Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-24- 016

Report to the Legislature

As required by RCW 72.09.770

May 1, 2025

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 24-016 on April 21, 2025 (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-24-016-1a
Finding:	A request for community EMS was not initiated before the incarcerated individual became non-responsive, resulting in delayed critical intervention.
Root Cause:	The evaluating nurse did not recognize the incarcerated individual's level of intoxication was life-threatening, leading to failure to escalate care in a timely manner.
Recommendations:	The Department of Corrections (DOC) Health Services should: 1. Review and update nursing protocols and forms to include the identification of stimulant intoxication symptoms.
Corrective Action:	The Department of Corrections (DOC) Health Services will: 1. Review and update nursing protocols and forms to include signs stimulant intoxication, along with specific guidelines for identifying clinical instability. 2. Implement mandatory training programs for all nursing staff focused on the updated protocols, emphasizing the importance of timely EMS requests in critical situations.
Expected Outcome:	1. DOC nursing staff will develop improved clinical skills, enabling them to recognize and respond to life-threatening intoxication promptly. 2. Enhanced quality of care for incarcerated individuals, including timely escalation and intervention in critical cases.

CAP ID Number:	UFR-24-016-1b
Finding:	A request for community EMS was not initiated before the incarcerated individual became non-responsive, resulting in delayed critical intervention.
Root Cause:	The evaluating nurse did not recognize the incarcerated individual's level of intoxication was life-threatening, leading to failure to escalate care in a timely manner.
Recommendations:	The Department of Corrections (DOC) Health Services should:

	1. Conduct targeted training sessions to improve nursing staff's ability to assess and respond to life-threatening intoxication cases.
Corrective Action:	The Department of Corrections (DOC) Health Services will: 1. Implement mandatory training programs for all nursing staff focused on the updated nursing protocols, emphasizing the importance of timely EMS requests in critical situations.
Expected Outcome:	1. DOC nursing staff will develop improved clinical skills, enabling them to recognize and respond to life-threatening intoxication promptly. 2. Enhanced quality of care for incarcerated individuals, including timely escalation and intervention in critical cases.