Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-22-010

Report to the Legislature

As required by RCW 72.09.770

July 21, 2022

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 22-010 on July 11, 2022 (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-22-010-1
Finding:	The east side housing unit does not have a staffed officers' station.
Root Cause:	Staffing Patterns and Workflow
Recommendation:	Maintain a security presence on the entire unit for direct monitoring and early detection of possible safety concerns.
Corrective Action:	Reestablish an officer's station on the east side to provide a workstation for officers that will permit consistent, direct observation of the unit they are responsible for monitoring.
Expected Outcome:	Improved safety of incarcerated individuals by increasing presence and visibility of Correctional Officers.

CAP ID Number:	UFR-22-010-2
Finding:	DOC staff did not recognize the behaviors being exhibited by the suspect prior to the incident as an indication that he was preparing to assault someone.
Root Cause:	Organizational transfer of knowledge
Recommendation:	During DOC initial and annual staff trainings, consider using the surveillance video of the time preceding this event as an example of observable behaviors that may indicate a need for staff intervention.
Corrective Action:	Evaluate current curricula used in initial and annual staff trainings to equip participants with knowledge and skills to recognize behaviors that may indicate a need for staff intervention.
Expected Outcome:	Improved safety of DOC staff and incarcerated individuals by recognizing potential concerns.