Department of Corrections
WASHINGTON STATE

Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-21-005

Report to the Legislature

As required by RCW 72.09.770

April 29, 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 21-005 on April 29, 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

Committee Recommendation	DOC Corrective Action	Expected Outcomes
1. Reinforce the importance of handoff communication with Community Correction Division (CCD) and Custody staff and ensure staff understands how to escalate individual care and safety concerns.	CCD and DOC custody leadership will direct their personnel to engage with the DOC Nurse Desk for appropriate triage and placement of violators, including bringing up risk concerns at the time of handoff.	Improved safety for incarcerated individuals.
2. Review the process for Community Corrections Specialists to have health needs reviewed prior to return from partial confinement in the community.	A checklist will be created to prompt community custody case managers to contact the DOC Nurse Desk when returning individuals on partial confinement back to prison.	Improved safety for individuals returning to custody with medical or mental health needs by allowing health care needs to be matched to services available by prison facility.
3. Ensure mental health screening upon intake, regardless of category of custody, in accordance with DOC Policy 630.500.	Communicate requirement for universal mental health screening at intake according to DOC Policies 630.500 and 610.040.	All incarcerated individuals arriving to DOC facilities from outside of DOC will be screened by mental health staff according to policy.
4. Re-evaluate what is generally issued to the newly incarcerated individuals for potential hazards that could enable self-harm and update policies to reflect approved changes.	DOC Custody and Mental Health will review all policies that enable issuance of potentially hazardous items for persons determined to be at risk for self-harm and ensure safe practices	Increased safety for incarcerated individuals.

Committee Recommendation	DOC Corrective Action	Expected Outcomes
5. Ensure nursing staff appropriately escalate needs to on call providers. Enforce the expectation that on call providers respond in a timely fashion. Ensure staff know how to escalate needs up the supervisory chain until the patient care need is satisfied. Health Services will ensure that those who are in on-call status answer their phones when called.	Confirm with all Health Service Managers (HSM) that staff have a clear notification process for mental health crisis response, to include both, during and after business hours. If a call is made to the on-call Mental Health provider and is not answered, staff should escalate up the supervisory chain until the patient care need is met.	The system to ensure patients with a mental health need will function reliably to supply that need.
6. Ensure equipment is accessible and in working order.	Develop a list and a maintenance schedule for critical health services equipment. This must include the emergency response vehicles and electric gurneys.	Functioning equipment is accessible when needed.
7. Ensure outreach to family and/or emergency contact after the death of an incarcerated individual.	Reinforce policy requirements for notifying immediate family and/or emergency contacts as soon as possible in the event of an incarcerated individual's death.	Notifications of the death of an incarcerated individual occur timely per policy.
8. Review policies that pertain to the care of persons deemed at risk of self-harm and assure they are consistent with best standards of practice; update if needed.	Collaborate with the Department of Health Suicide Prevention expert on best practices for patient risk stratification and monitoring within the first 24-48 hours of arrival to DOC.	Increased safety for incarcerated individuals.

Consultative remarks that do not directly correlate to causes of death, but should be considered for review by DOC:

1. Consider whether it would be of benefit for mental health providers to attend morning team huddles.
2. In this case, it appears that an assumption of safety was made because the patient had a negative urine drug screen. Consider a leadership discussion to share this lesson learned and discus the limitations of urine toxicology screening in this case as part of the evaluation of new intake patients.
3. As with most cases, team communication and the dynamics that promote “see something – say something” safety culture appeared to have been suboptimal in this team. DOC should continue to promote a culture of safety.