Unexpected Fatality Review DOC Corrective Action Plan

Unexpected Fatality UFR-23-025

Report to the Legislature

As required by RCW 72.09.770

April 14, 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 23-025 on April 4, 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-23-025-1
Finding:	There is no documentation of a formal decisional capacity evaluation in the health record after the incarcerated individual declined recommended care several times.
Root Cause:	Staff did not recognize the mental health symptoms and recent illness may have impacted the incarcerated individual's capacity to make informed health care decisions.
Recommendations:	DOC should provide education to DOC Health Services staff regarding the process to evaluate decisional capacity.
Corrective Action:	DOC should develop a protocol for evaluating decisional capacity and a plan to provide education to DOC Health Services facility staff on the protocol.
Expected Outcome:	Support for incarcerated individuals' autonomy to make care decisions.

CAP ID Number:	UFR-23-025-2a
Finding:	This individual had complex care needs requiring both medical and mental health support.
Root Cause:	The behavioral health transfer call discussion regarding appropriate housing did not include input from medical providers.
Recommendations:	DOC Health Services should use a multidisciplinary care team meeting that includes primary care, nursing, and behavioral health team members for individuals with complex medical and mental health needs.
Corrective Action:	DOC Health Services will develop a plan and protocol for the use of multidisciplinary team meetings to improve transitions of care for individuals with medical and mental health needs.
Expected Outcome:	Improved continuity of care for transferring individuals.

CAP ID Number:	UFR-23-025-2b
Finding:	This individual had complex care needs requiring both medical and mental health support.
Root Cause:	The behavioral health transfer call discussion regarding appropriate housing did not include input from medical providers.
Recommendations:	DOC Health Services should use a multidisciplinary care team meeting that includes primary care, nursing, and behavioral health team members for individuals with complex medical and mental health needs.

Corrective Action:	DOC should update the behavioral health transfer call criteria to include a care needs review by the Facility Medical Director to ensure medical care needs can be met.
Expected Outcome:	Improved continuity of care for transferring individuals.

CAP ID Number:	UFR-23-025-2c
Finding:	This individual had complex care needs requiring both medical and mental health support.
Root Cause:	The behavioral health transfer call discussion regarding appropriate housing did not include input from medical providers.
Recommendations:	DOC Health Services should use a multidisciplinary care team meeting that includes primary care, nursing, and behavioral health team members for individuals with complex medical and mental health needs.
Corrective Action:	DOC should develop written guidelines for transferring incarcerated individuals to the special needs unit.
Expected Outcome:	Improved continuity of care for transferring individuals.

CAP ID Number:	UFR-23-025-3
Finding:	Nursing care was insufficiently documented in the health record
Root Cause:	Nurses were not sufficiently documenting their assessments and nursing assistants were not documenting the care they provided in the health record.
Recommendations:	DOC should ensure that all nursing documentation is contained in the health record.
Corrective Action:	The chief nursing officer will provide education and establish a systemic accountability process that will ensure all nursing care is appropriately documented in the health record.
Expected Outcome:	All nursing care provided will be accurately reflected in the health record.

CAP ID Number:	UFR-23-025-4
Finding:	The incarcerated individual's urinary catheter was not properly managed.
Root Cause:	There was no care plan in place to support the individual with catheter care.
Recommendations:	DOC should ensure appropriate catheter care is being provided to all incarcerated individuals housed in prison facilities.
Corrective Action:	The Chief Medical Officer will verify with Facility Medical Directors that individuals with catheters have an appropriate care plan in place.
Expected Outcome:	Appropriate care support is provided to individuals with urinary catheters.