Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-022

Report to the Legislature

As required by RCW 72.09.770

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Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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Legislative Directive and 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 Unexpected Fatality Review 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.

This report describes the results of one such review and presents recommendations.

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.

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on July 10, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Penny Bhagia, Deputy Chief Medical Officer
- Patricia Paterson, Chief of Nursing
- Dr. Rae Simpson, Director – Quality Systems
- Darren Chlipala, Administrator
- Shane Evans, Administrator
- Dr. Rainey-Gibson, Director – Mental Health
- Dr. Ashley Espitia, Psychologist – Suicide Prevention Specialist
- Arpan Aulakh, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- Eric Jackson, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Rochelle Stephens, Men's Prisons Project Manager

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, Acting Director
- Ollie Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Karen Pastori, Health Services Consultant – Prevention and Community Health

This report includes a summary of the unexpected fatality, committee discussion, findings, and recommendations.

Fatality Summary

Year of Birth: 1969 (55 years old)

Date of Incarceration: April 2024

Date of Death: December 2024

At the time of death, this incarcerated individual was housed in a Washington State Department of Corrections facility.

His cause of death is asphyxia due to ligature hanging. The manner of his death is suicide.

A brief timeline of events prior to the incarcerated individual's death.

Day of Death	Event
21:52 – 04:25 hours	• Video review showed movement or lights turned on and off in the incarcerated individual's cell. • All required tier checks were conducted.
05:26 – 05:39 hours	• While conducting tier check, the Officer knocks on the incarcerated individual's cell door, does not receive response, and radios for the Sergeant (Sgt.) to report to the unit. • Additional custody and medical staff responded to the unit and began assessment of the incarcerated individual. • Due to the complex ligature apparatus the incarcerated individual was found in, responding staff initially had concerns of a possible homicide and a crime scene was declared rather than rendering immediate aid.
05:40 hours	• Shift Lieutenant (Lt.) leaves the incarcerated individual's cell and posts an officer.
05:53 – 06:05 hours	• Facility Medical Director (FMD) was notified that life-saving measures were not performed because the incarcerated individual had not been cut down. • FMD contacts Lt. and advised life-saving measures must be initiated until death could be declared.
06:14 – 06:32 hours	• Incarcerated individual is cut down.

	• Community Emergency Medical Services arrives on scene, conducts assessments, and declares incarcerated individual deceased. • Cell then secured.

UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee (MRC) and the DOC Critical Incident Review (CIR). The UFR Committee considered the information from both reviews and offered no recommendations for corrective action pertaining to direct cause of death.

A. The DOC conducted a CIR to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operational procedures.

    a. The incarcerated individual completed suicide between unit tier checks.

    b. The CIR identified policy and procedure concerns which did not directly correlate to the cause of death. These concerns are being remediated per DOC Policy 400.110 – Reporting and Reviewing Critical Incidents.

        i. The officer was uncertain how to appropriately notify and request help when he discovered the incident.

        ii. On arrival at the scene, responding staff assessed that the incarcerated individual was beyond the window of resuscitation and believed him to be deceased. Additionally, the complex ligature apparatus in which he was found caused staff to have concerns of a possible homicide. Based on these perceptions, responding staff initially secured the cell as a crime scene rather than immediately rendering aid.

B. The DOC MRC reviewed the health record, the delivery of medical and mental health care, and the concerns identified by the CIR. They did not identify any additional recommendations to prevent a similar fatality in the future.

    The MRC found:

    1. The incarcerated individual received appropriate care for his chronic medical conditions.

    2. He reported previous suicide attempts, denied current suicidal thoughts or plans, received appropriate mental health screenings and was being seen by a psychiatrist for medication management.

    3. He did not consistently attend the pill line to receive his medication, and the prescriber was not

notified of missed doses.

4. The incident occurred in the early morning hours, and some staff were unclear on roles and responsibilities during the emergency response.

5. The MRC recommended:

    a. Nursing will review the cause of absent notification when the patient did not attend pill line and improve the process so that notifications are made timely and according to DOC Policy 650.020 - Pharmaceutical Management and Nursing Procedure N-306.

    b. DOC conduct joint drills with a self-harm scenario on all shifts which would reinforce policy requirements, previous training, facilitate communication, and build rapport between custody and clinical staff for future responses.

C. The UFR Committee reviewed the unexpected fatality and discussed the following topics.

1. Pill line management.

    a. Members reviewed possible changes to improve safety and support individuals receiving pill line medications. These include ensuring overhead pages are clear and audible and prescribers are notified when an individual is not attending the pill line.

    b. DOC is implementing an electronic medication administration record which will facilitate communication and monitoring for incarcerated individuals receiving medications.

2. DOC emergency response procedures and staff training.

    a. UFR Committee members reviewed proposed updates to DOC's annual staff training, including updated content for suicide risk detection, responding to self-harm events, roles and responsibilities during an emergency, and procedures for pronouncement of death within a DOC facility.

3. Support for staff and incarcerated individuals following the incident.

    a. Tier checks and check-ins with mental health staff were completed for those incarcerated individuals who were affected by the death. Impacted staff members are proactively offered peer support through the DOC Employee Resilience Team and have access to the Employee Assistance Program (EAP).

UFR Committee Findings

The incarcerated individual died of asphyxia due to hanging. The manner of death is suicide.

UFR Committee Recommendations

The UFR committee did not issue any recommendations for corrective action.

Consultative remarks that do not directly correlate to cause of death, but may be considered for review by the Department of Corrections:

1. DOC should write and carry out a series of drills and training that normalize the role of Health Services clinical staff directing the medical components of an emergency response.
2. DOC should provide additional training for nursing staff to emphasize the requirements of the medication administration policy and protocol.