



# Unexpected Fatality Review DOC Corrective Action Plan

---

Unexpected Fatality UFR-22-022

## Report to the Legislature

As required by RCW 72.09.770

September 8, 2022

DOC Corrective Action, Publication Number 600-PL001

Cheryl Strange, Secretary  
[cheryl.strange@doc.wa.gov](mailto: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 22-022 on August 29, 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

<b>CAP ID Number:</b>	UFR-22-022-1
<b>Finding:</b>	Jail records for the deceased incarcerated individual were reviewed and found to be incomplete and included a "late entry" by nursing staff.
<b>Root Cause:</b>	Community jail staff do not have an electronic health record and notes can be missing from the file; waiting to be filed, not available.
<b>Recommendation:</b>	Verify the community jail is in compliance with contract requirements for housing DOC violators.
<b>Corrective Action:</b>	DOC will conduct a random sample quality assurance audit of medical records for DOC violators at the community jail where the incarcerated individual was housed to ensure contract requirements have been met.
<b>Expected Outcome:</b>	Ensure individuals under DOC community supervision are provided necessary medical care when housed in a community facility.