Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-24- 011

Report to the Legislature

As required by RCW 72.09.770

January 23, 2025

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 24-011 on January 13, 2025 (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-24-011-1
Finding:	The new unit control booth officer did not know where the ligature removal tool was stored.
Root Cause:	Lack of training and orientation for new control booth custody staff on ligature removal equipment.
Recommendations:	DOC should remind custody staff on appropriate use and location of the ligature removal tool.
Corrective Action:	DOC will evaluate standardized storage of ligature removal devices in unit control booths to increase accessibility.
Expected Outcome:	Decreased time to respond in the event of a ligature.

CAP ID Number:	UFR-24-011-2
Finding:	Responding staff paused lifesaving efforts while seeking clarification on DNR applicability.
Root Cause:	DOC has not provided training to staff on providing lifesaving measures during a self-harm event when the incarcerated individual has requested a DNR.
Recommendations:	DOC provide clarification to staff that the Do Not Resuscitate (DNR) request does not apply to self-harm events per Policy 620.010 Advance Directives.
Corrective Action:	DOC will issue a memo directing all staff to provide lifesaving measures when there is a self-harm event regardless of DNR status.
Expected Outcome:	Improved response to incarcerated individuals during a self-harm event.

CAP ID Number:	UFR-24-011-3
Finding:	Responding staff paused lifesaving efforts while seeking clarification on DNR applicability.
Root Cause:	DOC has not provided training to staff on providing lifesaving measures during a self-harm event when the incarcerated individual has requested a DNR.
Recommendations:	DOC should update the identification badge DNR flag language to include “Does not apply in instances of self-harm.”
Corrective Action:	DOC will update the identification badge DNR flag language to include “Does not apply in instances of self-harm.”

Expected Outcome:	Improved response to incarcerated individuals during a self-harm event.
CAP ID Number:	UFR-24-011-4
Finding:	Exterior cell window coverings created a safety and security concern, making it difficult for staff to observe the individual.
Root Cause:	Staff did not require the exterior cell window coverings to be removed in accordance with WAC 137-25-030.
Recommendations:	DOC should direct staff to ensure cell windows are not fully covered.
Corrective Action:	DOC will provide direction to staff regarding covering of cell windows.
Expected Outcome:	Improved safety, security and visibility.