

OFFICE OF THE  
**CORRECTIONS  
OMBUDS**

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FY 2023  
ANNUAL REVIEW OF  
UFR REPORTS,  
COMMITTEE  
RECOMMENDATIONS,  
& CORRECTIVE ACTION  
PLANS

# **UNEXPECTED FATALITIES IN WASHINGTON STATE DOC CUSTODY**

PREPARED BY  
THE OFFICE OF THE CORRECTIONS OMBUDS  
PURSUANT TO  
RCW 43.06C.080

RELEASED  
NOVEMBER 27, 2023

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## Executive Summary

The Office of the Corrections Ombuds is an active participant in the Department of Corrections (DOC) unexpected fatality review (UFR) process (RCW 72.09.770). Representatives from the DOC, the OCO, and the Department of Health (DOH) are required to attend each UFR. A representative from the Health Care Authority (HCA) also routinely participates. The public employees who represent their individual agencies gather at least monthly to form a multi-disciplinary, multi-agency review team and are uniquely qualified to understand what no single agency or group working alone can: how and why an incarcerated individual unexpectedly died while under the care and custody of the DOC.

During Fiscal Year 2023 (July 1, 2022 – June 30, 2023) the DOC:

- Published **29 UFR Reports**
- Published **21 Corrective Action Plans (CAPs)** associated with 21 of the UFR Reports
- Worked toward completion of **63 action items** identified in the 21 CAPs

As required by RCW 43.06C.080, the OCO prepared this report as a review of the status of the UFR Committee recommendations. Of the 63 action items, the OCO found that the DOC:

- Completed **56** action items
- Did not provide sufficient evidence to verify **3** action items
- Is still completing **4** action items

The OCO has expressed concerns that the **UFR Committee’s “consultative” recommendations** (those that the DOC determines to be outside of the direct cause of death) **are not formally managed and tracked by the UFR Committee to ensure follow-up has occurred.**

Additionally, the OCO is particularly concerned about **two of the top causes of unexpected deaths in DOC: suicides (6) and overdoses (10)**. While this report examines UFRs published during Fiscal Year 2023 (July 1, 2022-June 30, 2023), the number of deaths by suicide and overdose in the DOC continued to rise after the close of the reporting period. We continue to urge the DOC to implement: (1) meaningful, and universally available, substance use disorder treatment and (2) state-wide promotion of the 988 Suicide and Crisis Lifeline inside prisons.

The OCO values both continuous improvement and the trust of the people incarcerated in DOC facilities and all our stakeholders. We acknowledge that each UFR is only a small glimpse into the lives of the people who unexpectedly died in DOC custody. As an agency we observe not only the loss of life but the impact these deaths have on the people living and working in Washington’s corrections system. We remain hopeful that the work undertaken by the UFR Committee will help to prevent future unexpected fatalities of people in DOC’s care and custody.

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## Introduction

RCW 72.09.770 directs the Department of Corrections (DOC) to conduct an unexpected fatality review (UFR) in any case in which the death of an incarcerated individual is unexpected, or any case identified by the Office of the Corrections Ombuds (OCO) for review. Representatives from the DOC, the OCO, and the Department of Health (DOH) are required to attend each UFR. A representative from the Health Care Authority (HCA) also routinely participates in UFRs.

Each UFR results in a report, prepared and published by the DOC, that must be made public within 120 days following the fatality. The DOC may also create an associated corrective action plan (CAP) to implement a recommendation made by the UFR Committee. Every UFR report is delivered to the Governor and state legislators. The reports are also publicly available on the [DOC publications website](#) or by request in DOC law libraries.

In addition to the individual UFR reports, [RCW 43.06C.080](#) directs the OCO to issue an annual report to the legislature on the status of the implementation of unexpected facility review recommendations. Historically, this office reported on the status of UFR recommendations in our agency annual report. This year, however, we are publishing the UFR annual report as a standalone report. As in past years, this annual report will address the status of CAPs used to implement recommendations made in reports published by the DOC during the prior fiscal year.

## Standard Unexpected Fatality Review Timeline

[RCW 72.09.770\(1\)\(d\) - \(e\)](#) establishes the timeline for the UFR process:



**Day 1**  
Date of unexpected death



**Day 120**  
DOC must issue a report on the results of the UFR within 120 days of the death



**Day 130**  
DOC must develop an associated corrective action plan (CAP) within 10 days of issuing the report



**Day 250**  
DOC must implement associated CAP(s) within 120 days of development

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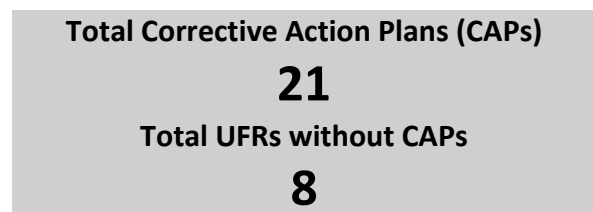
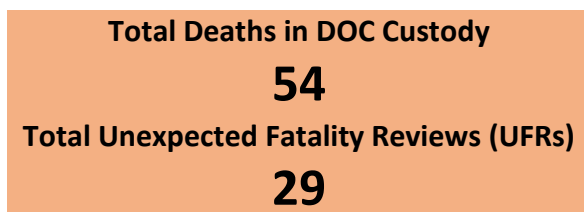
## Key Limitations

Limitations can be defined as those characteristics of design or methodology that impacted or influenced the interpretations of the findings.<sup>1</sup> The key limitations of this report are:

1. This report is produced by the Office of the Corrections Ombuds and relies on data provided to this office from the Department of Corrections.
2. Report accuracy may be affected by the quality and consistency of the DOC's internal tracking systems, which vary by facility.
3. Data in this report is current as of November 16, 2023. Information provided in this report is subject to change as a result of updated or additional records being added to the DOC's internal tracking system.

## Unexpected Fatality Review Reports in FY 2023

This OCO report covers unexpected fatality recommendations and reports published by DOC in Fiscal Year 2023 (July 1, 2022 to June 30, 2023). During this fiscal year, fifty-four (54) people died in DOC custody. Twenty-nine (29) of those deaths were identified as unexpected and reviewed through the UFR Committee process. The total number of Unexpected Fatality Reviews, Corrective Action Plans (CAP), and UFRs without CAPs are outlined in the orange and grey boxes below. Eight (8) of the twenty-nine (29) UFRs did not result in a recommendation for a Corrective Action Plan. Figure 1 shows the causes of death for all UFRs in FY 2023, Figure 2 outlines the number of UFR reports published per month, and Figure 3 displays details from Figure 1 with associated locations.



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<sup>1</sup> Price, James H. and Judy Murnan. "Research Limitations and the Necessity of Reporting Them." American Journal of Health Education 35 (2004): 66-67; Theofanidis, Dimitrios and Antigoni Fountouki. "Limitations and Delimitations in the Research Process." Perioperative Nursing 7 (September-December 2018): 155-163.

