Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-23-015

Report to the Legislature

As required by RCW 72.09.770

February 11, 2024

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 23-015 on February 01, 2024 (DOC publication 600-SR001). This document includes the required corrective action plan. The department is required to implement the corrective actions within 120 days from the corrective action plan publication.

Corrective Action Plan

CAP ID Number:	UFR-23-015-1
Finding:	A community nephrologist recommended changing from peritoneal dialysis to hemodialysis within seven days. Transitioning a patient from peritoneal dialysis to hemodialysis in DOC is rare and DOC currently lacks a process by which staff members manage the overall transfer and treatment timeline for patients. The lack of identified process and owner caused a delay beyond the seven-day recommendation.
Root Cause:	DOC's current process for managing nephrology care transitions including transfers of patients from the DOC facility that facilitates peritoneal dialysis to the DOC facility that facilitates hemodialysis was insufficient to provide the necessary care coordination for this case.
Recommendations:	DOC should conduct a root cause analysis with formal process improvement recommendations to support the care of incarcerated individuals who require urgent dialysis and prevent similar incidents in the future.
Corrective Action:	Urgent dialysis services and transition from peritoneal dialysis will be included in a Failure Mode Effects Analysis (FMEA) conducted by DOC HS targeted to improve care timelines.
Expected Outcome:	Increased safety and care outcomes for the incarcerated individuals who require urgent dialysis service and those who transition from peritoneal to hemodialysis.

CAP ID Number:	UFR-23-015-2a
Finding:	The tier check standards were not consistently followed by custody staff when conducting and documenting tier checks.
Root Cause:	Staff did not follow the standards for the tier check.
Recommendations:	Tier checks should be completed and documented in accordance with post orders and align with the conditions of confinement.
Corrective Action:	DOC leadership should pursue progressive discipline per Article 8 of the Teamsters Collective Bargaining Agreement when there is evidence that appropriately trained custody staff are not following post orders and DOC policy.
Expected Outcome:	Increased safety and care outcomes for the incarcerated individuals.

CAP ID Number:	UFR-23-015-2b
Finding:	Nursing staff documented an assessment that was not supported by video

	evidence.
Root Cause:	Nursing staff did not follow DOC procedures and nursing standards of practice.
Recommendations:	Nursing assessments should be completed and documented in accordance with DOC procedures and nursing standards of practice.
Corrective Action:	DOC leadership should pursue progressive discipline per Article 8 of the Teamsters Collective Bargaining Agreement when there is evidence that appropriately trained custody staff are not following post orders and DOC policy.
Expected Outcome:	Increased safety and care outcomes for the incarcerated individuals.