Fiscal Year 2024

Annual Review of UFR Reports, Committee Recommendations, & Corrective Action Plans

UNEXPECTED FATALITIES IN WASHINGTON STATE DOC CUSTODY

PREPARED BY

Office of the Corrections OMBUDS

PURSUANT TO RCW 43.06C.080

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Executive Summary

The Office of the Corrections Ombuds is an active participant in the Washington State Department of Corrections (WADOC) unexpected fatality review (UFR) process (RCW 72.09.770). Representatives from the WADOC, the OCO, and the Department of Health (DOH) are required to attend each UFR. A representative from the Health Care Authority (HCA) also routinely participates. The public employees who represent their individual agencies gather to form a multi-disciplinary, multi-agency review team and are uniquely qualified to understand what no single agency or group working alone can: how and why an incarcerated individual unexpectedly died while under the care and custody of the WADOC.

During Fiscal Year 2024 (July 1, 2023 – June 30, 2024) the WADOC published:

- **26 UFR reports**
- **26 Corrective Action Plans** (CAPs) associated with **13** of the UFR reports
- **13 UFR reports without Corrective Action Plans**
- **63 Consultative Remarks** from the UFR Committee

As required by RCW 43.06C.080, the OCO prepared this annual report as a review of the status of the UFR Committee recommendations. Of the 26 action items, the OCO found that the WADOC:

- Completed 20 action items from UFR CAPs
- Submitted proposals for two action items (pending funding review and approval)
- Is in progress on four action items

The OCO has expressed concerns that the **UFR Committee's "Consultative Remarks"** (those that the WADOC determines to be outside of the direct cause of death) are not formally managed or assigned to staff to ensure follow-up has occurred. In Fiscal Year 2024, the UFR Committee provided 63 recommendations that WADOC labeled as Consultative Remarks. **Of the 89 recommendations from the UFR Committee, WADOC created CAPs for 29% and chose to designate 71% of the recommendations as Consultative Remarks for WADOC to consider.**

Additionally, the OCO is particularly concerned about **two of the top causes of unexpected deaths in WADOC: overdoses and suicides.** We continue to urge the WADOC to implement: (1) meaningful, and universally available, substance use disorder treatment and (2) state-wide access to 988 Suicide and Crisis Lifeline services inside prisons.

The OCO values both continuous improvement and the trust of the people incarcerated in WADOC facilities and all our stakeholders. We acknowledge that each UFR is only a small glimpse into the lives of the people who unexpectedly died in WADOC custody. As an agency we observe not only the loss of life but the impact these deaths have on the people living and working in Washington's corrections system. We remain hopeful that the work undertaken by the UFR Committee will help to prevent future unexpected fatalities of people in WADOC's care and custody.

After negotiations, the WADOC agreed to three recommendations made by the OCO in this report:

- Recommendation 1: Convene quarterly Unexpected Fatality Review Committee process meetings.
- Recommendation 2: Track, assign, and respond to Unexpected Fatality Review Committee "Consultative Remarks."
- Recommendation 3: Prioritize access to the 988 Suicide and Crisis Lifeline inside WADOC prisons.

Introduction

RCW 72.09.770 directs the Washington State Department of Corrections (WADOC) to conduct an unexpected fatality review (UFR) in any case in which the death of an incarcerated individual is unexpected, or any case identified by the Office of the Corrections Ombuds (OCO) for review. Representatives from the WADOC, the OCO, and the Department of Health (DOH) are required to attend each UFR. A representative from the Health Care Authority (HCA) also routinely participates in UFRs.

Each UFR results in a report, prepared and published by the WADOC, that must be made public within 120 days following the fatality. The WADOC may also create associated Corrective Action Plans (CAPs) to implement recommendations made by the UFR Committee. Every UFR report is delivered to the Governor and state legislators. The reports are also publicly available on the DOC publications website or by request in WADOC law libraries.

In addition to the individual UFR reports, RCW 43.06C.080 directs the OCO to issue an annual report to the legislature on the status of the implementation of unexpected fatality review recommendations. As in past years, this annual report will address the status of CAPs used to implement recommendations made in reports published by the WADOC during the prior fiscal year.

Standard Unexpected Fatality Review Timeline

RCW 72.09.770(1)(d) - (e) establishes the timeline for the UFR process:

Day 1

Date of unexpected death

Day 120

WADOC must issue a report on the results of the UFR within 120 days of the death

Day 130

WADOC must develop an associated Corrective Action Plan (CAP) within 10 days of issuing the report

Day 250

WADOC must implement associated CAP(s) within 120 days of development

Key Limitations

Limitations can be defined as those characteristics of design or methodology that impact or influence the interpretations of the findings.[1] The key limitations of this report are:

1. This report is produced by the Office of the Corrections Ombuds and relies on data provided to this office from the WA Department of Corrections.
2. Report accuracy may be affected by the quality and consistency of the WADOC's internal tracking systems, which vary by facility.
3. Data in this report is current as of October 2024. The information provided in this report is subject to change as a result of updated or additional records being added to the WADOC's internal tracking system.

Unexpected Fatality Review Reports in Fiscal Year 2024

This OCO annual report covers unexpected fatality recommendations and reports published by WADOC in Fiscal Year 2024 (July 1, 2023, to June 30, 2024). During this fiscal year, 46 people died in WADOC custody. Of those deaths, 26 were identified as unexpected and reviewed through the UFR Committee process. The total number of Unexpected Fatality Reviews, Corrective Action Plans, and UFRs without CAPs are outlined in the boxes below.[2] Of the 26 UFRs, 13 did not result in WADOC CAPs. Figure 1 shows the causes of death for all UFRs in Fiscal Year 2024, Figure 2 outlines the number of UFR reports published per month, and Figure 3 displays details from Figure 1 with associated locations.

Total Deaths in WADOC Custody:
46

UFR Reports:
26

Total Corrective Action Plans:
26

UFRs with CAPs:
13

UFRs without CAPs:
13

Total UFR Consultative Remarks:
63

[1] Price, James H. and Judy Murnan. "Research Limitations and the Necessity of Reporting Them." American Journal of Health Education 35 (2004): 66-67; Theofanidis, Dimitrios and Antigoni Fountouki. "Limitations and Delimitations in the Research Process." Perioperative Nursing 7 (September-December 2018): 155-163.

[2] Data from Table 1: Fiscal Year 2024 UFRs & CAPs

Of the 26 unexpected fatalities in Fiscal Year 2024, the most common cause of unexpected death in WADOC was overdose. This was also the most common cause of unexpected death in Fiscal Year 2023. In Fiscal Year 2024, seven people died unexpectedly of overdose, five people died of suicide, and four people died of cancer. Three people died of vascular disease, three people died of infection/ sepsis, and three people died of respiratory complications. Diabetes was found to be the cause of death for one individual.