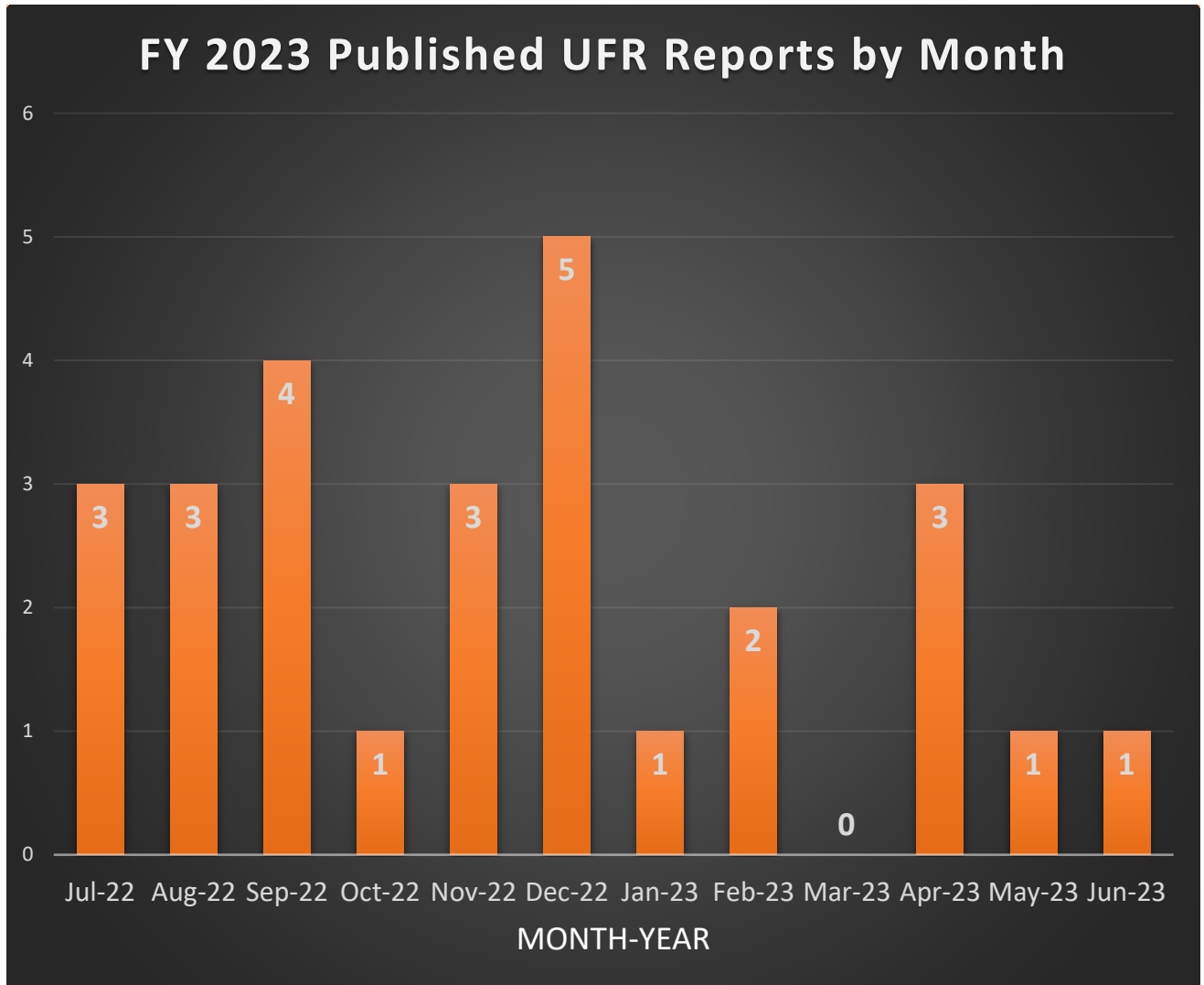
Figure 1. Number of Unexpected Fatality Review publications based on cause of death, defined by DOC. The highest number of deaths are highlighted in orange: overdose, suicide, and vascular disease.

<b>FY 2023 Published UFR Reports by Cause of Death</b>		
<b>Number of UFRs</b>	<b>Cause of Death</b>	<b>DOC Definition</b>
1	Homicide	A death that occurs during and is related to the action of one person directly causing the death of another.
<b>10</b>	<b>Overdose</b>	Includes deaths where the underlying cause of death is when the human body receives too much of a substance, or mix of substances, that results in the death of the person.
<b>6</b>	<b>Vascular Disease</b>	Includes deaths where leading cause was coronary artery disease, peripheral artery disease, aortic disease, or cerebrovascular disease.
3	Infection/Sepsis	Includes deaths where the leading cause was the result of complications from a bacterial, viral, or fungal infection.
1	Respiratory	Includes deaths where the leading cause of death is associated with lower respiratory infections, pneumonia, emphysema, COPD, or chronic bronchitis/asthma.
<b>6</b>	<b>Suicide</b>	Death caused by injuring oneself with the intent to die.
1	Accident	Any death that is caused by an unexpected event and is not intended, expected, or anticipated.
1	Medication Complications	Includes deaths associated with the administration of a medication, or its interaction with other medications, in a person's system.

Of the twenty-nine (29) unexpected fatalities, the most common cause of death was overdose. Ten (10) people died of overdose, six (6) people died of suicide, and six (6) people died of vascular disease. During FY 2023, three (3) people died of infection/sepsis, while respiratory, accident, homicide, and medication complications were found to be the cause of death for one (1) individual each.

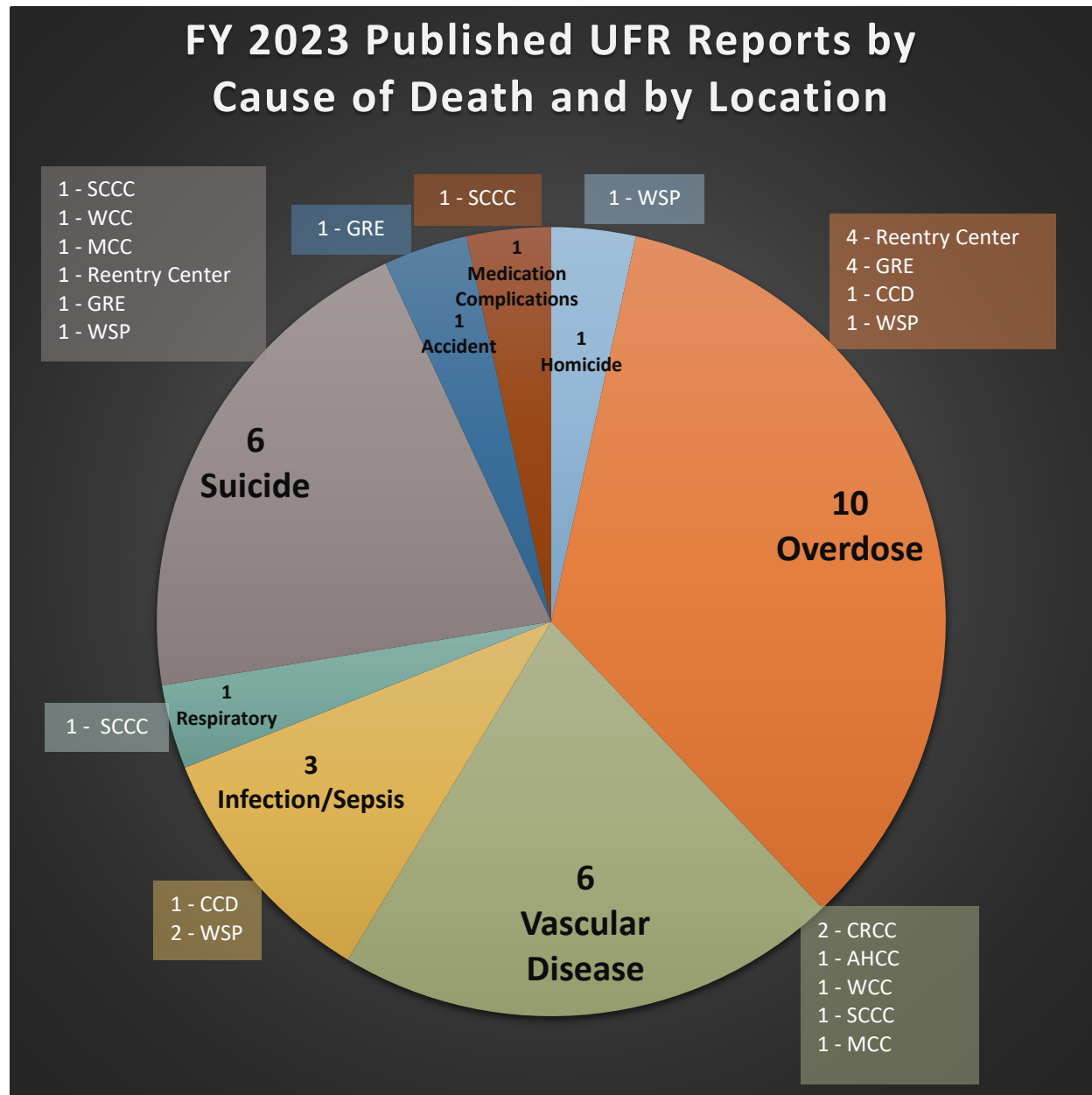
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Figure 2. Number of UFR reports published each month of Fiscal Year 2023 (July 2022 to June 2023).



