Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-22-016

Report to the Legislature

As required by RCW 72.09.770

September 12, 2022

DOC Corrective Action, Publication Number 600-PL001

Cheryl Strange, Secretary
cheryl.strange@doc.wa.gov

Unexpected Fatality Review
DOC Corrective Action Plan

DOC Corrective Action Publication Number 600-PL001

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 22-016 on September 2, 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-22-016-1
Finding:	The incarcerated individual was not on blood thinning medication while he was being cared for in a DOC Inpatient Unit (IPU) though he was at increased risk for forming blood clots during his post-operative period.
Root Cause:	DOC has no protocol or guidance for medical staff to follow regarding blood clot prevention for incarcerated individuals being cared for in a DOC IPU.
Recommendation:	Create and implement a protocol for the prevention of blood clots in incarcerated individuals being admitted to an IPU.
Corrective Action:	Update inpatient unit admission order sheet to include individual plan for blood clot prevention strategy.
Expected Outcome:	Improved safety and health outcomes for incarcerated individuals by decreasing the risk of an unexpected blood clot during an IPU stay.