Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-23-013

Report to the Legislature

As required by RCW 72.09.770

December 21, 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 23-013 on December 11, 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-23-013-1
Finding:	The incarcerated individual died of methamphetamine toxicity.
Root Cause:	During his approved visit he was given a balloon containing illegal drugs that he ingested. Signs of overdose were not reported to staff until the individual became non-responsive.
Recommendation:	Provide additional education to incarcerated individuals and their visitors related to the risk of overdose deaths from ingesting illicit substances.
Corrective Action:	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.
Expected Outcome:	Improved safety for incarcerated individuals.