



Unexpected Fatality Review DOC Corrective Action Plan

Unexpected Fatality UFR-25-002 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

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 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 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 UFR, 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.

Unexpected Fatality Review Committee Report

DOC issued the UFR-25-002 committee report on February 20, 2026 (DOC publication 600-SR001). This document includes the required corrective action plan. DOC is required to implement corrective actions within 120 days from the corrective action plan publication.

Corrective Action Plan

CAP ID Number:	UFR-25-002-1
Finding:	The quality and timeliness of care provided by the contracted jail to the decedent was inadequate and did not meet DOC's expectations of care.
Root Cause:	Jail medical staff were not aware of the decedent's admission to the jail until the morning of the decedent's death, leading to missed opportunities for intervention and aid.
Recommendations:	DOC should facilitate a formal debrief of this case with the contracted jail's leadership and medical staff, including review of identified care gaps and reemphasis of expectations regarding the quality and timeliness of care provided in contracted facilities.
Corrective Action:	DOC leadership will conduct a debrief with the community jail's leadership and medical staff to share identified concerns regarding the quality and timeliness of care in this case.
Expected Outcome:	Improved care and health outcomes for individuals housed in contracted jail facilities on DOC's behalf.