



# Unexpected Fatality Review DOC Corrective Action Plan

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## Unexpected Fatality UFR-25-024 Report to the Legislature

As required by RCW 72.09.770

March 27, 2026

DOC Corrective Action, Publication Number 600-PL001

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UFR-25-024 DOC Corrective Action Publication Number 600-PL001

## **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 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.

## Unexpected Fatality Review Committee Report

DOC issued the UFR-25-024 committee report on March 17, 2026 (DOC publication 600-SR001). This document includes the required corrective action plan. DOC is required to implement the corrective actions within 120 days from the corrective action plan publication.

### Corrective Action Plan

|                           |                                                                                                                                                                                                                               |
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| <b>CAP ID Number:</b>     | UFR-25-024 - 1                                                                                                                                                                                                                |
| <b>Finding:</b>           | Standards, practices, and expectations can be unclear and inconsistent in DOC's Residential Treatment Unit (RTU).                                                                                                             |
| <b>Root Cause:</b>        | DOC's RTUs do not have a comprehensive and dedicated governance policy.                                                                                                                                                       |
| <b>Recommendations:</b>   | DOC should finalize and implement a dedicated RTU policy to ensure that care and practices are standardized and DOC staff have clear direction on supporting individuals with a history of suicide attempts and/or self-harm. |
| <b>Corrective Action:</b> | Finalize and implement a DOC Residential Treatment Unit policy.                                                                                                                                                               |
| <b>Expected Outcome:</b>  | Safe and consistent RTU operations to support staff and incarcerated individuals in DOC's RTUs.                                                                                                                               |

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| <b>CAP ID Number:</b>     | UFR-25-024 - 2                                                                                                                                                                              |
| <b>Finding:</b>           | The decedent was housed in a single-person cell within the RTU which allowed for increased opportunity to die by suicide.                                                                   |
| <b>Root Cause:</b>        | The RTU has a common practice of housing individuals in single-cells, as the few two-person cells available are not commonly used due to difficulties with cellmate screening and matching. |
| <b>Recommendations:</b>   | DOC should enhance its RTU housing screening materials to better ensure that individuals with a history of suicide and/or self-harm are considered for housing with a cellmate.             |
| <b>Corrective Action:</b> | Finalize and implement a screening form to consider housing individuals in the Residential Treatment Unit with a cellmate, where appropriate.                                               |
| <b>Expected Outcome:</b>  | Improved health and safety outcomes for incarcerated individuals housed in DOC's RTUs.                                                                                                      |

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| <b>CAP ID Number:</b>     | UFR-25-024 - 3                                                                                                                                                                                       |
| <b>Finding:</b>           | In the two days prior to discovery of the decedent's body, tier checks were inconsistent and inadequate, leading to a delay in discovering the decedent and initiation of lifesaving measures.       |
| <b>Root Cause:</b>        | Custody officers conducted tier checks with and without the use of flashlights and at a pace that did not allow for adequate observation of each cell's interior and the wellbeing of its occupants. |
| <b>Recommendations:</b>   | DOC should include accountability measures in its ongoing tier check process improvement.                                                                                                            |
| <b>Corrective Action:</b> | DOC will complete a value stream mapping of the unit tier check process and                                                                                                                          |

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|                          | provide a report with recommended changes and compliance metrics to support monitoring changes for effectiveness. |
| <b>Expected Outcome:</b> | Improved unit operations and increased safety for incarcerated individuals.                                       |