Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-23-012

Report to the Legislature

As required by RCW 72.09.770

March 13, 2024

DOC Corrective Action, Publication Number 600-PL001

Cheryl Strange, Secretary
cheryl.strange@doc.wa.gov

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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 23-012 on March 3, 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-23-012-1
Finding:	The incarcerated individual's blood pressure control was not optimal.
Root Cause:	The initial Patient Centered Medical Home (PCMH) blood pressure metric was access to care (leading metric) rather than outcome measure (lagging metric). Success was defined as whether a visit occurred within the past 6 months rather than whether the treatment was effective in controlling the blood pressure.
Recommendations:	DOC should update the performance metrics to monitor the effectiveness of blood pressure treatment.
Corrective Action:	DOC will update the blood pressure (BP) management metric from access to care to effectiveness of care.
Expected Outcome:	Improved care outcomes for individuals diagnosed with high blood pressure.

CAP ID Number:	UFR-23-012-2
Finding:	Documentation does not show the primary care provider received and acted on the results of the blood pressure monitoring prior to the scheduled follow-up visit.
Root Cause:	The current process and tools for monitoring blood pressure treatment effectiveness are not optimally connected and staff use is inconsistent.
Recommendations:	DOC Health Services should adopt a statewide standard system to support the effective management of high blood pressure.
Corrective Action:	DOC Health Services will adopt the Patient Centered Medical Home blood pressure management pilot project as the statewide standard system.
Expected Outcome:	Improved monitoring and treatment for individuals diagnosed with high blood pressure.