Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-23-018

Report to the Legislature

As required by RCW 72.09.770

February 26, 2024

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 23-018 on February 16, 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-23-018-1
Finding:	The local community hospital discharged the incarcerated individual back to DOC after DOC's clinical staff advised they were unable to provide the necessary level of care.
Root Cause:	Premature discharge from the local community hospital to the DOC infirmary resulted in the incarcerated individual being placed at risk and required a hospital readmission.
Recommendations:	DOC Health Services should develop a strategy to help community hospitals understand the level of care that a DOC infirmary is able to provide.
Corrective Action:	DOC Health Services will develop an outreach proposal to partner with their local community hospitals to support care coordination and education.
Expected Outcome:	Increased safety and care outcomes for the incarcerated individuals.

CAP ID Number:	UFR-23-018-2
Finding:	The county jail transferred a seriously ill incarcerated individual to DOC without appropriate care coordination.
Root Cause:	Inadequate communication from county jail.
Recommendations:	DOC Health Services should improve communication and care handoffs between jail facilities and DOC health services.
Corrective Action:	DOC Health Services will develop an outreach proposal to increase communication and support care handoffs with jails.
Expected Outcome:	Improved care outcomes for individuals being transferred from jail to a DOC facility.