Fiscal Year 2024 Published WADOC UFR Reports by Cause of Death		
Number of UFRs	Cause of Death	WADOC Definition
7	Overdose	Includes deaths where the underlying cause of death is when the human body receives too much of a substance, or mix of substances, that results in the death of the person.
5	Suicide	Death caused by injuring oneself with the intent to die.
4	Cancer	Includes deaths characterized by the development of abnormal cells that divide uncontrollably and destroy normal body tissue.
3	Vascular Disease	Includes deaths where leading cause was coronary artery disease, peripheral artery disease, aortic disease, or cerebrovascular disease.
3	Infection/Sepsis	Includes deaths where the leading cause was the result of complications from a bacterial, viral, or fungal infection.
3	Respiratory	Includes deaths where the leading cause of death is associated with lower respiratory infections, pneumonia, emphysema, COPD, or chronic bronchitis/asthma.
1	Diabetes	Is an underlying disease associated with premature death from cardiovascular disease, stroke, heart failure, several cancers (liver, colorectal, kidney, and lung) and other diseases.

Figure 1. Number of Unexpected Fatality Review publications based on cause of death, defined by WADOC. The highest number of deaths are highlighted in green: overdose, suicide, and cancer.

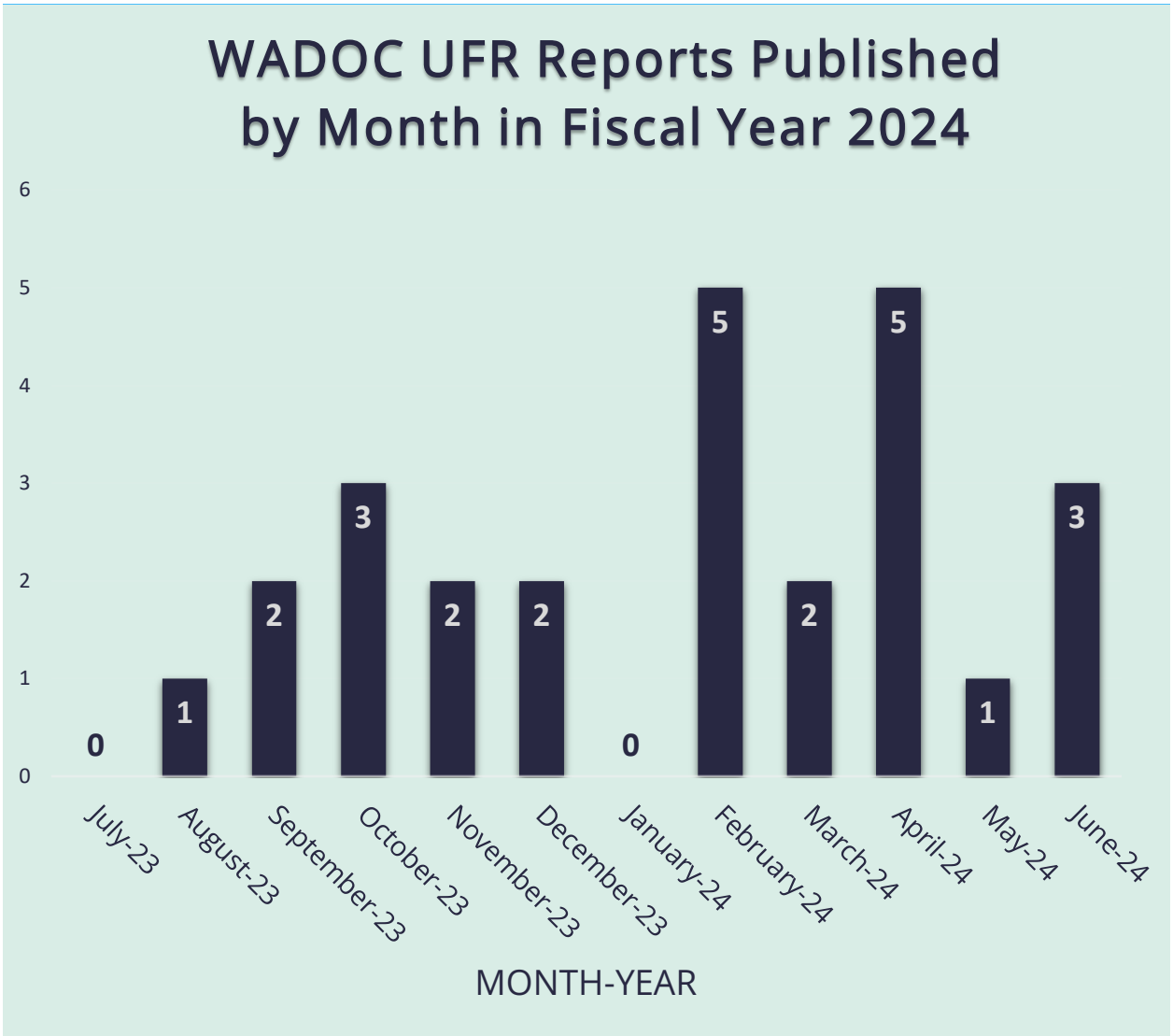

Figure 2. Number of WADOC UFR reports published each month of Fiscal Year 2024.

WADOC Prison Acronyms

AHCC	Airway Heights Corrections Center
CCCC	Cedar Creek Corrections Center
CBCC	Clallam Bay Corrections Center
CRCC	Coyote Ridge Corrections Center
MCCCW	Mission Creek Corrections Center for Women
MCC	Monroe Correctional Complex
OCC	Olympic Corrections Center
SCCC	Stafford Creek Corrections Center
WCC	Washington Corrections Center
WCCW	Washington Corrections Center for Women
WSP	Washington State Penitentiary

