



# Unexpected Fatality Review DOC Corrective Action Plan

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## Unexpected Fatality UFR-23-022 Report to the Legislature

As required by RCW 72.09.770

February 17, 2024

DOC Corrective Action, Publication Number 600-PL001

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

# Unexpected Fatality Review

## DOC Corrective Action Plan

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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 23-022 on February 07, 2024 (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

<b>CAP ID Number:</b>	UFR-23-022-1
<b>Finding:</b>	A diagnosis of blood in the urine is not automatically included in the DOC Cancer Care tracker and may have been meaningful to diagnose cancer at an early stage for this patient.
<b>Root Cause:</b>	Cancer Care Tracker does not include some diagnostic criteria that might enable DOC HS to identify cancer in early stages.
<b>Recommendations:</b>	DOC Health Services should review the DOC Cancer Care Tracker to decide if a diagnosis of blood in the urine should be included.
<b>Corrective Action:</b>	DOC Health Services Clinical Services Board will determine the criteria for including the diagnosis of blood in the urine to the DOC Cancer Care tracker.
<b>Expected Outcome:</b>	Additional clinical guidance for DOC Health Services staff to support the care of incarcerated individuals.

<b>CAP ID Number:</b>	UFR-23-022-2
<b>Finding:</b>	The Facility Medical Director and the Nurse Care Manager were not actively involved in this incarcerated individual's care.
<b>Root Cause:</b>	There is no written guidance for escalation of cases to the Facility Medical Director or referring to the Nurse Care Manager.
<b>Recommendations:</b>	DOC should develop general guidance for when an advanced practitioner should involve the Facility Medical Director and the Nurse Care Manager in patient care.
<b>Corrective Action:</b>	DOC Health Services Clinical Services Board will develop general guidance for referring cases to the Facility Medical Director (FMD) and Nurse Care Managers.
<b>Expected Outcome:</b>	Improve appropriate escalation of care to reduce barriers to access and delays in response.