Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-23-026

Report to the Legislature

As required by RCW 72.09.770

May 9, 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 23-026 on April 29, 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-23-026-1
Finding:	The incarcerated individual disclosed a suicide attempt and negative mental health symptoms within the last year during intake screening and did not receive a mental health evaluation.
Root Cause:	He denied current suicidal thoughts and was not targeted for mental health services.
Recommendations:	DOC 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.
Corrective Action:	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.
Expected Outcome:	Incarcerated individuals who may be at higher risk of completing suicide will be identified at intake, evaluated and offered appropriate treatment and support.