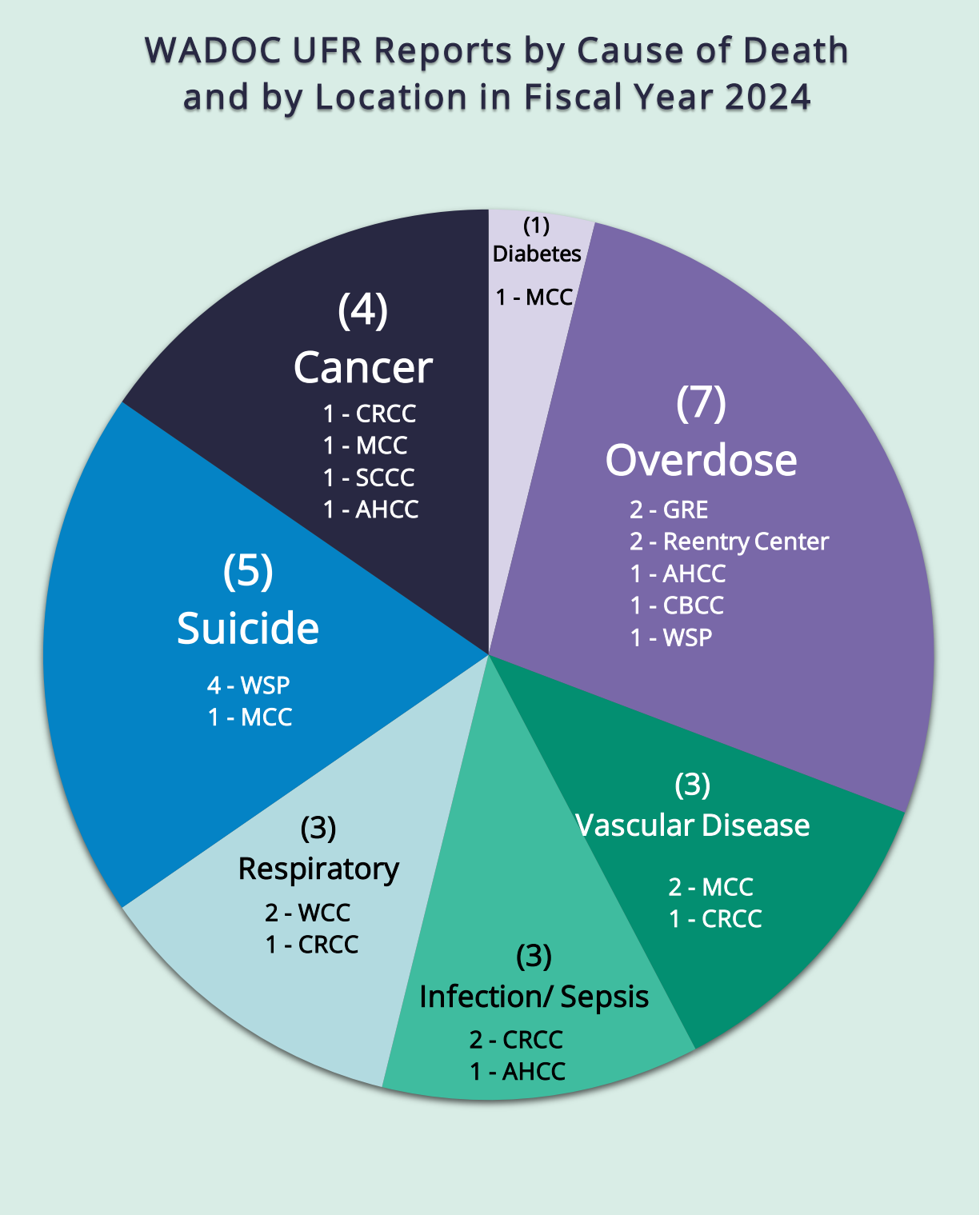

Figure 3. WADOC Unexpected Fatality Reviews published in Fiscal Year 2024 by cause of death and location.

Compliance Review of UFR Corrective Action Plans

To assess the WADOC's compliance with the Corrective Action Plans (CAPs) generated from UFR Committee recommendations, the OCO reviewed the WADOC's CAP tracking system and related evidence.[3] Following a review of this documentation, the OCO sent clarifying questions and met with WADOC UFR Committee leadership to discuss findings and request additional information and evidence.

The OCO compiled our findings for all Fiscal Year 2024 CAPs in Appendix 1. Additionally, Table 1: Fiscal Year 2024 UFRs & CAPs outlines all Fiscal Year 2024 UFRs, dates of publication, location and cause of death, along with the number of CAPs and Consultative Remarks that came from UFR Committee reviews. UFR reports and CAPs are linked in the table for readers to be able to see the full details of the Committee reviews. The OCO also includes full UFR reports at the end of the office's Monthly Outcome Reports so that incarcerated individuals have an additional way to access these reports. All reports are available on DOC's Publications website and in WADOC prison law libraries by request.

Of the 26 UFR reports in Fiscal Year 2024, 50% resulted in Corrective Action Plans. These 13 CAPs outlined a total of 26 action items. Of the 26 action items, WADOC completed 85%. Of the 26 action items, four items are still in progress and relate to updates to policy or funding, which often take longer than the timelines allotted for CAPs.

Review of UFR Committee Consultative Remarks

In addition to the 26 CAP action items associated with 13 UFR reports, the UFR Committee offered 63 Consultative Remarks for WADOC consideration. **Of the 89 recommendations from the UFR Committee, WADOC created CAPs for 29% and designated 71% of the recommendations as Consultative Remarks for WADOC to consider.** All Committee Consultative Remarks are outlined in Appendix 2.

In Fiscal Year 2023, WADOC created a tracking system for UFR related CAPs. As of Fiscal Year 2024, additional recommendations provided by the UFR Committee are now included in this tracking system. However, WADOC only tracks the "Consultative Remarks" as a list and when reviewed by the OCO, there was no attached evidence of completion or staff assigned to these recommendations. The OCO is also concerned with WADOC's designation of CAP versus Consultative Remark when it comes to Committee recommendations.

[3] The OCO relied on evidence and data provided by the WADOC to assess the status of Committee recommendations. The results of this compliance review may be impacted if the evidence or data was faulty.

Table 1: Fiscal Year 2024 WADOC UFRs & CAPs						
UFR	Date Published	Location	Cause of Death	Fatality Date	# of CAPs	# of Consultative Remarks
23-002	8/3/23	WCC	Respiratory	1/4/23	No CAPs	0
23-005	9/14/23	MCC	Suicide	5/17/23	1	4
23-006	9/22/23	GRE	Overdose	5/27/23	3	1
23-007	10/9/23	WSP	Suicide	6/11/23	No CAPs	3
23-008	10/10/23	WSP	Suicide	6/12/23	No CAPs	4
23-009	10/13/23	WSP	Suicide	6/16/23	No CAPs	4
23-010	11/21/23	Reentry Center	Overdose	7/24/23	1	3
23-011	11/27/23	AHCC	Overdose	7/30/23	No CAPs	0
23-012	3/3/24	MCC	Vascular Disease	8/6/23	2	5
23-013	12/11/23	CBCC	Overdose	8/13/23	1	1
23-014	12/21/23	Reentry Center	Overdose	8/23/23	1	2
23-015	2/1/24	MCC	Diabetes	10/4/23	3	2
23-016	2/10/24	CRCC	Respiratory	10/13/23	No CAPs	2
23-017	2/23/24	CRCC	Cancer	10/26/23	No CAPs	1
23-018	2/16/24	WCC	Respiratory	10/22/23	2	0
23-019	6/25/24	MCC	Vascular Disease	11/28/23	No CAPs	1
23-020	6/17/24	WSP	Overdose	11/20/23	No CAPs	3
23-021	3/19/24	MCC	Cancer	11/20/23	2	3
23-022	2/7/24	SCCC	Cancer	10/10/23	2	2
23-023	4/12/24	AHCC	Cancer	12/15/23	No CAPs	8
23-024	4/25/24	GRE	Overdose	12/27/23	1	2
23-025	4/4/24	CRCC	Infection/ Sepsis	12/6/23	6	2
23-026	4/29/24	WSP	Suicide	12/31/23	1	3
24-002	5/16/24	CRCC	Infection/ Sepsis	1/17/24	No CAPs	2
24-005	6/26/24	CRCC	Vascular Disease	2/22/24	No CAPs	1
24-006	4/30/24	AHCC	Infection/ Sepsis	1/1/24	No CAPs	4
Totals					26	63