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Figure 3. Unexpected Fatality Reviews published in Fiscal Year 2023 (July 1, 2022 – June 30, 2023) by cause of death and location. Locations: Airway Heights Corrections Center (AHCC), Stafford Creek Corrections Center (SCCC), Washington Corrections Center (WCC), Monroe Correctional Complex (MCC), Washington State Penitentiary (WSP), Graduated Reentry (GRE), and Community Custody Division (CCD).



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## Compliance Review of Corrective Action Plans

To assess the DOC's compliance with the Corrective Action Plans generated from UFR Committee recommendations, the OCO reviewed the DOC's CAP tracking system and related evidence.<sup>2</sup> Following a review of this documentation, the OCO sent clarifying questions and met with DOC Health Services Leadership to discuss findings and request additional information and evidence. The OCO compiled our findings in **TABLE 1: FY 2023 (July 1, 2022-June 30, 2023) UFRs & CAPs** and **TABLE 2: FY 2023 (July 1, 2022-June 30, 2023) CAP Review**. More information about DOC Corrective Action Plans and additional UFR Committee recommendations can be found in the full UFR and CAP reports, links included in Table 1.

TABLE 1: Fiscal Year 2023 (July 1, 2022-June 30, 2023) UFRs & CAPs					
UFR #	Date Published	Location	Cause of Death	Action Items	CAP Date Published
<a href="#">22-010</a>	07/11/22	WSP	Homicide	2	<a href="#">07/21/22</a>
<a href="#">22-011</a>	07/21/22	Reentry Center	Overdose	2	<a href="#">07/29/22</a>
<a href="#">22-013</a>	08/05/22	GRE	Overdose	2	<a href="#">08/15/22</a>
<a href="#">22-014</a>	08/02/22	CRCC	Vascular Disease	1	<a href="#">08/12/22</a>
<a href="#">22-016</a>	09/02/22	WSP	Infection/Sepsis	1	<a href="#">09/12/22</a>
<a href="#">22-017</a>	09/19/22	Reentry Center	Suicide	0	No CAP
<a href="#">22-018</a>	07/25/23	GRE	Suicide	0	No CAP
<a href="#">22-019</a>	09/30/22	GRE	Accident	0	No CAP
<a href="#">22-020</a>	09/30/22	AHCC	Vascular Disease	1	<a href="#">10/10/22</a>
<a href="#">22-021</a>	10/17/22	GRE	Overdose	3	<a href="#">10/27/22</a>
<a href="#">22-022</a>	08/29/22	Community Custody	Infection/Sepsis	1	<a href="#">09/08/22</a>
<a href="#">22-023</a>	11/10/22	WSP	Overdose	0	No CAP
<a href="#">22-024</a>	11/17/22	WCC	Vascular Disease	6	<a href="#">11/23/22</a>
<a href="#">22-025</a>	11/10/22	SCCC	Medication Complications	0	No CAP
<a href="#">22-026</a>	12/09/22	SCCC	Suicide	7	<a href="#">12/19/22</a>
<a href="#">22-027</a>	12/09/22	GRE	Overdose	1	<a href="#">12/19/22</a>
<a href="#">22-028</a>	12/13/22	Reentry Center	Overdose	2	<a href="#">12/23/22</a>
<a href="#">22-029</a>	12/15/22	SCCC	Vascular Disease	3	<a href="#">12/23/22</a>
<a href="#">22-030</a>	12/27/22	Reentry Center	Overdose	4	<a href="#">01/06/23</a>
<a href="#">22-031</a>	01/23/23	CRCC	Vascular Disease	0	No CAP
<a href="#">22-032</a>	02/13/23	WCC	Suicide	4	<a href="#">02/23/23</a>
<a href="#">22-033</a>	02/23/23	Community Custody	Overdose	1	<a href="#">03/01/23</a>
<a href="#">22-034</a>	04/07/23	Reentry Center	Overdose	3	<a href="#">04/13/23</a>
<a href="#">22-035</a>	03/09/23	WSP	Infection/Sepsis	0	No CAP
<a href="#">22-036</a>	04/24/23	GRE	Overdose	1	<a href="#">05/04/23</a>
<a href="#">22-037</a>	04/07/23	SCCC	Respiratory	1	<a href="#">04/17/23</a>
<a href="#">23-001</a>	05/01/23	WSP	Suicide	0	No CAP
<a href="#">23-003</a>	05/22/23	MCC	Vascular Disease	7	<a href="#">06/01/23</a>
<a href="#">23-004</a>	06/20/23	MCC	Suicide	10	<a href="#">06/30/23</a>

<sup>2</sup> The OCO relied on evidence and data provided by the DOC to assess the status of Committee recommendations. The results of this compliance review may be impacted if the evidence or data was faulty.

