Unexpected Fatality Review
DOC Corrective Action Plan

UFR-25-005

Report to the Legislature

As required by RCW 72.09.770

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DOC Corrective Action, Publication Number 600-PL001

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Legislative Directive and Governance

Engrossed Substitute Senate Bill 5119 (2021)

RCW 72.09.770 requires the Department of Corrections (DOC) to convene an Unexpected Fatality Review committee to review any case in which the death of an incarcerated individual was unexpected, or in any case identified by the Office of the Corrections Ombuds (OCO) for review.

The purpose of the Unexpected Fatality Review (UFR) is to develop recommendations for DOC and the legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for incarcerated individuals in DOC's custody.

Within ten days of completion of the Unexpected Fatality Review, DOC must publish an associated corrective action plan to implement any recommendations made by the review team. DOC will then have 120 days to implement that plan.

Disclosure of Protected Health Information

RCW 72.09.770 requires DOC to disclose protected health information - including mental health and sexually transmitted disease records - to UFR committee members. Federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying substance use information to state, federal, or local agencies in the course of conducting audits or evaluations mandated by statute or regulation.

DOC issued the UFR 25-005 Committee Report on September 8, 2025 (DOC publication 600-SR001). This document is the associated corrective action plan. DOC is required to implement corrective action within 120 days of publication.

Corrective Action Plan

CAP ID Number:	UFR-25-005 - 1
Finding:	The Health Services response to the decedent's kite did not appropriately address the concerns raised or prompt an urgent clinical evaluation, despite language that may have indicated a need for timely clinical attention.
Root Cause:	Nursing staff did not consistently follow the established guidelines for triaging and responding to kites, due to gaps in training, unclear expectations, and limited oversight of the triage process.
Recommendations:	Strengthen the Health Services kite triage process by implementing standardized criteria to ensure kite response is timely and appropriate.
Corrective Action:	Nursing leadership will develop, implement and provide training on a statewide nursing protocol that requires a Registered Nurse 2 (RN2) or higher to triage incoming Health Services kites. The protocol will include guidance to help nursing staff promptly recognize concerning symptoms or safety-related language concerns requiring clinical follow-up.
Expected Outcome:	Nursing staff will be better equipped to triage and respond appropriately to incoming Health Services kites in a timely and clinically appropriate way. Appropriate triage and response support improved outcomes for incarcerated individuals.