Observations

In this section, the OCO discusses observations related to the leading causes of unexpected deaths in WADOC custody in Fiscal Year 2024: overdose, suicide, and cancer. The OCO also highlights Corrective Action Plans (CAPs) associated with sepsis/infection, respiratory, and vascular disease related unexpected deaths. Additionally, this section includes more information about CAPs, Consultative Remarks, Critical Incident Review (CIR) policy updates, tier checks associated with UFRs, and unexpected deaths that occurred in solitary confinement, restrictive, or specialized housing units.

Overdoses in WADOC Custody

Overdose was the most common cause of deaths reviewed by the Unexpected Fatality Review Committee in Fiscal Year 2024. The WADOC published UFR reports for seven people who died by overdose while housed at WSP, CBCC, AHCC, a WADOC Reentry Center, or on Graduated Reentry (GRE).

Seven related UFR reports (23-006, 23-010, 23-011, 23-013, 23-014, 23-020, and 23-024) include more details of the Committee's review of overdoses. These UFRs outline seven action items associated with WADOC CAPs. Two of the seven overdose related reviews did not include CAPs. **There were 12 additional UFR Consultative Remarks associated with these overdose related deaths.**

The following Corrective Action Plans from the above UFR reports relate to overdoses in Fiscal Year 2024:

- GRE leadership recommend policy language or create a protocol to establish timelines for completion of GRE participant requirements and follow-up requirements.
- Within available resources, WADOC will distribute naloxone kits to participants transferring into the GRE program.
- WADOC should enforce contract requirements for lab vendors to provide timely lab results.
- WADOC [should] update reentry center procedures that outline requirements for searches, counts, drug testing, facility security, and substance use assessment referrals.
- Create a statewide communication to be placed in visiting rooms, sent out via kiosk, and given to visitors which identifies dangers of ingesting drugs, recent deaths after ingesting drugs, and the likelihood of people involved in the introduction of drugs to be prosecuted for introduction and death of an individual.

- Reentry center leadership in partnership with SARU leadership [should] develop a plan to expand SUD services for reentry center participants.
- WADOC will submit a funding request for legislative consideration in the 2024-2025 biennium to support expansion of medication assisted treatment or opioid use disorder.

Additional Consultative Remarks from the UFR Committee can be found in Appendix 2.

Suicides in WADOC Custody

In Fiscal Year 2024, the WADOC published UFR reports for five individuals who died by suicide while living at WSP and MCC. **Suicide was the second most common cause of deaths reviewed by the UFR Committee.**

Five related UFR reports (23-005, 23-007, 23-008, 23-009, 23-026) include more details of the Committee's review of suicide. These UFRs outline two action items associated with WADOC CAPs. Three of the five suicide-related reviews did not include Corrective Action Plans. **There were 18 additional UFR Consultative Remarks associated with these suicide related deaths.**

The following Corrective Action Plans from the above UFR reports relate to suicides in Fiscal Year 2024:

- Install additional safety barriers on the upper tier of the residential treatment unit.
- Mental health intake screening protocol will be updated to require individuals who report a history of suicide attempt within the last year to be flagged for further mental health evaluation.

Additional Consultative Remarks from the UFR Committee can be found in Appendix 2.

Cancer-Related Deaths in WADOC Custody

Cancer was the third most common cause of deaths reviewed by the UFR Committee. The WADOC published UFR reports for four people who died by cancer while housed at MCC, CRCC, AHCC, and SCCC.

Four related UFR reports (23-017, 23-021, 23-022, 23-023) include more details of the Committee's review of overdoses in Fiscal Year 2024. These UFRs outline four action items associated with WADOC CAPs. Two of the four cancer-related reviews did not include Corrective Action Plans. **There were 14 additional UFR Consultative Remarks associated with these cancer-related deaths.**

The following CAPs from the above UFR reports are for cancer-related deaths in FY 2024:

- WADOC will conduct a multidisciplinary Healthcare Failure Mode and Effect Analysis regarding care delays.
- WADOC will develop a standard process for obtaining and reviewing consult reports and test results.
- WADOC Health Services Clinical Services Board will determine the criteria for including diagnosis of blood in urine to the WADOC Cancer Care tracker.
- WADOC Health Services Clinical Services Board will develop general guidance for referring cases to the Facility Medical Director and Nurse Care Managers.

Additional Consultative Remarks from the UFR Committee can be found in Appendix 2.

Sepsis/Infection, Vascular Disease, and Respiratory-Related Deaths in WADOC Custody

In Fiscal Year 2023, the cause of death for six UFRs was vascular disease, three infection/sepsis, and one respiratory. **In Fiscal Year 2024, the number of UFRs related to vascular disease decreased from six to three, while infection/sepsis remained the same at three, and respiratory causes of death increased from one to three.** Deaths in Fiscal Year 2024 UFR reports attributed to respiratory complications occurred at Washington Corrections Center (WCC) and CRCC; sepsis/infection occurred at CRCC and AHCC; and vascular disease at MCC and CRCC. The OCO is interested in finding systemic changes that may help prevent sepsis/infection, vascular disease, and respiratory related deaths in WADOC custody.

The following CAPs were associated with respiratory-related deaths reviewed by the UFR Committee in FY 2024:

- WADOC Health Services will develop an outreach proposal to partner with their local community hospitals to support care coordination and education.
- WADOC Health Services will develop an outreach proposal to increase communication and support care handoffs with jails.

The following CAPs were associated with vascular disease-related deaths reviewed by the UFR Committee:

- WADOC will update the blood pressure (BP) management metric from access to care to effectiveness of care.
- WADOC Health Services will adopt the Patient Centered Medical Home blood pressure management pilot project as the statewide standard system.