<b>TABLE 2: Fiscal Year 2023 (July 1, 2022-June 30, 2023) CAP Review</b>			
<b>UFR #</b>	<b>UFR Committee Recommendation</b>	<b>DOC Corrective Action Plan (CAP) Description</b>	<b>DOC CAP Status</b>
UFR-22-010	Maintain a security presence on the entire unit for direct monitoring and early detection of possible safety concerns.	Reestablish an officer's station on the east side to provide a workstation for officers that will permit consistent, direct observation of the unit they are responsible for monitoring.	<b>CAP Completed</b>
UFR-22-010	During DOC initial and annual staff trainings, consider using the surveillance video of the time preceding this event as an example of observable behaviors that may indicate a need for staff intervention.	Evaluate current curricula used in initial and annual staff trainings to equip participants with knowledge and skills to recognize behaviors that may indicate a need for staff intervention.	<b>CAP Completed</b>
UFR-22-011	Ensure reentry center staff are conducting required searches.	Retrain staff, counsel staff in compliance with DOC progressive discipline.	<b>CAP Completed</b>
UFR-22-011	Update the contract to include purchasing supplemental fentanyl test strips.	Purchase fentanyl test strips and implement fentanyl testing with all urine drug screens.	<b>CAP Completed (past deadline)</b>
UFR-22-013	Develop and implement a protocol for staff to follow when an incarcerated individual requests medication for the treatment of OUD.	Update current medication assisted treatment protocols to include guidance for staff to follow when an incarcerated individual requests medication assistance for the treatment of OUD.	<b>CAP Completed</b>
UFR-22-013	Expand medication assisted treatment options for incarcerated individuals with OUD.	Investigate options and develop a proposal for the DOC leadership consideration to expand medication assisted treatment for incarcerated individuals with a diagnosis of OUD.	<b>CAP Completed</b>
UFR-22-014	Ensure incarcerated individuals receiving treatment for chronic medical conditions are assigned to a primary care provider.	Develop and implement a policy or protocol requiring incarcerated individuals with chronic medical conditions to be assigned a primary care provider	<b>CAP Completed (past deadline)</b>
UFR-22-016	Create and implement a protocol for the prevention of blood clots in incarcerated individuals being admitted to an IPU.	Update inpatient unit admission order sheet to include individual plan for blood clot prevention strategy.	<b>CAP Completed (past deadline)</b>
UFR-22-020	Educate DOC medical providers on accepted care pathways for stroke prevention.	Utilize contracted medical consultant to conduct statewide clinical education for DOC medical providers on managing stroke risk followed up by development and deployment of accepted stroke prevention and care pathways.	<b>CAP Completed (past deadline)</b>
UFR-22-021	Explore expansion of treatment options for incarcerated individuals diagnosed with OUD.	Investigate options and develop a proposal for DOC leadership consideration to expand medication assisted treatment options.	<b>CAP Completed</b>

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UFR-22-021	Develop and implement a formal process for tracking and documenting drug screening results for individuals in the GRE program.	Implement a policy or protocol establishing expectations for GRE staff to monitor receipt of drug screen results in a timely manner.	<b>Insufficient Evidence<sup>3</sup></b>
UFR-22-021	Provide staff guidance and training on how to configure the lab portal to send email notifications when drug screen results are ready for review.	Provide training and require all Reentry Corrections Specialists to configure the lab portal to send email notifications when drug screen results are ready for review.	<b>Insufficient Evidence</b>
UFR-22-022	Verify the community jail is in compliance with contract requirements for housing DOC violators.	DOC will conduct a random sample quality assurance audit of medical records for DOC violators at the community jail where the incarcerated individual was housed to ensure contract requirements have been met.	<b>CAP Completed</b>
UFR-22-024	Inform staff an AED should be brought to a medical emergency response and identify which staff members are responsible to transport the AED to the scene.	Update Policy 890.620 Emergency Medical Treatment to clarify expectations and responsibilities for staff responding to a medical emergency.	<b>CAP Completed</b>
UFR-22-024	Expand availability of and access to AEDs in DOC prisons.	Conduct a statewide audit of the number and location of AEDs in each facility and consider placement of AED in each control booth in the facilities.	<b>CAP Completed (past deadline)</b>
UFR-22-024	Update DOC Policy 890.620 Emergency Medical Treatment to require periodic emergency response drills that include health service, custody staff, and the use of an emergency response vehicle at facilities where they are located.	Facility custody and health service leadership ensure emergency response drills are conducted quarterly on each shift.	<b>CAP Completed</b>
UFR-22-024	Ensure medical emergency response vehicles are ready and capable of meeting the need statewide.	Require facilities with emergency response vehicles to: a. Evaluate the functionality of their vehicle to ensure it is appropriately equipped b. Develop a protocol for their use that identifies when they are to be used, who will be responsible for driving to the scene, and a contingency plan for when vehicle is not available c. Provide training to staff responsible for responding to medical emergencies d. Include emergency vehicle readiness check as part of the monthly facility safety inspection.	<b>Insufficient Evidence</b>

<sup>3</sup> The OCO has reported a CAP status of “Insufficient Evidence” in instances where DOC’s evidence did not address all aspects of the CAP.

UFR-22-024	DOC Health Services resume annual emergency response training as mandated by DOC Policy 890.620 Emergency Medical Treatment.	Require all Health Services departments to resume annual emergency response training.	<b>CAP Completed (past deadline)</b>
UFR-22-024	Offer training opportunities to all employees to maintain CPR certification as required for their position per DOC Policy 890.620 Emergency Medical Treatment.	Develop and implement a plan to ensure all required DOC employees are current with certification requirements.	<b>CAP Completed</b>
UFR-22-026	Explore options for expanding medical isolation capacity in DOC facilities.	Develop a proposal to expand medical isolation capacity for DOC leadership review and consideration.	<b>CAP Completed (date of completion not identified)</b>
UFR-22-026	Ensure mental health staff are notified when an incarcerated individual is placed in medical isolation/quarantine or an alternative housing location.	Update the following to clarify that any incarcerated individual on medical isolation, regardless of reason, include directives for mental health notification and rounding expectations. · WA State DOC COVID-19 Mental Health/Psychiatry Response Guideline · Safety Exposure Control Guide · Communicable Disease, Infection Prevention, and Immunization Program · WA State DOC COVID-19 Screening, Testing, and Infection Control Guideline Version 33.1 (R. 9/13/2022)	<b>CAP Completed</b>
UFR-22-026	Consider amendment of policy 630.500 to be more descriptive of the role of Mental Health staff, including Psychiatrists, in the care and well-being of persons admitted to an alternate housing unit or on medical isolation.	Update Policy 630.500 – Mental Health Services Section VII or create and deploy a MH protocol that includes MH service expectations for individuals being housed in an alternate housing unit or on medical isolation.	<b>CAP Completed</b>
UFR-22-026	Establish a process for multidisciplinary care planning for managing complex cases or situations (i.e., medical isolation, mental health concerns, alternative housing).	Develop a policy or protocol establishing criteria and expectations for care planning at least weekly for persons in medical isolation.	<b>CAP Completed</b>
UFR-22-026	Improve staff awareness of suicide risk and need for mental health referrals when an incarcerated individual displays concerning behavior changes.	1. Develop a plan to restart annual in-person suicide awareness training, and 2. Reinforce the use of DOC Form 13-420 “Request for Mental Health Assessment” during the monthly facility “Place-safety Musters.”	<b>CAP Completed</b>
UFR-22-026	Establish written procedures to ensure alternate housing units are managed and operated with the same safety and security expectations as established housing units.	Create an operations manual and post orders for alternative housing units to ensure they are managed and operated safely and securely.	<b>CAP Completed</b>

