Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-22-008

Report to the Legislature

As required by RCW 72.09.770

June 13, 2022

DOC Corrective Action, Publication Number 600-PL001

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Legislative Directive

Engrossed Substitute Senate Bill 5119 (2021)

Unexpected Fatality Review Governance

RCW 72.09.770 requires the Department of Corrections (DOC) to convene an Unexpected Fatality Review (UFR) committee and meeting in any case "in which the death of an incarcerated individual is unexpected, or any case identified by the Office of the Corrections Ombuds." The department is also required to issue a report on the results of the review within 120 days of the fatality and, within 10 days of completion of the review, develop an associated corrective action plan to implement any recommendations made by the review team. The statute took effect July 25, 2021.

The "primary purpose of the unexpected fatality review shall be the development of recommendations to the department and legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for prisoners in the custody of the department."

"'Unexpected fatality review' means a review of any death that was not the result of a diagnosed or documented terminal illness or other debilitating or deteriorating illness or condition where the death was anticipated and includes the death of any person under the jurisdiction of the department, regardless of where the death actually occurred. A review must include an analysis of the root cause or causes of the unexpected fatality, and an associated corrective action plan for the department to address identified root causes and recommendations made by the unexpected fatality review team under this section."

Unexpected Fatality Review Committee Report

The department issued the UFR committee report 22-008 on June 4, 2022 (DOC publication 600-SR001). This document includes the required corrective action plan. The department is required to implement the corrective actions within 120 days of the publication of the committee report.

Corrective Action Plan

CAP ID Number:	UFR-22-008-1
Finding:	Incarcerated Individual had known cardiac condition and a seizure disorder but there was no evidence of a systematic approach to chronic disease management. Systematic care may have identified reversible contributing factors.
Root Cause:	Lack of standardized management of cardiac conditions and seizure disorder while incarcerated.
Recommendation:	Educate health services staff on accepted care pathways for cardiac and seizure disorders to ensure that incarcerated individuals receive care according to best practices of evidence-based medicine.
Corrective Action:	Develop and implement guidance to standardize the management of care provided to incarcerated individuals who have cardiac conditions and seizure disorders.
Expected Outcome:	Improved health outcomes by standardizing care delivered to incarcerated individuals who have cardiac conditions and seizure disorders.

CAP ID Number:	UFR-22-008-2
Finding:	The medical record indicated that the incarcerated individual had a history of refusing care such as lab work and off-site specialty trips, but there was no unifying documentation of his decision-making process nor the counseling by providers. Improved documentation of care decisions would ensure DOC can protect incarcerated individuals' rights to refuse while identifying those who might be amenable to motivational interviewing or other interventions.
Root Cause:	Lack of reliable documentation for incarcerated individuals' refusals of care such as offsite care appointments and blood draws.
Recommendation:	Ensure that appropriate clinical follow-up occurs with incarcerated individuals when they have declined recommended care. Policy/protocol should: a) Formalize a process for follow-up with incarcerated individuals who have missed, cancelled, or declined appointments, tests/procedures, or generally decline care,

	b) Give tangible guidance to staff integrating an assessment of the acuity of the incarcerated individual's clinical condition to determine the frequency and insistence to be used for follow-up after care refusals, and c) Provide an acceptable "off ramp" for incarcerated individuals who have life-limiting illness to decline routine medical care and opt toward comfort-based care.
Corrective Action:	Develop and implement policy / protocol to ensure that documented follow-up occurs with incarcerated individuals when they have declined recommended care to help promote improved understanding of the rationale, alternative options that might be available, and risks associated with declining care.
Expected Outcome:	DOC will provide documented follow-up, at least annually, to incarcerated individuals when they have declined recommended care. This will promote informed shared decision making between the clinical team and the incarcerated individual providing an opportunity for them to change their previous decision about declining recommended care.

CAP ID Number:	UFR-22-008-3
Finding:	2 staff and 3 incarcerated individuals stated that unit staff do not require incarcerated individuals to conduct a "standing" count. Following the policy for a standing count may have helped identify this incarcerated individual's need for help earlier in the emergency.
Root Cause:	Drift in adherence to required security and safety procedures to require incarcerated individuals to wake-up and stand when count is conducted resulted in DOC staff not being able to verify the incarcerated individuals' ability to comply with this procedure earlier in the chain of events leading up to the emergency.
Recommendation:	Require facility leadership to observe a "standing" count at least once per week to ensure compliance with policy requirements.
Corrective Action:	Require facility's custody leadership to observe a "standing" count at least once per week to ensure compliance with policy requirements.
Expected Outcome:	The health, safety and security of incarcerated individuals is routinely verified.

CAP ID Number:	UFR-22-008-4
Finding:	The incarcerated individual was not taking medications as prescribed and, per review, it appears that the prescribing provider was unaware of the lapse.
Root Cause:	Lack of an agreed upon prescriber role in the management of self-carry medications by incarcerated individuals allowed unaddressed non-adherence to continue for longer than optimum.
Recommendation:	Ensure policies and procedures regarding medication management are followed by staff including guidance on:

	a) Medications required to be administered via “pill line” versus those available as “keep on person,” b) Expectations for nursing and/or pharmacy staff to alert the prescribing provider that a “keep on person” medication has not been ordered in the appropriate timeframe by the incarcerated individual so that the provider can have compliance conversations with the incarcerated individual, and c) Quality assurance procedures to ensure that medications are in stock as needed. Consider establishing PAR levels of commonly needed medications in facility pharmacy stock.
Corrective Action:	Review and update: DOC Policy 650.020 Pharmaceutical Management; Pharmaceutical Management and Formulary Manual; and Nursing Procedure N-306. Document communication of updates to DOC health services staff.
Expected Outcome:	Improved incarcerated individual safety by improving the consistency of medication management.

CAP ID Number:	UFR-22-008-5
Finding:	There is no evidence that this incarcerated individual was physically assessed while COVID positive one month prior to his death; further, despite having high risk conditions, there is no evidence that this incarcerated individual was offered antiviral treatment to reduce the risk of more severe COVID course.
Root Cause:	Lack of systematic, gap-proof plan of care to address needs of those with high comorbidity burden in COVID outbreaks. Further, nursing and practitioner staffing did not appear adequate to the need of the large outbreak.
Recommendation:	Ensure that incarcerated individuals with health conditions that may place them at higher risk of COVID-related complications receive appropriate care when diagnosed with COVID-19.
Corrective Action:	Review and update medical Covid-19 risk and treatment guidelines. Document communication of updates to DOC health services staff.
Expected Outcome:	Improved health outcomes by standardizing care delivered to incarcerated individuals who have medical conditions placing them at higher risk of complications due to COVID-19 infection.

The purpose and use of this report is subject to RCW 72.09.770.