specific offsite crew post-orders but that lacks consistency across the statewide system.

    - OCO did not find DOC policy language requiring post-release medical support to incarcerated individuals who contracted illnesses or sustained injuries as a result of activities taken due to their incarceration.

    - Both the Blood-Borne Pathogen and HIV-related DOC policies have not been updated since 2015. Neither appear to address the circumstance of an incarcerated person who becomes infected on a work crew and steps to take, other than to file an Accident Injury report and report the incident to the supervisor.

    - There is a lack of policy verbiage requiring the taking of immediate statements from those present onsite, which would be helpful as the immediacy of recollection fades over the following days.

Outcomes

- DOC took immediate action to ensure that new PPE was ordered and available to work crews at the facility.

- The complainant was provided with L&I information to ensure he could obtain treatment for Hepatitis C without personal expense post-release. He ultimately tested negative for HIV.

- After consultation with Human Resources, DOC agreed to ensure that relevant staff would be interviewed even if they were on leave if needed for investigations.

[1] The AHCC RN referenced in this report relayed that she attempted to make the complainant an appointment with an outside clinic that he could utilize post-release but was unable due to not having the complainant's Apple ID.

- AHCC staff agreed to review post orders to ensure staff filling the escorting officer role had necessary training and information regarding what to do in the future if confronted with a hazardous situation.

Recommendations

- Conduct a review and revision of workplace safety policies and procedures to:
    - Require audits of Hazard Assessments and/or Job Safety Analyses to ensure that they are conducted at, and reflective of, all worksites prior to beginning work;
    - Ensure the correct PPE is provided in accordance with the assessed needs of the workplace;
    - Ensure clear, consistent instruction is given to incarcerated work crew members regarding what they should do if directed to handle material for which they are not equipped;
    - Prohibit escorting officers from ordering workers to handle hazardous materials without the appropriate PPE and training; and
    - Require more robust accident injury responses, including photographic documentation of the site and statements from all relevant individuals by the end of shift
        - This would help protect DOC from liability as well as provide a record from which learning and improvements can take place

- Conduct a review and revision of healthcare policies and procedures to:
    - Revise PEP protocols to include correct dosage amounts;
    - Ensure adequate training of all medical staff who may be involved in PEP and that they have access to the correct protocols;
    - Review communication between medical staff such as occurred here, that sufficient oversight and review is in place;
    - Ensure continuity of care, particularly for injuries occurring due to a person's incarceration.

- Create an internal quality assurance process to ensure healthcare-related events involving substantiated cases of misdiagnosis or medication error are brought forth to the attention of headquarters staff who have the authority to evaluate and mandate corrective action.

- Strengthen the grievance process to ensure that it is both fair and thorough, including ensuring:
    - All relevant witnesses are interviewed;
    - Findings are not made without supporting evidence;
    - Staff actions are fully reviewed, investigated, and addressed, even if corrective action has been taken;

- Grievances are responded to timely;
- Staff responses do not act to minimize incarcerated persons' complaints; and
- Ensure higher levels of appeal review the quality of investigation at lower levels of the grievance investigation, and areas of improvement that are found are documented and communicated to appropriate staff