



Unexpected Fatality Review DOC Corrective Action Plan

Unexpected Fatality UFR-25-017 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 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-25-017 committee report on March 24, 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

CAP ID Number:	UFR-25-017 - 1
Finding:	A tier check was missed prior to the decedent being discovered by custody officers with a tablet charging cord around their neck in their cell.
Root Cause:	Unit floor officers were gathered in the officer's station and distracted by conversation with an incarcerated individual who was standing in the doorway; the conversation eliminated officer presence on the unit floor, obscured officer view of unit activity, and delayed initiation of the required hourly tier check.
Recommendations:	DOC should include accountability measures in its ongoing tier check process improvement.
Corrective Action:	Complete a value stream mapping of the unit tier check process and provide a report with recommended changes and compliance metrics to support monitoring changes for effectiveness.
Expected Outcome:	Improved unit operations and increased safety for incarcerated individuals.

CAP ID Number:	UFR-25-017 - 2
Finding:	The unit booth officer believed the decedent's cell was empty and allowed an incarcerated individual serving as the unit's porter into the decedent's cell for cleaning on an unscheduled day while the decedent was present in the cell.
Root Cause:	The unit schedule was not posted in the unit's control booth and the booth officer who was new to their position, therefore, did not have access to this information during this incident.
Recommendations:	DOC should ensure that unit booth officers have access to vital information, including the unit schedule.
Corrective Action:	Print and post the unit schedule in the unit control booth.
Expected Outcome:	Improved unit operations and increased safety for incarcerated individuals.

CAP ID Number:	UFR-25-017 - 3
Finding:	There was limited officer presence in the unit dayroom and on the tiers during this incident.
Root Cause:	Unit floor officers were gathered in the officer's station and distracted by conversation with an incarcerated individual who was standing in the doorway; the conversation eliminated officer presence on the unit floor and obscured officer view of unit activity.
Recommendations:	DOC should emphasize the importance of continued officer presence in the

	unit, which will help ensure the safety and security of incarcerated individuals and DOC staff.
Corrective Action:	Disseminate a directive to unit supervisors to ensure custody officer presence in unit dayrooms when incarcerated individuals are present.
Expected Outcome:	Improved unit operations and increased safety for incarcerated individuals.

CAP ID Number:	UFR-25-017 - 4
Finding:	The unit booth officer believed the decedent's cell was empty and allowed an incarcerated individual serving as the unit's porter into the decedent's cell for cleaning on an unscheduled day while the decedent was present in the cell.
Root Cause:	The unit booth officer was new to their position and had limited training and access to information on the unit schedule, roster, and empty vs. unoccupied cells.
Recommendations:	DOC should emphasize to unit booth officers the importance of cell occupancy verification prior to an incarcerated individual being admitted to another individual's cell.
Corrective Action:	Disseminate a directive requiring unit booth officers verify cell occupancy prior to allowing a unit porter or other incarcerated individual to enter a cell for cleaning.
Expected Outcome:	Improved unit operations and increased safety for incarcerated individuals.