

Unexpected Fatality Review DOC Corrective Action Plan

Unexpected Fatality UFR-23-010 Report to the Legislature

As required by RCW 72.09.770

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DOC Corrective Action, Publication Number 600-PL001

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Legislative Directive

Engrossed Substitute Senate Bill 5119 (2021)

Unexpected Fatality Review Governance

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 23-010 on November 21, 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-23-010-1
Finding:	Contractor failed to follow DOC Reentry Center procedures regarding pat searches, room searches, inside security checks, drug testing and area searches which allowed contraband into the facility.
Root Cause:	Lack of clear direction and oversight.
Recommendations:	 DOC update Reentry Center procedures for pat searches, room searches, counts, inside security checks, drug testing, and area searches within 90 days. DOC work towards Reentry Center inclusion in DOC Policy 420.150 Counts, which currently applies only to prisons.
Corrective Action:	DOC update reentry center procedures that outline requirements for searches, counts, drug testing, facility security, and substance use assessment referrals.
Expected Outcome:	Clear direction will lead to increased safety and support for staff, contractors, and incarcerated individuals.