



Unexpected Fatality Review DOC Corrective Action Plan

Unexpected Fatality UFR-21-002 Report to the Legislature

As required by Engrossed Substitute Senate Bill [5119](#) (2021)

February 08, 2022

DOC Corrective Action, Publication Number 600-PL001

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Note: Information request can be sent to the Risk Mitigation Director

Unexpected Fatality Review 21-002

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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 on February 02, 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
Consistently categorize deaths as expected or unexpected.	Recognizing that each death in Washington prisons undergoes review by a clinical mortality committee, DOC must revise the manner of designating which deaths merit further review via Unexpected Fatality Review.	<p><i>Continuous healthcare quality improvements.</i></p> <p>Deaths which would benefit from review beyond a clinical Mortality Review Committee would be consistently identified.</p>
Improve educational efforts on the risks of polypharmacy.	Enter an alert for medications associated with fall risk in the elderly (Beers criteria) into the computerized pharmaceutical order entry system.	<p><i>Increased safety in medication prescribing.</i></p> <p>Clinicians will see an alert on their work screens when prescribing medications the American Geriatrics Society has identified as contributors to fall risk in older patients and could reconsider medication management.</p>
Conduct routine fall risk assessments for high-risk patients.	Include fall risk assessment on a standardized checklist for use as appropriate by medical assistants to room patient for routine appointments with primary care providers.	<p><i>Improved fall prevention.</i></p> <p>Patients who may benefit from fall prevention interventions will be identified.</p>

Committee Recommendation	DOC Corrective Action	Expected Impacts
<p>Improve access to health care services for severely mentally ill patients.</p>	<p>Discuss ways to measure patient outcome disparities for the mental health residential treatment units in order to inform interventions.</p>	<p><i>Improved understanding of whether serious mental illness impacts health outcomes for individuals incarcerated by WA DOC.</i></p> <p>Health outcome disparities experienced by individuals with serious mental illness can be examined to devise intervention.</p>
<p>Establish team-based care staffing and processes as the standard approach to overall patient care.</p>	<p>Contract with a Lean Healthcare consulting firm to begin establishing team-based care delivery.</p>	<p><i>Availability of expertise needed to make multidisciplinary process improvements.</i></p>
<p>Improve reliability of primary care provider notification after a fall.</p>	<p>Develop the framework for a fall prevention program through the geriatric work group.</p>	<p><i>Patients at risk of falls can be offered intervention.</i></p>