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UFR-22-026	DOC should begin tracking the availability of negative pressure medical isolation rooms.	Create a centralized database to track availability of negative pressure medical isolation rooms for DOC facilities.	<b>CAP Completed</b>
UFR-22-027	Review and refine the current SUD referral process to provide clear direction for staff to follow when assisting an individual who reports a history of illicit substance use in maintaining their sobriety.	Schedule a Value Stream Mapping for stakeholders to evaluate and make process recommendations for assisting individuals with a history of illicit substance use in maintaining their sobriety.	<b>CAP Completed</b>
UFR-22-028	Review and refine the current substance use disorder referral process to provide clear direction for staff to follow when assisting an individual who reports a history of illicit substance use in maintaining their sobriety.	Schedule a Value Stream Mapping for stakeholders to evaluate and make process recommendations for assisting individuals with a history of illicit substance use in maintaining their sobriety.	<b>CAP Completed</b>
UFR-22-028	The case plan for incarcerated individuals who receive a positive drug screen should be reviewed with the supervisor as soon as possible to discuss options and the plan documented.	Develop and implement a process that requires a supervisory level of review for individuals who have positive consecutive drug screens. The meeting will be documented in the case management plan and will include a review of their substance use history, a person-centered intervention plan, the risk posed to themselves and the community, the decision to refer for community substance use disorder assessment or to return the individual to full confinement for their safety.	<b>CAP Completed</b>
UFR-22-029	The DOC diabetes workgroup should create a “Diabetes Care Pathway” that identifies when a specialist should be consulted, including a presentation of the case to Rubicon MD requesting treatment recommendations when an individual presents with poorly controlled blood sugar. If the virtual consult recommendations are not effective, consider an in-person appointment with an Endocrinologist.	Develop and implement guidance to standardize care pathways for diabetes treatment and management.	<b>CAP Completed</b>
UFR-22-029	DOC should educate Health Services clinical staff on accepted care pathways for the prevention and treatment of heart disorders to ensure that incarcerated individuals receive care according to the best practices of evidence-based medicine.	Develop and implement guidance to standardize care pathways for prevention and treatment of heart conditions.	<b>CAP Completed</b>
UFR-22-029	DOC practitioners should issue a prescription for aspirin when it is medically indicated.	The DOC Director of Pharmacy will issue a communication reminding all clinical staff that aspirin can be prescribed when medically indicated.	<b>CAP Completed</b>

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UFR-22-030	All reentry center staff will have Narcan administration training.	Provide Narcan administration training to all staff.	<b>CAP Completed</b>
UFR-22-030	All emergency medical equipment and supplies should be marked with appropriate signage and their locations known and accessible to all staff.	Install signage and orient staff to location of all emergency medical equipment and supplies.	<b>CAP Completed</b>
UFR-22-030	Inspect medical emergency response equipment and supplies on a regular basis.	Conduct monthly safety inspections per DOC Policy 890.000 Safety Program and document on DOC Form 16-347 Monthly Safety and Sanitation Inspection.	<b>CAP Completed</b>
UFR-22-030	When a defective piece of critical equipment is identified during an inspection, the concern should be communicated to staff and the supervisor responsible for fixing the concern.	Conduct monthly safety inspections per DOC Policy 890.000 Safety Program and note any equipment defects on DOC Form 16-347 Monthly Safety and Sanitation Inspection. Provide a copy of the form to the responsible supervisor and to the facility safety representative. Document the date corrective action was taken prior to filing the inspection as completed.	<b>CAP Completed</b>
UFR-22-032	Ensure tier checks and observations are done according to DOC policy, operational memorandum, and post orders of the unit.	Conduct training with the living unit officers on DOC policy, operational memorandum, and post orders of the unit regarding conducting tier checks and required documentation.	<b>CAP Completed</b>
UFR-22-032	Ensure DOC policy is followed when an individual is housed alone.	Educate facility staff that a review must occur to continue housing someone alone.	<b>CAP Completed</b>
UFR-22-032	Develop a process for incarcerated individuals to be able to notify staff in an emergency.	Deploy a method for incarcerated individuals to notify staff in the event of an emergency.	<b>CAP Completed</b>
UFR-22-032	Review DOC Policy 630.500 Mental Health Services and provide direction for the completion and resolution of the "Request for Mental Health Assessment" form 13-420.	Provide additional direction regarding the completion and resolution of the "Request for Mental Health Assessment" form 13-420 for facility staff.	<b>CAP Completed</b>
UFR-22-033	DOC work with the community jail custody and their medical staff to discuss their ability to provide incarcerated individuals with MAT and the assistance DOC can provide to assist incarcerated individuals needing connected to a community treatment program when they reenter their community.	DOC conduct a debrief with the contracted community jail custody and their medical staff.	<b>CAP Completed</b>
UFR-22-034	Reentry centers should conduct table-top exercises, safety discussions and planning with all staff to include the location and use of all emergency response equipment related to fentanyl overdoses.	Reentry centers will conduct table-top exercises, safety discussions and planning with all staff at a minimum quarterly.	<b>CAP Completed</b>

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UFR-22-034	DOC should develop a process as part of the reentry partial confinement program eligibility screening with the Substance Abuse Recovery Unit to verify the incarcerated individual's substance use disorder assessment and treatment needs prior to approval for transfer.	DOC will explore options and develop a process as part of the reentry center eligibility screening with the DOC Substance Abuse Recovery Unit staff to verify the incarcerated individual's substance use disorder assessment and treatment status/need prior to transfer similar to the Graduated Reentry screening process.	<b>CAP Completed</b>
UFR-22-034	Reentry centers should review and discuss DOC policies related to substance use, searches, employment checks, and requirements for DOSA participants with staff.	Reentry centers will conduct a review and discussion of DOC policies related to substance use, searches, employment checks, and requirements for DOSA participants with staff. Participation in reviews will be documented.	<b>CAP Completed</b>
UFR-22-036	DOC should develop a process as part of the reentry partial confinement program eligibility screening with the Substance Abuse Recovery Unit (SARU) to verify the incarcerated individual's substance use disorder assessment and treatment needs prior to approval for transfer.	DOC will explore options and develop a process as part of the GRE eligibility screening with SARU staff to verify the incarcerated individual's substance use disorder assessment and treatment status/need prior to transfer, similar to the Reentry Center screening process.	<b>CAP Completed</b>
UFR-22-037	DOC should explore a modification of the policy that governs death bed visits (DOC 450.300 Visits for Incarcerated Individuals) with the goals of increasing the number of people (family and other incarcerated individuals) allowed to visit in the facility and to be present when someone dies and to better support incarcerated individuals receiving end-of-life care.	DOC Health Services will meet with the owner of DOC policy 450.300 to discuss the UFR Committee's recommendation and propose language for inclusion in the policy to ensure incarcerated individuals who are receiving end-of-life care have the option of in-person visitation.	<b>CAP Completed (past deadline)</b>
UFR-23-003	Health Services leadership will support the clinical staff in reinforcing the need for immediate care escalation to a community emergency room or hospital in the case of suspected acute coronary syndrome.	DOC Health Services will conduct an education conference (M&M) for clinical decision making in patients with chest pain to reinforce the learning.	<b>CAP Completed</b>
UFR-23-003	DOC Health Services should consider adopting the SBAR (Situation-Background-Assessment-Recommendation) reporting template as a standard communication tool for nurse to on-call provider telephone communication.	Develop and implement a SBAR reporting template for nursing staff to use when communicating with on-call providers.	<b>CAP Completed</b>

