Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-24-004

Report to the Legislature

As required by RCW 72.09.770

September 13, 2024

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 24-004 on September 03, 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

CAP ID Number:	UFR-24-004-1
Finding:	The incarcerated individual was prescribed medication to assist in managing his mental health symptoms, with increasing daily dosages over time. He did not receive follow-up clinical testing to monitor medication effects.
Root Cause:	The absence of an electronic health record contributed to the lack of follow-up testing to monitor medication effects. This deficiency highlights the need for DOC to provide education and guidelines to augment current prescribing practices and effective medication monitoring.
Recommendations:	Until an electronic health record system is implemented, DOC should provide education and care management guidelines that augment current prescribing practices and facilitate medication monitoring.
Corrective Action:	DOC will provide education and deploy care management guidelines that augment current prescribing practices, along with comprehensive monitoring and management of prescribed medications.
Expected Outcome:	Improved health outcomes for incarcerated individuals.