Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-23-004

Report to the Legislature

As required by RCW 72.09.770

June 30, 2023

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 23-004 on June 20, 2023 (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

CAP ID Number:	UFR-23-004-1
Finding:	There was an opportunity for better communication between medical, mental health and custody staff regarding the rationale and safety needs for the incarcerated individual's placement in the close observation area.
Root Cause:	There is not a process/protocol to guide the interdisciplinary communication and collaboration between health service teams and custody staff.
Recommendation:	A process for formal Multidisciplinary Team (MDT) meeting should be developed when an individual is placed in a close observation area for safety monitoring to include options for after business hours communications.
Corrective Action:	Develop and implement minimum standards for conducting Multidisciplinary Team meetings to discuss care plans and housing of individuals in close observation areas.
Expected Outcome:	Improved communication and support for staff and incarcerated individuals.

CAP ID Number:	UFR-23-004-2a
Finding:	The conditions of confinement for an individual being housed in the close observation area were changed without a formal suicide risk assessment being conducted.
Root Cause:	The mental health staff member who decreased the conditions of confinement had the authority to decrease the conditions of confinement but was not as familiar with the mental health history of the incarcerated individual and chose not to conduct a formal suicide risk assessment.
Recommendation:	Formalize and standardize onboarding to ensure all mental health staff are trained on where, when, and how to conduct close observation area assessments when there are concerns about suicide or self-harm or other sensitive mental health concerns.
Corrective Action:	Provide and document training to custody and health services staff on general suicide prevention and the policy and procedures for incarcerated individuals being housed in a close observation area.
Expected Outcome:	Improved support and safety for incarcerated individuals.

CAP ID Number:	UFR-23-004-2b
Finding:	The conditions of confinement for an individual in the close observation area were decreased without a formal suicide risk assessment being conducted.
Root Cause:	The mental health staff member who decreased the conditions of confinement had completed suicide prevention training per his license requirements, however it was not the DOC in-person version of the training.
Recommendation:	Improve staff awareness that self-harm events may be a suicide attempt and not an attention seeking behavior.
Corrective Action:	Develop a plan to restart annual in-person suicide awareness training and continue to provide and document appropriate onboarding and training for mental health staff.
Expected Outcome:	Improved support and safety for incarcerated individuals.

CAP ID Number:	UFR-23-004-2c
Finding:	The custody officers working in the close observation area did not understand which clothing items were allowable for the incarcerated individual after the conditions of confinement were decreased.
Root Cause:	The custody officers did not understand which items were allowable had not received DOC annual in-person suicide risk training.
Recommendation:	Formalize and standardize onboarding to ensure all custody staff are trained on how to follow the written conditions of confinement and to seek clarification from the mental health staff when they have questions.
Corrective Action:	Provide and document training to custody staff on general suicide prevention and the policy and procedures for incarcerated individuals being housed in a close observation area.
Expected Outcome:	Improved support and safety for incarcerated individuals.

CAP ID Number:	UFR-23-004-3
Finding:	The brief assessment of the incarcerated individual's self-harm/suicidality between the mental health staff member and the incarcerated individual did not occur in a confidential manner.
Root Cause:	The mental health staff member chose not to utilize a confidential space when assessing the individual's suicidality.
Recommendation:	Develop guidance for utilizing confidential settings for communications with incarcerated individuals housed in a close observation area.
Corrective Action:	Create and implement a protocol or guideline for assessing suicide risk.
Expected Outcome:	Improved support and safety for incarcerated individuals.

CAP ID Number:	UFR-23-004-4
Finding:	DOC does not have an electronic health record that providers can easily reference to obtain an incarcerated individual's mental health history.
Root Cause:	DOC does not have an electronic health record and the psychologist who relaxed conditions did not have the benefit of having the incarcerated individual's mental health history readily available.
Recommendation:	DOC should acquire an electronic health record.
Corrective Action:	Health Services leadership continue the process to acquire an electronic health record when full legislative funding becomes available.
Expected Outcome:	Improved patient safety and improved provider access to medical information.

CAP ID Number:	UFR-23-004-5
Finding:	The close observation area post orders were not consistently followed by custody staff when conducting and documenting tier checks, searching the incarcerated individual's cell, and monitoring the supplemental video.
Root Cause:	Staff did not follow the standards for the unit post.
Recommendation:	Tier checks, cell searches and supplemental video monitoring should be completed and documented in accordance with post orders and align with the conditions of confinement. DOC should consider adding the language "health and wellness" check to describe the purpose of a tier check during training.
Corrective Action:	DOC leadership should pursue progressive discipline per Article 8 of the Teamsters 117 Collective Bargaining Agreement when there is evidence that appropriately trained custody staff are not following post orders and DOC policy.
Expected Outcome:	DOC leadership will ensure policy and post orders are being followed.

CAP ID Number:	UFR-23-004-6
Finding:	DOC Policy 890.620 Emergency Medical Treatment was not followed during the medical emergency response. The emergency response kit was not fully stocked, and staff were not familiar with the use of equipment.
Root Cause:	There were gaps in knowledge and training for Health Services staff.
Recommendation:	DOC should require medical emergency response drills with medical and custody staff.
Corrective Action:	Health care and custody staff will participate in joint emergency response drills regularly that will include an evaluation and debrief by both a member of custody and health services.
Expected Outcome:	Improved timeliness of emergency response and treatment, and patient outcomes.

CAP ID Number:	UFR-23-004-7
Finding:	DOC Policy 890.620 Emergency Medical Treatment was not followed during the medical emergency response. A nurse did not immediately respond to the location.
Root Cause:	Staff did not follow DOC Policy and nursing protocol standards.
Recommendation:	Nursing staff should immediately respond to a medical emergency.
Corrective Action:	DOC leadership should pursue progressive discipline per Article 8 of the Teamsters 117 Collective Bargaining Agreement when there is evidence that appropriately trained staff are not following DOC policy and protocols.
Expected Outcome:	DOC leadership will ensure timeliness of emergency response, treatment, and patient outcomes.

CAP ID Number:	UFR-23-004-8
Finding:	Staff working in the close observation area may be at increased risk for desensitization and fatigue due to the repetitive nature of the duties, working overtime shifts, and the intensity of working with incarcerated individuals in crisis.
Root Cause:	DOC has not formally evaluated options to mitigate the potential impacts to staff working in a specialized close observation unit environment.
Recommendation:	Recommend DOC conduct a statewide survey of staff who work in or with incarcerated individuals housed in the close observation area (i.e., medical providers, religious coordinators, custody officers, classification counselors, hearings officers, nurses, mental health staff) to identify opportunities to increase staff engagement and promote safety for the incarcerated individuals in their care.
Corrective Action:	Develop and conduct a statewide survey of staff working with individuals in the close observation area to identify opportunities to increase staff engagement and promote safety for the incarcerated individuals.
Expected Outcome:	Developing a deeper understanding of the experience that leads to desensitization and fatigue in the close observation area and identifying opportunities for improvement in engagement and safety of incarcerated individuals.