UFR-23-003	DOC should update the health plan language and policy to reflect any DOC staff member, contractor, or volunteer can request a 911 community emergency response.	A proposed revision to the DOC Health Plan will be submitted granting authority to any DOC staff member, contractor, or volunteer to request a 911 community emergency response in the event of a life-threatening emergency.	<b>CAP Completed</b>
UFR-23-003	Facility Health Services leadership should conduct routine unit/department meetings.	Health Services leadership will establish the cadence and documentation of routine facility level unit/department meetings.	<b>CAP Completed</b>
UFR-23-003	Health Services leadership should conduct rounds in the facilities.	Health Services leadership establish the cadence and documentation of leadership rounding in the facilities.	<b>CAP Completed</b>
UFR-23-003	DOC should acquire an electronic health record.	Health Services leadership continue acquiring an electronic health record as full legislative funding becomes available.	<b>In Process</b>
UFR-23-003	Health Services should reinvigorate the onboarding, orientation, and training of staff, ensuring a complete basic understanding on the part of all clinical staff of where to locate applicable policies, protocols, and guidelines.	Health Services leadership will post all protocols and guidelines, including those applicable to nursing staff, in one central location and ensure all clinical staff have access to and knowledge of this repository.	<b>CAP Completed</b>
UFR-23-004	Nursing staff should immediately respond to a medical emergency.	DOC leadership should pursue progressive discipline per Article 8 of the Teamsters 117 Collective Bargaining Agreement when there is evidence that appropriately trained staff are not following DOC policy and protocols.	<b>CAP Completed</b>
UFR-23-004	A process for formal Multidisciplinary Team (MDT) meeting should be developed when an individual is placed in a close observation area for safety monitoring to include options for after business hours communications.	Develop and implement minimum standards for conducting Multidisciplinary Team meetings to discuss care plans and housing of individuals in close observation areas.	<b>CAP Completed</b>
UFR-23-004	Formalize and standardize onboarding to ensure all mental health staff are trained on where, when, and how to conduct close observation area assessments when there are concerns about suicide or self-harm or other sensitive mental health concerns.	Provide and document training to custody and health services staff on general suicide prevention and the policy and procedures for incarcerated individuals being housed in a close observation area.	<b>CAP Complete</b>
UFR-23-004	Improve staff awareness that self-harm events may be a suicide attempt and not an attention seeking behavior. 004-2b	Develop a plan to restart annual in-person suicide awareness training and continue to provide and document appropriate onboarding and training for mental health staff.	<b>CAP Complete</b>

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UFR-23-004	Formalize and standardize onboarding to ensure all custody staff are trained in how to follow the written conditions of confinement and to seek clarification from the mental health staff when they have questions.	Provide and document training to custody staff on general suicide prevention and the policy and procedures for incarcerated individuals being housed in a close observation area.	In Process
UFR-23-004	Develop guidance for utilizing confidential settings for communications with incarcerated individuals housed in a close observation area.	Create and implement a protocol or guideline for assessing suicide risk.	CAP Completed
UFR-23-004	DOC should acquire an electronic health record.	Health Services leadership continue the process to acquire an electronic health record when full legislative funding becomes available.	In Process
UFR-23-004	Tier checks, cell searches and supplemental video monitoring should be completed and documented in accordance with post orders and align with the conditions of confinement. DOC should consider adding the language “health and wellness” check to describe the purpose of a tier check during training.	DOC leadership should pursue progressive discipline per Article 8 of the Teamsters 117 Collective Bargaining Agreement when there is evidence that appropriately trained custody staff are not following post orders and DOC policy.	CAP Completed
UFR-23-004	DOC should require medical emergency response drills with medical and custody staff.	Health care and custody staff will participate in joint emergency response drills regularly that will include an evaluation and debrief by both a member of custody and health services.	In Process
UFR-23-004	Recommend DOC conduct a statewide survey of staff who work in or with incarcerated individuals housed in the close observation area (i.e., medical providers, religious coordinators, custody officers, classification counselors, hearings officers, nurses, mental health staff) to identify opportunities to increase staff engagement and promote safety for the incarcerated individuals in their care.	Develop and conduct a statewide survey of staff working with individuals in the close observation area to identify opportunities to increase staff engagement and promote safety for the incarcerated individuals.	CAP Completed

**Observations**

Nearly 90 percent of UFR Committee recommendations, as reflected in DOC’s Corrective Action Plans, were completed by the DOC. The OCO’s review also noted certain areas of particular concern.

**Compliance Tracking**

**DOC created a tracking system for UFR related Corrective Action Plans. Additional recommendations provided by the UFR Committee are not included in this tracking process.**

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RCW 72.09.770(4)(a) states, “[a] [UFR] 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*” (emphasis added).

During Fiscal Year 2023 (July 1, 2022-June 30, 2023), the DOC developed a comprehensive system for tracking the completion of UFR related CAPs. The OCO was able to review extensive documentation for the majority of CAPs to verify that the Department had taken the necessary actions to comply with each Plan. The OCO found most DOC CAPs focused on policy, protocol, education, and training updates. Some CAP items were duplicated across multiple UFRs due to common causes of death. However, there was insufficient evidence for the OCO to report on DOC compliance with all UFR Committee recommendations, specifically those outside of DOC Corrective Action Plans. In order for the OCO to report on DOC compliance with all UFR recommendations, a DOC system is needed for tracking consultative recommendations and action items not included in CAPs.

In Fiscal Year 2023 (July 1, 2022-June 30, 2023), OCO staff who are members of the UFR Committee completed Root Cause Analysis training through the American Society for Quality (ASQ). This training amplified OCO’s existing concerns regarding the timeline of DOC’s Root Cause Analyses for unexpected fatalities. Since Corrective Action Plans are only linked to direct causes of death, DOC’s root cause analysis that begins based on Critical Incident Report (CIR) timelines misses opportunities for corrective action related to warning signs, events leading up to the person’s death, and preventative opportunities. The UFR Committee often provides recommendations that may have functioned as protective barriers to actions like suicide; however, since they may not be linked to the direct cause of death, these recommendations are not tracked in DOC’s CAP tracking system. The OCO encourages the creation of evidence-based tracking for UFR recommendations that may not fall under a Corrective Action Plan.

Of the twenty-nine (29) reviewed deaths, Corrective Action Plans were created for twenty-one (21) UFRs, in addition to the Committee’s consultative notes and recommendations. Following UFR Committee reviews, the OCO provided input and edits to DOC draft UFR publications. In this fiscal year, additional OCO staff joined the Committee, and the office created a tracking system for the office’s UFR concerns, questions, and input. The OCO also began highlighting UFR Recommendations in our Monthly Outcome Reports (MORs).

