# Unexpected Fatality Review
# DOC Corrective Action Plan

## Unexpected Fatality UFR-22-037

## Report to the Legislature

As required by RCW 72.09.770

April 17, 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 22-037 on April 7, 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

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| **CAP ID Number:** | UFR-22-037-1 |
| **Finding:** | In-person visitation for incarcerated individuals receiving end-of-life care is allowed on a case-by-case basis. |
| **Root Cause:** | DOC does not have a policy or standard procedure governing visitation for terminally ill individuals receiving end-of-life care. |
| **Recommendation:** | DOC should explore a modification of the policy that governs death bed visits (DOC 450.300 Visits for Incarcerated Individuals) with the goals of increasing the number of people (family and other incarcerated individuals) allowed to visit in the facility and to be present when someone dies and to better support incarcerated individuals receiving end-of-life care. |
| **Corrective Action:** | DOC Health Services will meet with the owner of DOC policy 450.300 to discuss the UFR Committee's recommendation and propose language for inclusion in the policy to ensure incarcerated individual's who are receiving end-of-life care have the option of in-person visitation. |
| **Expected Outcome:** | Improved support for incarcerated individuals and their families. |