Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-23-021

Report to the Legislature

As required by RCW 72.09.770

March 29, 2024

DOC Corrective Action, Publication Number 600-PL001

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

Unexpected Fatality Review
DOC Corrective Action Plan

DOC Corrective Action Publication Number 600-PL001

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 23-021 on March 19, 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-23-021-1
Finding:	Care delays occurred during the course of the incarcerated individual's illness.
Root Cause:	Both DOC and community medical providers failed to follow-up on abnormal diagnostic test results.
Recommendations:	DOC should conduct a multi-disciplinary Healthcare Failure Mode and Effect Analysis (H-FMEA) to look at this case in addition to two other cases previously identified with care delays.
Corrective Action:	DOC will conduct a multidisciplinary Healthcare Failure Mode Effects and Analysis (H-FMEA) regarding care delays for this and two other identified cases.
Expected Outcome:	Improved coordination and timeliness of care delivery.

CAP ID Number:	UFR-23-021-2
Finding:	There was no evidence that the abnormal ultrasound result was received or reviewed by DOC providers.
Root Cause:	The DOC process for receiving and acting on reports and results from offsite visits with community providers contains an unacceptable level of variability.
Recommendations:	DOC should explore the development of a tracking tool for external provider consult reports and test results.
Corrective Action:	DOC will develop a standard process for obtaining and reviewing consult reports and test results.
Expected Outcome:	Improved care coordination and outcomes for individuals.