### **Suicides in DOC Custody**

**In Fiscal Year 2023 (July 1, 2022 – June 30, 2023), the DOC published UFR reports for six (6) people who died by suicide while living at SCCC, WCC, MCC, WSP, Reentry Center, or on GRE.**

Six (6) related UFR reports (22-017, 22-018, 22-026, 22-032, 23-001, 23-004) include more details of the Committee’s review of suicides in fiscal year 2023. These UFRs outline twenty-one

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(21) action items associated with DOC CAPs. Three (3) of the six (6) suicide-related reviews did not include Corrective Action Plans. Additional UFR Consultative Remarks are outlined in **TABLE 3: Suicide Related UFR Consultative Remarks.**

**UFR Committee recommendations for the six (6) suicide reviews are listed below:**

- Explore options for expanding medical isolation capacity in DOC facilities.
- Ensure incarcerated individual on medical isolation/quarantine status have access to mental health services.
- Improve staff awareness of suicide risk and the need for a referral to the Mental Health Team when an incarcerated individual displays concerning behavior changes.
- Establish written procedures to ensure alternative housing units are managed and operated with the same security expectations established in housing units as defined by the security matrix.
- Consider amendment of DOC Policy 630.500 Mental Health Services to be more descriptive of the role of mental health staff, including psychiatrists, in the care and well-being of person admitted to an alternative house unit or on medical isolation/quarantine status.
- Establish a process for multidisciplinary care planning (MDT) for the management of complex cases or situations (i.e., medical isolation, mental health concerns, alternative housing placement).
- DOC should begin tracking the availability of pressurized medical isolation rooms.
- Ensure tier checks and observations are done according to DOC policy and the operational memorandum of the unit.
- Ensure DOC policy is followed when an individual is assigned single-man cell housing.
- Develop a process for incarcerated individuals to be able to notify staff in an emergency.
- Review DOC Policy 630.500 Mental Health Services and provide additional direction for the completion and resolution of the “Request for Mental Health Assessment” form 13-420.
- Conduct a statewide survey of staff who work in or with incarcerated individuals housed in the Close Observation Area (COA) (i.e., medical providers, religious coordinators, custody officers, classification counselors, hearings officers, nurses, mental health staff) to identify opportunities to increase staff engagement and promote safety for the incarcerated individuals in their care.
- Review and recommend updates to the suicide prevention policy and associated forms at the next scheduled mental health leadership meeting.

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- Tier checks should be completed in accordance with post orders and align with the conditions of confinement.
- Recommend changing the language in the post orders from a tier check to a “health and wellness” check and provide additional training.
- DOC should resume annual in-person suicide prevention training.
- DOC should require medical emergency response drills with medical and custody staff.
- Formalize and standardize onboarding and ensure mental health staff are trained related to conducting COA assessments in a confidential manner, and how to utilize and implement conditions of confinement.

<b>TABLE 3: Fiscal Year 2023 (July 1, 2022-June 30, 2023) Suicide Related UFR Consultative Remarks</b>				
<b>UFR #</b>	<b>UFR Publication Date</b>	<b>Location of Death</b>	<b>CAP Action Items</b>	<b>Additional UFR Consultative Remarks</b>
22-017	09/19/22	Reentry Center	0 (No CAP)	1. Referrals to the Community Response Unit should be updated when any pertinent safety concern arises.
22-018	07/25/23	GRE	0 (No CAP)	1. DOC should ensure that incarcerated individuals are offered an opportunity to reengage after a care declination. 2. DOC should consider ways to provide additional support when an incarcerated individual experiences a major life event.  3. DOC Health Services should ensure that elevated blood sugars are appropriately addressed by primary care providers. This will be addressed in the Patient Centered Medical Home model of care being implemented by DOC.
22-026	12/09/22	SCCC	7	No additional remarks/recommendations.
22-032	02/13/23	WCC	4	1. DOC should evaluate the current mental health team staffing model to address case load volume and investigate the possibility of job-related fatigue.  2. DOC should evaluate the process for timing and the need for a follow up mental health visit when there is an after-hours call to the Mental Health Duty Officer (MHDO).  3. Evaluate the infrastructure needs to have a dedicated private and confidential space for medical and mental health intake screenings.  4. Evaluate the infrastructure needs to equip all cells at the male reception center with an electronic emergency notification system.  5. DOC should evaluate the staff resources available at the male reception facility to include a dedicated Health Services

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				<p>staff to collaborate with community jails to increase communication for incarcerated individuals' care needs.</p> <p>6. For traumatic events, DOC should ensure follow up support is provided for staff and incarcerated individuals with the appropriate support staff (Critical Incident Stress Management team, Staff Psychologists, and the Mental Health Team).</p>
23-001	05/01/23	WSP	0 (No CAP)	1. The OCO offered to partner with the Department of Health to upload DOH educational material to the incarcerated individuals' Securus tablets.
23-004	06/20/23	MCC	10	1. DOC should continue the implementation of the Patient Centered Medical Home care model at their facilities.

## 988 Suicide and Crisis Lifeline

**In July 2022, Washington launched the state 988 Suicide and Crisis Lifeline, meant to provide support to people experiencing thoughts of suicide, a mental health crisis, or emotional distress.**

Washington State's 988 suicide and crisis line has been expanded and guided by legislation, specifically House Bill 1477 and 1134 (2021 and 2023). The hotline has seen a dramatic increase in calls over the past year.<sup>4</sup> The OCO, as well as representatives from the Department of Health and Health Care Authority, have urged the DOC to allow incarcerated individuals to access this resource. However, the DOC has been reluctant to facilitate or promote 988 calls from its facilities. The DOC states that its resistance is rooted in concern that individuals in crisis will not alert DOC staff of their state of mind.

The OCO views this differently: individuals who report thoughts of suicide to 988 will have the opportunity to receive immediate support from trained crisis line staff, especially individuals in solitary confinement and during non-business hours like nights and weekends when mental health staff often are not on site. The OCO continues to encourage the use of 988 services for incarcerated individuals and is in communication with the Department of Health (DOH) and DOC.

The OCO also encouraged DOC to move forward with the Residential Treatment Unit (RTU) Workgroup, which was paused throughout the COVID pandemic. Additional OCO staff joined the RTU Workgroup in 2023 and continue to participate in the collaborative development of RTU-specific policy, which currently does not exist.

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<sup>4</sup> Furfaro, Hannah. *What's happened since Washington's 988 crisis line launched last year?* The Seattle Times. July 15, 2023.

## **Overdoses in DOC Custody**

**In Fiscal Year 2023, (July 1, 2022 – June 30, 2023), the DOC published UFR reports for ten (10) people who died by overdose while at Washington State Penitentiary (WSP), on community custody, Graduated Reentry (GRE), or at a DOC reentry center.**

Ten (10) related UFR reports (22-011, 22-013, 22-021, 22-027, 22-028, 22-030, 22-033, 22-034, 22-036, and 22-023) include more details of the Committee's review of overdoses in fiscal year 2023. These UFRs outline nineteen (19) action items associated with DOC CAPs. One (1) of the ten (10) overdose related reviews did not include Corrective Action Plans. Additional UFR Consultative Remarks are outlined in **TABLE 4: Overdose Related UFR Consultative Remarks.**

**UFR Committee recommendations for the ten (10) overdose reviews are listed below:**

- Ensure reentry staff are conducting required searches.
- Test for fentanyl during all drug screens.
- Develop and implement a protocol for staff to follow when an incarcerated individual requests medication for the treatment of Opioid Use Disorder (OUD).
- Investigate available options to expand medication assisted treatment options for incarcerated individuals with OUD.
- Explore expansion of treatment options for incarcerated individuals diagnosed with OUD.
- Develop and implement a formal process for tracking and documenting drug screening results for individuals in the GRE program.
- Provide staff guidance and training on how to configure the lab portal to send email notifications when drug screen results are ready for review.
- Review and refine the current Substance Use Disorder (SUD) referral process to provide clear direction for staff to follow when assisting an individual who reports a history of illicit substance use in maintain their sobriety.
- All reentry center staff should be training and up to date on First Aid/CPR as well as "hands on" training with Narcan administration.
- All reentry center staff should be trained on the location of Narcan and AEDs, and aware of how to access them during an emergency.
- All reentry center emergency response equipment should be functional and routinely checked per DOC policy 890.620 Emergency Medical Treatment, including the AEDs.
- Safety equipment issues in the reentry center should be immediately reported and a backup plan communicated to all staff members.