The following CAPs were associated with sepsis/infection-related deaths reviewed by the UFR Committee:

- WADOC should develop a protocol for evaluating decisional capacity and plan to provide education to WADOC Health Services facility staff on the protocol.
- WADOC Health Services will develop a plan and protocol for the use of multidisciplinary team meetings to improve transitions of care for individuals with medical and mental health needs.
- WADOC should update the behavioral health transfer call criteria to include a care needs review by the Facility Medical Director to ensure medical care needs can be met.
- WADOC should develop written guidelines for transferring incarcerated individuals to the [Sage] special needs unit.
- The Chief Nursing Officer will provide education and establish a systemic accountability process that will ensure nursing care is appropriately documented in the health records.
- The Chief Medical Officer will verify with Facility Medical Directors that individuals with catheters have an appropriate care plan in place.

Additional Consultative Remarks from the UFR Committee can be found in Appendix 2.

CIR Recommendations and Policy Update

The WADOC Critical Incident Review (CIR) policy influences the timeline and process of agency reviews of incidents that occur in WADOC facilities. DOC 400.110 says these reviews exist to "inform risk mitigation and continuous improvement efforts." Moreover, RCW 72.09.770(4)(a), states that an unexpected fatality 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."

WADOC's CIR reports are an important document associated with most UFR Committee reviews. When timelines for the CIR are set at the time of the person being pronounced dead, information related to what occurred leading to the person's passing may not be automatically provided to the Committee. Knowing that critical information may not be readily available to most Committee members, OCO staff frequently request additional records from the WADOC and conduct a separate records review and analysis. Often, after performing independent records review and analysis, OCO staff have requested that the additional records be made available to all members so that the UFR Committee can have a more robust and thorough discussion.

Beginning in 2022, the OCO has consistently raised concerns about the inconsistent and arbitrary delineation of timelines associated with Critical Incident Reviews, as well as the quality of the WADOC CIR reports reviewed in most UFR Committee meetings. Additionally, the OCO has often expressed worries about missing or incomplete Root Cause Analyses (RCA) for UFR Committee reviews, and conveyed apprehension about the Committee's ability to fulfill the statutory requirements of the UFR law if the root causes remain unidentified and unaddressed. Over the past two years, the OCO has consistently communicated technical modifications that the WADOC could make to DOC policy 400.110 Critical Incident Reviews that would alleviate many of the above concerns.

The OCO applauds the WADOC's decision to make significant changes to DOC policy 400.110 Critical Incident Reviews in July 2024. The new policy directs the WADOC Critical Incident Review team to "[d]etermine the event's root causes" and include their analysis in the final CIR document. If followed, these changes facilitate the WADOC's compliance with RCW 72.09.770(4), which states a UFR 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."

CAPS, Consultative Remarks, and Cause of Death

Currently, the WADOC chooses to only track UFR Committee recommendations as Corrective Action Plans (CAPs) if the department identifies the recommendation as directly linked to the individual's cause of death. In UFR reports, the WADOC notes the other UFR Committee recommendations as "[c]onsultative remarks that do not directly correlate to cause of death but may be considered for review by the Department of Corrections." RCW 72.09.770 says WADOC will create a Corrective Action Plan for the department to address recommendations made by the UFR Committee.

The OCO has expressed concerns about WADOC determining CAPs based on direct link to causes of death and the limited tracking and follow through when UFR Committee recommendations are determined to be consultative. In Fiscal Year 2024, WADOC did not publish CAPs for 50% of the UFR reports. **The WADOC chose to separate a significant number of recommendations from the UFR Committee as "Consultative Remarks" and not track them as CAPs – 63 total or 71% of UFR Committee recommendations in Fiscal Year 2024.**

Tier Checks / Wellness Checks

The OCO expressed concerns that multiple UFR reviews found WADOC staff violated DOC policy 420.320 Searches of Facilities and the individuals who had passed had not been discovered early enough to attempt life-saving measures. Additionally, the OCO and other UFR Committee members have recommended "tier checks" be changed to "wellness checks" across WADOC and an added emphasis on the goal of ensuring people living in WADOC prison facilities are safe and alive.

UFRs in Solitary Confinement and Specialized Housing Units

In 2024, the OCO published Part I and Part II of a three-part report series on Solitary Confinement directed by the Washington State Legislature in Engrossed Substitute Senate Bill (ESSB) 5187 (2023-2024), Sec. 117 (7).

Two of the deaths reviewed by the UFR Committee in Fiscal Year 2024 occurred while the person was housed in solitary confinement:

- UFR 23-002: respiratory Washington Corrections Center
- UFR 23-019: vascular Monroe Correctional Complex

Four of the deaths reviewed by the UFR Committee in Fiscal Year 2024 occurred while the person was housed in an infirmary:

- UFR 23-015: diabetes Monroe Correctional Complex
- UFR 23-018: respiratory Washington Corrections Center
- UFR 23-021: cancer Monroe Correctional Complex
- UFR 23-022: cancer Stafford Creek Corrections Center

Two of the deaths reviewed by the UFR Committee in Fiscal Year 2024 occurred while the person was housed in the Sage unit, which is a specialized nursing care unit at Coyote Ridge Corrections Center:

- UFR 23-016: respiratory
- UFR 23-025: infection/sepsis

Three of the deaths reviewed by the UFR Committee in Fiscal Year 2024 occurred while the person lived in a Residential Treatment Unit (RTU):

- UFR 23-005: suicide Monroe Correctional Complex – SRTC (formerly SOU)
- UFR 23-007: suicide Washington State Penitentiary – BAR units
- UFR 23-009: suicide Washington State Penitentiary – BAR units

OCO Recommendations & WADOC Responses

In early November 2024, the OCO provided the WADOC with a draft of this report which included the following three UFR recommendations. On December 4, 2024, the OCO received the WADOC's initial response to the draft report and recommendations. On December 19, 2024, OCO and DOC leadership teams met and were able to negotiate the following outcomes.

Presented below in this public report are three recommendations which, if followed, would support the WADOC's work to change practices or policies to prevent fatalities and strengthen safety and health protections for incarcerated individuals under the care and custody of the WADOC. Following each OCO recommendation is a summary of WADOC's response.

Recommendation 1: Convene quarterly Unexpected Fatality Review Committee process meetings.

The OCO recommends that the WADOC establish a regular process meeting, including representatives from all participating agencies of the UFR Committee, to review the Committee's practices to strengthen the UFR systemic review process. We encourage standing systemic review meetings, ideally quarterly, that include subject matter experts and UFR Committee members.

> **Summary of WADOC Response to OCO Recommendation 1:** The WADOC agreed to implement process review meetings which will occur quarterly during time already held for UFR review meetings. The meetings will include standing UFR Committee members as well as subject matter experts. These process reviews will offer opportunities for attendees to develop and review agreed-upon meeting practices. Additionally, process reviews will provide time for DOC to update Committee members on progress related to tracked consultative remarks.

Recommendation 2: Track, assign, and respond to Unexpected Fatality Review Committee "Consultative Remarks."

