Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-24-007

Report to the Legislature

As required by RCW 72.09.770

July 29, 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 #24-007 on July 19, 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-24-007-1
Finding:	The current DOC system of classification and the Health Services support needs coding tool did not identify that this incarcerated individual, diagnosed with autism, required additional staff support and had need for accommodation.
Root Cause:	The current DOC processes for identifying, case managing, and housing individuals with developmental disabilities during incarceration are not standardized.
Recommendations:	DOC should review and update their classification and health services support needs coding processes to better support individuals with developmental disabilities.
Corrective Action:	DOC Health Services will recommend to the Executive Leadership Team the establishment of a workgroup to review current DOC practice, identify gaps, and make recommendations for improvement to standardize processes and protocols for identifying, coding, classifying and appropriately housing incarcerated individuals with intellectual and developmental disabilities, including autism.
Expected Outcome:	Standardized processes will better support incarcerated individuals and staff.