Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-21-004

Report to the Legislature

As required by RCW 72.09.770

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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 21-004 on February 16, 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 Impacts
1. When a medical emergency occurs, reinforce the expectation for employees to describe the situation clearly so that the responders bring the necessary equipment.	Training will be updated to ensure that trainers deliver curriculum that sets the expectation to provide a clear and concise initial notification during an incident/event to help expedite and appropriately resource each emergency medical response. This will include qualified responders moving to the scene with the appropriate functional equipment. This training will be offered at initial onboarding during CORE, and in annual in-service updates.	Radio calls for emergency response include the details necessary to prepare responders.

Committee Recommendation	DOC Corrective Action	Expected Impacts
2. Clarify the requirements for responders, including medical employees, to bring necessary equipment to avoid the potential for a delay of care.	Each facility will set up quarterly exercises/drills to help prepare staff to respond to a variety of scenarios that require them to assess initial notification received via radio call and respond to the site with appropriate staff and equipment. The team will use the monthly emergency management drill format to document these exercises regularly.	Staff are prepared to respond to emergencies that occur and have all necessary equipment at the scene of emergencies to intervene safely and effectively.
3. Reinforce expectations for following emergency response practices and protocols.	Each facility will set up quarterly exercises/drills to help prepare staff to respond leveraging practices required by Basic Life Support and clinic protocols. The team will use the monthly emergency management drill format to participate and document these exercises regularly.	Department of Corrections staff will sharpen emergency response knowledge and skills by regular team drills.

Committee Recommendation	DOC Corrective Action	Expected Impacts
4. Accurately identify older adults at risk for fall through periodic screening and improve employee knowledge on recognizing fall risks.	Health Services will use the DOC Safe Ambulation Committee to develop and implement a robust fall prevention program. The program will include a fall risk screening protocol, post-fall assessments, and options to reduce the risk of falls.	Older adults who are at heightened risk for falls are identified and provided with preventions.

Committee Recommendation	DOC Corrective Action	Expected Impacts
5. Reduce fall risks by involving an interdisciplinary team to address all aspects of fall prevention, which may include: a. Prescribers and/or nurses to conduct screenings and carry out post-fall assessments. b. Physical therapist(s) to assess function/mobility levels, determine need for assistive devices, and develop exercise program to improve balance and gait. c. Clinical pharmacist to review medication lists of patients at high risk and identify medications that may increase fall risks.	Health Services will use the DOC Safe Ambulation Committee to develop a fall prevention program including screenings, post-fall assessment, and intervention options within prison to improve care of individuals at risk for falls.	Older adults who have high risk of falls are provided with preventive services and care before and after falls.

Committee Recommendation	DOC Corrective Action	Expected Impacts
6. When and individual sustains a fall, even if a fall seems minor or is unwitnessed, DOC should develop and implement a process to assess if there are injuries and the cause of the fall. The process should include a clinical evaluation to assess for injury and a root cause analysis to assess for cause.	Each facility will develop a standardized process for assessment of individuals at risk for falls and follow up after patients fall in prison.	Individuals who fall in prison have appropriate care and planning to prevent repeat falls.
7. Replace broken clinical equipment promptly.	Training will be conducted to ensure that staff remove and replace non-functional/broken equipment as soon as it is determined to not function as designed. Medical staff will perform regular checks and request maintenance be performed of broken or damaged clinical equipment to ensure functionality of equipment.	Medical staff completes routine checks and repairs of clinical equipment.
8. Ensure follow-up appointment after a course of treatment is completed to improve patient outcomes.	Provide training to medical staff and set expectation to ensure that medical staff plan post-treatment appointments for all patients as appropriate.	Medical providers complete regular follow up after treatment for all patients.

Committee Recommendation	DOC Corrective Action	Expected Impacts
9. Provide prompt referral to a specialist when no improvement is noted or when progression of disease is observed that increases risk of injury or safety of a patient.	Medical staff will be trained and given expectations to ensure that staff review patient progress on all individuals undergoing treatment and escalate care to higher level provider if no improvement or disease progression is noted.	Health Services provide a timely referral to a specialist if patient does not improve or disease worsens.