The OCO recommends that the WADOC adhere to RCW 72.09.770.

> **Summary of WADOC Response to OCO Recommendation 2:** The WADOC agreed to assign each consultative remark to a DOC staff member for tracking and completion. Additionally, DOC will cross reference consultative remarks with existing CAPs to determine whether there is overlap.

Recommendation 3: Prioritize access to the 988 Suicide and Crisis Lifeline inside WADOC prisons.

The OCO recommends that the WADOC develop a plan to swiftly operationalize access to 988 services for people in total confinement in Washington State DOC prisons. In Fiscal Year 2024, the OCO convened and facilitated meetings with the Department of Health, DOC, and 988 specialists and continued to alert DOC leadership to the urgent need for access to supplemental suicide and crisis services inside prisons. Following initial meetings, the DOH recognized the gap in services and assumed responsibility for the workgroup on 988 in carceral settings. The OCO urges the WADOC to demonstrate its commitment by taking an active role in the DOH's 988 Carceral Workgroup.

> **Summary of WADOC Response to OCO Recommendation 3:** The WADOC agreed to assign a DOC staff lead to engage with the multi-jurisdiction workgroup that has been working to advance 988 services in corrections settings with the intention of creating a protocol unique to WADOC prisons.

Appendix 1 – Fiscal Year 2024: UFR Corrective Action Plans

Office of the Corrections OMBUDS	Fiscal Year 2024 CAP Review			
UFR Corrective Action Plan	UFR Committee Recommendation	WADOC CAP Description	WADOC CAP Status	CAP Due Date
23-005-1	WADOC should install safety barriers that continue to the ceiling on the upper tier in the residential treatment unit.	Install additional safety barriers on the upper tier of the residential treatment unit.	**Complete**	January 12, 2024
23-006-1	WADOC should establish a deadline for participants to obtain a substance use assessment upon transfer to the GRE program.	GRE leadership recommends policy language or create a protocol to establish timelines for completion of GRE participant requirements and follow-up requirements.	**Complete**	January 20, 2024
23-006-2	GRE case managers should provide naloxone kits to all participants transferring into the GRE program.	Within available resources, WADOC will distribute naloxone kits to participants transferring into the GRE program.	**Complete**	January 20, 2024
23-006-3	WADOC should enforce contract requirements for lab vendor to provide timely lab results.	WADOC will seek contracts with other lab vendors if current vendor is unable to comply with contract requirements.	**Complete**	January 20, 2024
23-010-1	WADOC update Reentry Center procedures for pat searches, room searches, counts, inside security checks, drug testing, and area searches within 90 days. WADOC work towards Reentry Center inclusion in DOC Policy 420.150 Counts, which	WADOC update reentry center procedures that outline requirements for searches, counts, drug testing, facility security, and substance use assessment referrals.	**Complete**	March 20, 2024

	currently applies only to prisons.			
23-012-1	WADOC should update the performance metrics to monitor the effectiveness of blood pressure treatment.	WADOC will update the blood pressure (BP) management metric from access to care to effectiveness of care.	**Complete**	July 1, 2024
23-012-2	WADOC Health Services should adopt a statewide standard system to support the effective management of high blood pressure.	WADOC Health Services will adopt the Patient Centered Medical Home blood pressure management pilot project as the statewide standard system.	**Complete**	July 1, 2024
23-013-1	Provide additional education to incarcerated individuals and their visitors related to the risk of overdose deaths from ingesting illicit substances.	Create a statewide communication to be placed in visiting rooms, sent out via kiosk, and given to visitors which identifies dangers of ingesting drugs, recent deaths after ingesting drugs, and the likelihood of people involved in the introduction of drugs to be prosecuted for introduction and death of an individual.	**Complete**	April 9, 2024
23-014-1	WADOC Substance Use Recovery Unit (SARU) staff should continue to partner with reentry center staff to support and expand SUD treatment services in reentry centers as resources permit.	Reentry center leadership in partnership with SARU leadership develop a plan to expand SUD services for reentry center participants.	**Complete**	April 19, 2024

23-015-1	WADOC should conduct a root cause analysis with formal process improvement recommendations to support the care of incarcerated individuals who require urgent dialysis and prevent similar incidents in the future.	Urgent dialysis services and transition from peritoneal dialysis will be included in a Failure Mode Effects Analysis (FMEA) conducted by WADOC HS targeted to improve care timelines.	**Complete**	May 31, 2024
23-015-2a	Tier checks should be completed and documented in accordance with post orders and align with the conditions of confinement.	WADOC leadership should pursue progressive discipline per Article 8 of the Teamsters Collective Bargaining Agreement when there is evidence that appropriately trained custody staff are not following post orders and WADOC policy.	**Complete**	May 31, 2024
23-015-2b	Nursing assessments should be completed and documented in accordance with WADOC procedures and nursing standards of practice.	WADOC leadership should pursue progressive discipline per Article 8 of the Teamsters Collective Bargaining Agreement when there is evidence that appropriately trained custody staff are not following post orders and WADOC policy.	**Complete**	May 31, 2024
23-018-1	WADOC Health Services should develop a strategy to help community hospitals understand the level of care that a WADOC infirmary is able to provide.	WADOC Health Services will develop an outreach proposal to partner with their local community hospitals to support care coordination and education.	**Proposal Complete**	June 15, 2024
23-018-2	WADOC Health Services should improve communication and care handoffs between jail	WADOC Health Services will develop an outreach proposal	**Proposal Complete**	June 15, 2024

	facilities and WADOC health services.	to increase communication and support care handoffs with jails.		
23-021-1	WADOC 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.	WADOC will conduct a multidisciplinary Healthcare Failure Mode Effects and Analysis (H-FMEA) regarding care delays for this and two other identified cases.	**Complete**	July 17, 2024
23-021-2	WADOC should explore the development of a tracking tool for external provider consult reports and test results.	WADOC will develop a standard process for obtaining and reviewing consult reports and test results.	**In Progress**	July 17, 2024
23-022-1	WADOC Health Services should review the WADOC Cancer Care Tracker to decide if a diagnosis of blood in the urine should be included.	WADOC Health Services Clinical Services Board will determine the criteria for including the diagnosis of blood in the urine to the WADOC Cancer Care tracker.	**Complete**	June 6, 2024
23-022-2	WADOC should develop general guidance for when an advanced practitioner should involve the Facility Medical Director and the Nurse Care Manager in patient care.	WADOC Health Services Clinical Services Board will develop general guidance for referring cases to the Facility Medical Director (FMD) and Nurse Care Managers.	**Complete**	June 6, 2024
23-024-1	WADOC should request funding for substance use disorder treatment services to allow provision of MOUD continually to all incarcerated individuals who need treatment.	WADOC will submit a funding request for legislative consideration in the 2024-2025 biennium to support expansion of medication assisted treatment for opioid use disorder.	**In Progress**	August 23, 2024

