Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-24-008

Report to the Legislature

As required by RCW 72.09.770

September 1, 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 24-008 on August 22, 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-24-008-1
Finding:	A licensed practical nurse (LPN) performed a restrictive housing assessment that was not reviewed by the delegating registered nurse (RN) and did not contain vital signs.
Root Cause:	It has become accepted not to perform vital signs during restrictive housing assessment and for RNs not to review and co-sign when assessment is performed by an LPN.
Recommendations:	DOC should provide direction regarding restrictive housing assessments.
Corrective Action:	DOC clinical leadership will provide clear direction regarding restrictive housing assessments requiring vital signs, a plan of care and oversight by an RN.
Expected Outcome:	Improved care for incarcerated individuals in restrictive housing.

CAP ID Number:	UFR-24-008-2
Finding:	The incarcerated individual declined several doses of his medication for opioid use disorder (MOUD) medication.
Root Cause:	There is no requirement to assess an incarcerated individual who is declining medication while in restrictive housing.
Recommendations:	DOC should update nursing protocol to direct a scheduled nurse visit when there is a missed dose of MOUD medication.
Corrective Action:	DOC clinical leadership will update protocol to direct a scheduled nurse visit when an incarcerated individual misses a dose of critical medication.
Expected Outcome:	Improved care for incarcerated individuals.

CAP ID Number:	UFR-24-008-3a
Finding:	Clinical staff to include nurses and physician assistant misinterpreted the early signs of sepsis as withdrawal, falling prey to selection bias and failing to recognize use of unsterile needles as a risk factor and widen the differential diagnosis to include bacterial endocarditis.
Root Cause:	Clinical staff did not utilize appropriate diagnostic curiosity or recognize the increased infection risk for an incarcerated individual using home-made syringes.
Recommendations:	DOC health services should propagate a culture of heightened diagnostic curiosity and effective clinical decision making when faced with patients whose vital signs, labs, or symptoms are not completely explained by the working diagnostic hypothesis; further, a culture of shared responsibility where teams

	actively discuss patients is highly recommended.
Corrective Action:	DOC Health Services will provide education to support clinical decision-making for incarcerated individuals with symptoms of sepsis.
Expected Outcome:	Improved care for incarcerated individuals.

CAP ID Number:	UFR-24-008-3b
Finding:	Clinical staff to include nurses and physician assistant misinterpreted the early signs of sepsis as withdrawal, falling prey to selection bias and failing to recognize use of unsterile needles as a risk factor and widen the differential diagnosis to include bacterial endocarditis.
Root Cause:	Clinical staff did not utilize appropriate diagnostic curiosity or recognize the increased infection risk for an incarcerated individual using home-made syringes.
Recommendations:	DOC health services should propagate a culture of heightened diagnostic curiosity and effective clinical decision making when faced with patients whose vital signs, labs, or symptoms are not completely explained by the working diagnostic hypothesis; further, a culture of shared responsibility where teams actively discuss patients is highly recommended.
Corrective Action:	DOC will conduct an internal review of sepsis cases to identify opportunities for improvement.
Expected Outcome:	Improved care for incarcerated individuals.

CAP ID Number:	UFR-24-008-4
Finding:	Incarcerated individual tested positive twice on clinical toxicology screens for non-prescribed substances and there was no clinical follow-up with incarcerated individual.
Root Cause:	The MOUD protocol does not provide clear direction for clinical response to positive toxicology results.
Recommendations:	DOC should update the MOUD protocol to include recommended clinical responses when there is a positive toxicology result, provide education to staff on the changes to protocol and offer ideas for engaging incarcerated individuals diagnosed with substance use disorder in their care planning.
Corrective Action:	DOC Addiction Medicine team should update the MOUD protocol to include recommended clinical responses when there is a positive toxicology result, provide education to staff on the changes to protocol and offer ideas for engaging incarcerated individuals diagnosed with substance use disorder in their care planning.
Expected Outcome:	Improved care and care planning for incarcerated individuals diagnosed with substance use disorder.

CAP ID Number:	UFR-24-008-5
Finding:	Wellness checks for the incarcerated individual were not consistently documented per policy.
Root Cause:	There is no written process for performing and documenting of a nursing wellness check in the restricted housing unit.
Recommendations:	DOC should provide clear direction on how to perform and document a wellness check for incarcerated individuals in a restricted housing unit.
Corrective Action:	DOC Health Services leadership should provide clear direction on how to perform and document a nursing wellness check for incarcerated individuals in a restricted housing unit.
Expected Outcome:	Consistent nursing wellness checks and documentation.