Unexpected Fatality Review DOC Corrective Action Plan

Unexpected Fatality UFR-22-026

Report to the Legislature

As required by RCW 72.09.770

December 19, 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 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 22-026 on December 9, 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-22-026-1
Finding:	DOC has inadequate housing space for managing medical isolation patients during an infectious disease outbreak, and there is no capacity in the community to absorb DOC patients.
Root Cause:	Insufficient infrastructure in DOC facilities to safely house and care for patients requiring medical isolation.
Recommendation:	Explore options for expanding medical isolation capacity in DOC facilities.
Corrective Action:	Develop a proposal to expand medical isolation capacity for DOC leadership review and consideration.
Expected Outcome:	Improved infrastructure and capacity for managing medical isolation patients.

CAP ID Number:	UFR-22-026-2
Finding:	Mental health staff were not notified that he was in medical isolation in an alternative housing unit.
Root Cause:	DOC does not have a standard process requiring notification of mental health staff when an individual is placed in medical isolation/quarantine or an alternative housing unit.
Recommendation:	Ensure mental health staff are notified when an incarcerated individual is placed in medical isolation/quarantine or an alternative housing location.
Corrective Action:	Update the following to clarify that any incarcerated individual on medical isolation, regardless of reason, include directives for mental health notification and rounding expectations. • WA State DOC COVID-19 Mental Health/Psychiatry Response Guideline • Safety Exposure Control Guide • Communicable Disease, Infection Prevention, and Immunization Program • WA State DOC COVID-19 Screening, Testing, and Infection Control Guideline Version 33.1 (R. 9/13/2022)
Expected Outcome:	Mental health staff will be aware when an incarcerated individual is on isolation/quarantine status or in an alternative housing location will have regular mental health support.

CAP ID Number:	UFR-22-026-3
Finding:	The incarcerated individual did not receive mental health wellness checks while housed in medical isolation.
Root Cause:	DOC Policy 630.500 – Mental Health Services section VII does not include mental health service expectations for individuals being housed in an alternate housing unit or in medical isolation.
Recommendation:	Consider amendment of policy 630.500 to be more descriptive of the role of Mental Health staff, including Psychiatrists, in the care and well-being of persons admitted to an alternate housing unit or on medical isolation.
Corrective Action:	Update Policy 630.500 – Mental Health Services Section VII or create and deploy a MH protocol that includes MH service expectations for individuals being housed in an alternate housing unit or on medical isolation.
Expected Outcome:	Improved Mental Health access for medically isolated individuals.

CAP ID Number:	UFR-22-026-4
Finding:	There was inadequate mental health planning and support due to absence of health services team communication regarding this at-risk individual housed in medical isolation.
Root Cause:	A lack of care coordination and communication regarding the incarcerated individual's mental health needs between custody, mental health, psychiatry, nursing, and primary care staff.
Recommendation:	Establish a process for multidisciplinary care planning for managing complex cases or situations (i.e., medical isolation, mental health concerns, alternative housing).
Corrective Action:	Develop a policy or protocol establishing criteria and expectations for care planning at least weekly for persons in medical isolation.
Expected Outcome:	Improved mental health access and support for individuals in medical isolation.

CAP ID Number:	UFR-22-026-5
Finding:	The incarcerated individual was not referred for mental health services when staff noticed behavior changes.
Root Cause:	Staff did not know how to refer or did not realize his behavior changes warranted a referral to mental health.
Recommendation:	Improve staff awareness of suicide risk and need for mental health referrals when an incarcerated individual displays concerning behavior changes.
Corrective Action:	1. Develop a plan to restart annual in-person suicide awareness training, and 2. Reinforce the use of DOC Form 13-420 "Request for Mental Health Assessment" during the monthly facility "Place-safety Musters."
Expected Outcome:	Increased opportunity for mental health intervention when an incarcerated individual may be experiencing a mental health crisis.

CAP ID Number:	UFR-22-026-6
Finding:	Custody wellness/tier check in the alternative housing unit were not consistently completed as required in the “Security Inspection Matrix” attached to DOC policy 420.370 – Security Inspections.
Root Cause:	Lack of an operations manual or post orders for alternative housing units.
Recommendation:	Establish written procedures to ensure alternate housing units are managed and operated with the same safety and security expectations as established housing units.
Corrective Action:	Create an operations manual and post orders for alternative housing units to ensure they are managed and operated safely and securely.
Expected Outcome:	Consistent safety and security procedures in alternative housing units.

CAP ID Number:	UFR-22-026-7
Finding:	When alternative housing options were being considered, the infection prevention physician was incorrectly informed that there were no negative pressure medical isolation rooms available in any facility.
Root Cause:	DOC has no centralized tracking system for the availability of negative pressure medical isolation rooms.
Recommendation:	DOC should begin tracking the availability of negative pressure medical isolation rooms.
Corrective Action:	Create a centralized database to track availability of negative pressure medical isolation rooms for DOC facilities.
Expected Outcome:	Improved management of housing options for individuals who require a negative pressure medical isolation room.