23-025-1	WADOC should provide education to WADOC Health Services staff regarding the process to evaluate decisional capacity.	WADOC should develop a protocol for evaluating decisional capacity and a plan to provide education to WADOC Health Services facility staff on the protocol.	**Complete**	August 2, 2024
23-025-2a	WADOC Health Services should use a multidisciplinary care team meeting that includes primary care, nursing, and behavioral health team members for individuals with complex medical and mental health needs.	WADOC Health Services will develop a plan and protocol for the use of multidisciplinary team meetings to improve transitions of care for individuals with medical and mental health needs.	**Complete**	August 2, 2024
23-025-2b	WADOC Health Services should use a multidisciplinary care team meeting that includes primary care, nursing, and behavioral health team members for individuals with complex medical and mental health needs.	WADOC should update the behavioral health transfer call criteria to include a care needs review by the Facility Medical Director to ensure medical care needs can be met.	**Complete**	August 2, 2024
23-025-2c	WADOC Health Services should use a multidisciplinary care team meeting that includes primary care, nursing, and behavioral health team members for individuals with complex medical and mental health needs.	WADOC should develop written guidelines for transferring incarcerated individuals to the special needs unit (Sage).	**Complete**	August 2, 2024
23-025-3	WADOC should ensure that all nursing documentation is contained in the health record.	The chief nursing officer will provide education and establish a systemic accountability process that will ensure all nursing care is appropriately documented in the health record.	**In Progress**	August 2, 2024

23-025-4	WADOC should ensure appropriate catheter care is being provided to all incarcerated individuals housed in prison facilities.	The Chief Medical Officer will verify with Facility Medical Directors that individuals with catheters have an appropriate care plan in place.	**Complete**	August 2, 2024
23-026-1	WADOC should update the mental health intake process to ensure an incarcerated individual has a mental health appraisal for further evaluation if they report a suicide attempt within the last year.	Mental health intake screening protocol will be updated to require individuals who report a history of suicide attempt within the last year to be flagged for further mental health evaluation.	**In Progress**	August 27, 2024

Appendix 2 – Fiscal Year 2024: Additional UFR Committee Recommendations

Office of the Corrections OMBUDS	Fiscal Year 2024 Consultative Remarks Review
UFR	**UFR Committee Consultative Remarks**
23-005	1. The OCO highlighted the need for greater awareness of the lack of statewide post-prison housing and treatment resources for hard-to-place individuals which may impact release date. OCO requested WADOC consider including a trigger for case managers to ask for additional support in locating housing. **TRACKING ONLY** 2. WADOC should explore options for peer programming support groups to educate incarcerated individuals in suicide prevention. **TRACKING ONLY** 3. WADOC Health Services should explore proactively offering annual primary care visits for each incarcerated individual that has not been seen in the last calendar year. **TRACKING ONLY** 4. WADOC should explore options for utilization of the 988-suicide prevention hotline. **IN PROGRESS**
23-006	1. WADOC should investigate partnering with DOH to enhance overdose education support for contracted transitional housing staff. **TRACKING ONLY**
23-007	1. WADOC should explore options for coffee access in residential treatment units. **TRACKING ONLY** 2. WADOC should continue to pursue an electronic health record as full legislative funding becomes available. **IN PROGRESS** 3. WADOC should continue to pursue options for utilization of the 988-suicide prevention hotline. **IN PROGRESS**
23-008	1. WADOC should continue working toward the implementation of an electronic medication administration record (E-MAR) system. **IN PROGRESS** 2. WADOC HS should work toward making an annual primary care visit standard for each resident in prisons. **TRACKING ONLY** 3. WADOC should continue to pursue an EHR when legislative funding becomes available, which would support automatic notifications if an individual has not had a routine primary care visit in the last year. **IN PROGRESS**

	4. WADOC should continue to pursue options for utilization of the 988-Suicide prevention hotline. **IN PROGRESS**
23-009	1. The UFR Committee recommended exploring options to limit the amount of coffee purchased by residents of a residential treatment unit. **TRACKING ONLY** 2. The Committee recommended making an annual primary care visit standard for each incarcerated individual in prison. **TRACKING ONLY** 3. The Committee recommended continuing to pursue an electronic health record (EHR) when full legislative funding becomes available to automate notifications if an individual has not had a routine primary care visit in the last year. **IN PROGRESS** 4. The Committee recommended WADOC conduct an educational Morbidity & Mortality conference to educate staff. **COMPLETE**
23-010	1. The UFR Committee recommended WADOC explore the possibility of reviewing violator records and assessments to integrate into the central medical file to support care needs. **TRACKING ONLY** 2. The Committee recommended WADOC continue to pursue an electronic health record (EHR) to interface with community health systems when funding becomes available. **IN PROGRESS** 3. The Committee recommended WADOC explore options for obtaining community care information using a health information exchange like One-Health port. **TRACKING ONLY**
23-012	1. WADOC should continue to pursue funding for an electronic health record (EHR) to replace paper health records and to support interface with community health systems. **IN PROGRESS** 2. WADOC should ensure required tasks are completed and documented in accordance with policy and unit post orders. **COMPLETE** 3. WADOC should review the process to improve paper record processes while awaiting an EHR. **TRACKING ONLY** 4. WADOC should review the process for documenting alert button activation including when an incarcerated individual declines services after activating the alert button. **TRACKING ONLY** 5. The OCO requests WADOC consider changing the name of "tier-checks" to "wellness-checks" to reinforce the purpose of the checks to ensure appropriate behavior and wellbeing of the incarcerated individual. **TRACKING ONLY**

23-013	1. The UFR Committee recommended WADOC explore telehealth options to expand current substance use disorder treatment and seek additional funding to support the expansion of services. **COMPLETE**
23-014	1. WADOC should look for opportunities to seek alternatives for sobriety support instead of returning the individual to full confinement until appropriate substance use treatment can be arranged. **TRACKING ONLY** 2. WADOC should continue to pursue opportunities and strategies to reduce prohibited substances from entering the facilities as resources permit. **TRACKING ONLY**
23-015	1. WADOC should consider changing the name of "tier-checks" to "wellness-checks" to reinforce the purpose of the checks are to ensure appropriate behavior and wellbeing of the incarcerated individual. **TRACKING ONLY** 2. WADOC has initiated a structured training program for transport officers, focusing on the proper securing of wheelchairs during transport. This training will be maintained on a continuous basis. **COMPLETE**
23-016	1. WADOC should look for opportunities to educate community providers on the care and support WADOC is able to provide for transplant recipients. **TRACKING ONLY** 2. WADOC should implement the use of interdisciplinary or multidisciplinary care conferences as part of their patient-centered medical home model of care delivery. **COMPLETE**
23-017	1. WADOC should continue implementing the end-of-life care program. **COMPLETE**
23-019	1. WADOC should continue to pursue an electronic health record when full legislative funding becomes available. **IN PROGRESS**
23-020	1. WADOC should identify opportunities that support information sharing between custody and health services. **TRACKING ONLY** 2. WADOC should evaluate feasibility for developing an automated notification to Health Services when an individual tests positive for an illicit substance once an electronic system is implemented. **TRACKING ONLY** 3. WADOC should evaluate projected resource impacts for Health Services to conduct a substance use assessment and identify possible treatment opportunities when an incarcerated individual tests positive for an illicit substance during incarceration. **TRACKING ONLY**

