Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-22-032

Report to the Legislature

As required by RCW 72.09.770

February 23, 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 22-032 on February 13, 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-22-032-1
Finding:	The custody tier checks conducted during this incident were out of compliance with DOC policy requirements.
Root Cause:	Custody staff did not correctly conduct and document their tier checks.
Recommendation:	Ensure tier checks and observations are done according to DOC policy, operational memorandum, and post orders of the unit.
Corrective Action:	Conduct training with living unit officers on DOC policy, operational memorandum, and post orders of the unit regarding conducting tier checks and required documentation.
Expected Outcome:	Improved safety for incarcerated individuals.

CAP ID Number:	UFR-22-032-2
Finding:	DOC Policy 420.140 Cell/Room Assignment was not followed when the incarcerated individual remained housed alone in the cell after the initial emergency without the required higher levels of review.
Root Cause:	Staff did not recognize DOC Policy 420.140 applied in this case.
Recommendation:	Ensure DOC policy is followed when an individual is housed alone.
Corrective Action:	Educate facility staff that a review must occur to continue housing someone alone.
Expected Outcome:	Improved safety for incarcerated individuals.

CAP ID Number:	UFR-22-032-3
Finding:	There is no way for an incarcerated individual to directly summon staff if they are secured in their cell at the male reception facility.
Root Cause:	The facility does not have speakers or emergency call buttons in their cells.
Recommendation:	Develop a process for incarcerated individuals to be able to notify staff in an emergency.
Corrective Action:	Deploy a method for incarcerated individuals to notify staff in the event of an emergency.
Expected Outcome:	Increased safety for incarcerated individuals.

CAP ID Number:	UFR-22-032-4
Finding:	Mental health staff reviewed the “Request for Mental Health Assessment” form 13-420 and determined follow up with the incarcerated individual was not necessary.
Root Cause:	The mental health staff member believed the situation was a custody housing request and not a mental health concern.
Recommendation:	Review DOC Policy 630.500 Mental Health Services and provide additional direction for the completion and resolution of the “Request for Mental Health Assessment” form 13-420.
Corrective Action:	Provide additional direction regarding the completion and resolution of the “Request for Mental Health Assessment” form 13-420 for facility staff.
Expected Outcome:	Improved care communication.