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- A debrief with the contracted community jail custody and their medical staff to discuss the noted documentation deficiencies, the clinical opiate withdrawal scale (COWS) protocol, and the assistance DOC can provide to assist incarcerated individuals needing connected to medication assisted treatment (MAT).
- Reentry centers should conduct emergency response drills, table-top exercises, safety discussions and planning with all staff.
- Reentry centers should review and discuss DOC policies related to substance use, searches, employment checks, and requirements for DOSA participants with staff.
- DOC should develop a process as part of the reentry partial confinement program eligibility screening with the Substance Abuse Recovery Unit (SARU) to verify the incarcerated individual’s substance use disorder assessment and treatment needs prior to approval for transfer.

<b>TABLE 4: Fiscal Year 2023 (July 1, 2022-June 30, 2023) Overdose Related UFR Consultative Remarks</b>				
<b>UFR #</b>	<b>Date Published</b>	<b>Location of Death</b>	<b>No. of CAPs</b>	<b>Additional UFR Consultative Remarks</b>
22-011	07/21/22	Reentry Center	2	1. Consider providing education to reentry center incarcerated individuals and staff regarding the dangers of fentanyl.
22-013	08/05/22	GRE	2	1. Provide education to incarcerated individuals and department employees regarding the dangers of fentanyl and the benefits of medication assisted treatment for OUD.  2. Continue to progress toward acquiring an electronic health record.
22-021	10/17/22	GRE	3	1. Offer incarcerated individuals overdose harm reduction training prior to their reentry into the community.  2. Update DOC Policy 420.380 Drug/Alcohol Testing to clarify expectations for monitoring and documenting drug screening results when the test is sent to a contract lab.
22-027	12/09/22	GRE	1	No additional remarks/recommendations.
22-028	12/13/22	Reentry Center	2	No additional remarks/recommendations.
22-030	12/27/22	Reentry Center	4	1. Due to potency of fentanyl, DOC should investigate the feasibility of increasing the amount of Narcan supplies available for use by staff and for distribution to incarcerated individuals entering the community.
22-033	02/23/23	Community Custody	1	1. DOC contract administration staff provide a briefing to the UFR Committee regarding the Department’s contract review and renewal process for jails contracted to house individuals who have been arrested on a Secretary’s Warrant (SW).  2. DOC should continue to explore ways to enhance communication with community jails to facilitate

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				connecting incarcerated individuals with OUD with MAT program in their community prior to their release from DOC sanction. DOC Community Custody Division staff will coordinate with the DOC Nurse Desk as required.
22-034	04/07/23	Reentry Center	3	1. DOC should continue to explore and when possible, expand options for incarcerated individuals with a diagnosis of opioid use disorder to receive medication assisted therapy prior to reentering the community. For example, adopting the use of Sublocade injections to provide a bridge for individuals who need to access services in the community.
22-036	04/24/23	GRE	1	The OCO recommended DOC classification explore a centralized screening process for GRE and Reentry Centers.
22-023	11/10/22	WSP	0 (No CAP)	1. UFR committee identified conflict in policy language between DOC 620.200 Death of an Incarcerated Individual that allows advanced practitioners to pronounce a death, while DOC 890.620 Emergency Medical Treatment requires resuscitation efforts to continue until otherwise directed by a physician unless a “Do Not Resuscitate” advance directive is in place. Recommend DOC 890.620 be updated to reflect authority of advanced practitioners to direct discontinuation of resuscitation efforts and pronounce a death.

### Community Corrections Division (CCD)

Under [RCW 72.09.770\(4\)\(b\)](#)<sup>5</sup>, “[j]urisdiction of the department’ does not include persons on community custody under the supervision of the department.” Therefore, the UFR Committee’s reach into the DOC’s Community Corrections Division (CCD) is very limited: outside of prisons, the Committee may only review the unexpected deaths of people who, at the time of death, were in “partial confinement” or “violation status” being held in a jail or prison.

The OCO has authority to provide independent oversight for people in partial confinement. Partial confinement includes Reentry Centers, which are managed by the Reentry Division of DOC. However, other types of partial confinement exist which fall under the CCD’s jurisdiction, including Graduated Reentry (GRE), Electronic Home Monitoring (EHM), and Community Parenting Alternative (CPA).

The small reach of the OCO into the CCD via the UFR process has revealed significant policy violations, lack of consistency throughout the division, and what may be an over-reliance on swift and certain arrests in place of meaningful opportunities for substance use disorder treatment as provided for in a swift and certain community-based sanction.

<sup>5</sup> RCW 72.09.770: Unexpected fatality review – Records – Discovery. Chapter 72.09 RCW all relate to the Department of Corrections.



According to the DOC, the Department currently supervises 12,845 people on community supervision<sup>6</sup>. This is a population of Washingtonians living in our communities who are vulnerable to actions or inactions of DOC's CCD staff, and who, unfortunately, have little access to independent oversight.

## Looking Ahead: OCO UFR Work in FY 2024

The OCO continues to strengthen communication with DOC related to corrective action and reporting. After the OCO flagged UFR reports that did not include OCO edits and feedback, the DOC agreed to notify the OCO of final report drafts prior to publication to mitigate this issue for future reports. The DOC also agreed that there needs to be a system created for tracking additional Committee recommendations now that there is one in place for CAPs.

Over the next year, the OCO will continue to participate in unexpected fatality reviews, expand upon the office's tracking systems, apply tools from Root Cause Analysis trainings, and encourage thoughtful questions and recommendations as part of the UFR Committee.

The OCO recognizes that these reviews are a small glimpse into the lives of the people who have died unexpectedly in DOC custody. While this report focuses on our office's obligations as outlined in RCW 43.06C.080, we would like to remind readers to bear in mind that the data and numbers reported here represent individual lives and members of our community. The OCO, on behalf of the UFR Committee, acknowledges the ripple effects of grief these deaths have on friends, family, and loved ones in and outside the prison walls, as well as their impact on the staff who supported and cared for them. We remain hopeful that the recommendations set forth by this Committee will help to prevent future loss of life.

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<sup>6</sup> Department of Corrections Fact Card, September 30, 2023. Accessed November 15, 2023, at [www.doc.wa.gov/docs/publications/reports/100-RE004.pdf](http://www.doc.wa.gov/docs/publications/reports/100-RE004.pdf).