Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-25-004

Report to the Legislature

As required by RCW 72.09.770

June 2, 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 25-004 on May 23, 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-25-004 – 1a
Finding:	Nursing staff did not initially recognize the incarcerated individual's symptoms were life-threatening, resulting in delayed critical intervention.
Root Cause:	The current DOC Medical Emergency Response Form (DOC 13-440) does not provide guidance for identifying or prompt immediate request for EMS response for signs of clinical instability.
Recommendations:	Nursing leadership review and update DOC Medical Emergency Response Form (DOC 13-440) to include guidance for recognizing and managing clinical instability.
Corrective Action:	Nursing leadership will revise DOC Medical Emergency Response Form (DOC 13-440) with visual cues to better equip staff to quickly recognize and escalate care for incarcerated individuals showing signs of clinical instability.
Expected Outcome:	1. Improved emergency response as Department staff will be better equipped with information and skills needed to effectively respond to medical emergencies. 2. Timely request for EMS and improved outcomes for incarcerated individuals.

CAP ID Number:	UFR-25-004 – 1b
Finding:	There was a delay in requesting a community EMS response.
Root Cause:	Nursing staff did not initially recognize the patient's symptoms were life-threatening, resulting in a delayed EMS activation.
Recommendations:	Enhance Health Services Emergency Response training to include recognizing and responding to signs of clinical instability and reinforces timely request for community EMS.
Corrective Action:	The DOC Health Services team will implement mandatory training programs for all nursing staff focused on the updated nursing protocols and forms with emphasis on early recognition of clinical instability and prompt request for EMS response.
Expected Outcome:	1. Improved emergency response as Department staff will be better equipped with information and skills needed to effectively respond to medical emergencies. 2. Timely request for EMS and improved outcomes for incarcerated individuals.

CAP ID Number:	UFR-25-004 – 1c
Finding:	A delay occurred in requesting a community EMS response.
Root Cause:	Nursing staff did not initially recognize the severity of the patient's symptoms and the need for EMS activation and intervention.
Recommendations:	Facility leaders should implement routine emergency response drills and conduct post-action emergency response debriefs to enhance staff preparedness. These exercises should focus on improving communication, refining the process for engaging community EMS and ensuring timely medical intervention.
Corrective Action:	DOC's medical emergency response process will include readiness drills to reinforce best practices for managing medical emergencies.
Expected Outcome:	1. Department staff will be better equipped with information, skills, and equipment needed to effectively assess and respond to medical emergencies. 2. Improved quality of care for incarcerated individuals, including timely recognition, escalation, and intervention in critical situations.