23-021	1. WADOC should look for opportunities to continue partnering with DOH on nutrition and unintended weight loss support resources. **TRACKING ONLY** 2. WADOC should continue to implement the Patient Centered Medical Home model of care to offer multidisciplinary team support and care planning for individuals with nutritional and weight-related challenges. **IN PROGRESS** 3. WADOC should explore removing the word "offender" from the WADOC electronic death report. **TRACKING ONLY**
23-022	1. WADOC should continue to pursue funding for an electronic health record (EHR) to replace paper files and allow interface with community health systems. **IN PROGRESS** 2. WADOC should pursue implementation of clinical grand rounds and a peer review program in the coming year. **TRACKING ONLY**
23-023	1. WADOC should review current religious and person-centered practices regarding end-of-life care and final wishes for their body after death. **TRACKING ONLY** 2. WADOC should explore options to expand access to written material and language translation services for non-English speakers including translating the statewide orientation handbook. **TRACKING ONLY** 3. WADOC should explore options for chaplain resources in multiple language and religions. **TRACKING ONLY** 4. WADOC HS should provide feedback to the community hospital regarding end-of-life decision making for DOC patients. **TRACKING ONLY** 5. WADOC should contact the DOH POLST registry program to explore options for DOH inclusion. **TRACKING ONLY** 6. WADOC should continue to request resources for an electronic health record that supports documentation, scheduling, and electronic communication with community care providers. **IN PROGRESS** 7. WADOC should develop an informational brochure for community care providers regarding incarcerated individuals' right to direct care decisions. **TRACKING ONLY** 8. The Committee requests the report highlight the need for guardianship resources for Washington state residents and processes/guidelines for individual cases to be expedited. **TRACKING ONLY**
23-024	1. As funding allows, WADOC should continue to expand options for incarcerated individuals with a diagnosis of opioid use disorder to receive medication assisted therapy prior to reentering the community. **TRACKING ONLY**

	2. WADOC Health Services should explore the possibility of utilizing the Behavioral Health Administrative Services Organization recovery navigators to offer additional sobriety support for GRE participants. **TRACKING ONLY**
23-025	1. WADOC should request the residential treatment unit workgroup require a multidisciplinary team when transferring an individual and develop an orientation and training to address impacts of transfer to other settings. **TRACKING ONLY** 2. WADOC should continue to pursue an electronic health record to support care transitions. **IN PROGRESS**
23-026	1. WADOC should expedite the release of the new Critical Incident Review Policy to support the critical incident review teams. **COMPLETE** 2. WADOC should continue to advocate for an electronic health record to facilitate communication with community and jail providers. **IN PROGRESS** 3. WADOC should retain hand-held incident response videos via the department's record retention schedule. **TRACKING ONLY**
24-002	1. WADOC should explore using a multi-pronged, creative approach to positively impact vaccination rates. **TRACKING ONLY** 2. WADOC should start advanced care planning conversations during intake for incarcerated individuals at intake and revisit annually regardless of age. **TRACKING ONLY**
24-005	1. WADOC should continue to pursue an electronic health record when full legislative funding becomes available. **IN PROGRESS**
24-006	1. WADOC nursing leadership should provide additional training on performing respiratory evaluations and clinical monitoring. **TRACKING ONLY** 2. WADOC Health Services should consider gathering information on the number of individuals declining facility infirmary admission and the reason for the decline, with the goal of decreasing declination rates. **TRACKING ONLY** 3. WADOC Health Services should continue implementation of the Patient Centered Medical Home model and include proactive outreach to individuals with known care needs who are not engaged. **IN PROGRESS** 4. The Committee recommends staff clearly document in the health record the information and guidance provided to the incarcerated individual when there is a care declination. **TRACKING ONLY**

Appendix 3 – Fiscal Year 2024 Update: Fiscal Year 2023 Insufficient Evidence or In Progress CAPs

Updates: Fiscal Year 2023 CAPs[4]				
UFR	UFR Committee Recommendation	CAP Language	2023 Review Status	2024 Review Update
UFR-22-021	Develop and implement a formal process for tracking and documenting drug screening results for individuals in the GRE program.	Implement a policy or protocol establishing expectations for GRE staff to monitor receipt of drug screen results in a timely manner.	**Insufficient Evidence[5]**	**Complete**
UFR-22-021	Provide staff guidance and training on how to configure the lab portal to send email notifications when drug screen results are ready for review.	Provide training and require all Reentry Corrections Specialists to configure the lab portal to send email notifications when drug screen results are ready for review.	**Insufficient Evidence**	**Complete**
UFR-22-024	Ensure medical emergency response vehicles are ready and capable of meeting the need statewide.	Require facilities with emergency response vehicles to: a. Evaluate the functionality of their vehicle to ensure it is appropriately equipped b. Develop a protocol for their use that identifies when they are to be used, who will be responsible for driving to the scene, and a contingency plan for when vehicle is not available c. Provide training to staff responsible for	**Insufficient Evidence**	**Complete**

[4] Updates for all Fiscal Year 2023 CAPs marked as insufficient evidence or in progress from OCO's FY 2023 Annual UFR Report

[5] The OCO identifies "Insufficient Evidence" in instances where WADOC's evidence did not address all aspects of the CAP.

		responding to medical emergencies d. Include emergency vehicle readiness check as part of the monthly facility safety inspection.		
UFR-23-003	WADOC should acquire an electronic health record.	Health Services leadership continue acquiring an electronic health record as full legislative funding becomes available.	In Progress	In Progress
UFR-23-004-2c	Formalize and standardize onboarding to ensure all custody staff are trained in how to follow the written conditions of confinement and to seek clarification from the mental health staff when they have questions.	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.	In Progress	In Progress
UFR-23-004	WADOC should acquire an electronic health record.	Health Services leadership continue the process to acquire an electronic health record when full legislative funding becomes available.	In Progress	In Progress
UFR-23-004-2b	WADOC should require medical emergency response drills with medical and custody staff.	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.	In Progress	Complete