Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-024

Report to the Legislature

As required by RCW 72.09.770

August 15, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Tim Lang, Secretary
tim.lang@doc1.wa.gov

Table of Contents

Unexpected Fatality Review Committee Report

UFR-24-024 Report to the Legislature–600-SR001

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.

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. Poonam Bhagia, Deputy Chief Medical Officer
- Patricia Paterson, Chief of Nursing
- Dr. Eric Rainey-Gibson, Director of Behavioral Health
- Dr. Ashley Espitia, Suicide Prevention Specialist
- Darren Chlipala, Health Services Administrator
- Shane Evans, Health Services Administrator
- Dr. Rae Simpson, Director – Quality Systems
- 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: 1993 (31-years-old)

Date of Incarceration: February 2017

Date of Death: December 2024

At the time of death, the decedent was housed in a prison facility.

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

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

Day of Death	Event
12:18 hours	• A peer who lives in the unit stops at the decedent's cell front and speaks with the decedent for approximately one minute.
12:19 hours	• Custody staff conducts a routine tier check.
12:22 hours	• Last observed movement noted from within the decedent's cell.
13:33 hours	• Routine tier check conducted. Custody staff observe that the decedent is not moving and initiate radio notification to respond to scene.
13:35 hours	• Custody Supervisor responds to scene, unlocks decedent's cell door, performs primary survey and discovers the ligature on decedent's neck, and goes back to booth to retrieve a cutting tool to remove ligature.
13:37 – 13:54 hours	• Ligature is removed and the decedent is repositioned out of the cell to the tier to initiate care. • Cardiopulmonary Resuscitation (CPR) is initiated and Automated External Defibrillator (AED) is applied. • On-site medical staff arrive and contribute to the response effort.
13:54 – 14:44 hours	• Community Emergency Medical Services (EMS) arrives, assumes care, and transports the decedent to the helicopter.
14:45 hours	• Life Flight staff determine that the decedent has died.

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 in formulating recommendations.

A. The DOC Mortality Review Committee (MRC) reviewed the medical record, the care delivered and provided the following findings and recommendations.

    1. The MRC found:

        a. The decedent was receiving appropriate care for her medical and gender-affirming care needs.

        b. She was receiving mental health treatment and declined medication for symptom management due to fears that it would interfere with her hormone therapy.

        c. She had multiple suicide risk factors, including a history of self-harm during times of high emotion.

            i. The denial of housing with a preferred cellmate appears to have been a strong emotional stressor.

        d. During the emergency response, rescue breaths were administered by a Corrections Officer using an Ambu bag. They were not administered in coordination with chest compressions the Nurse was providing. This was not thought to contribute to the death.

            i. Custody and clinical staff receive different CPR training curricula, which may affect interdepartmental coordination during an emergency medical response.

            ii. Training for nursing staff is ongoing, focusing on emergency response documentation, proper equipment use, and role clarification.

            iii. The presence of volunteer EMT-certified employees at the facility may contribute to role ambiguity during a medical emergency response.

    2. The MRC recommended:

        a. Submission of a proposal to improve CPR team synchronization, role expectations, and common understanding of goals of CPR for all DOC staff whether this continues different training programs or unifies the training expectations.

        b. Add regular multidisciplinary CPR and Emergency drills to provide opportunities to practice and debrief together prior to real-life emergency response.

        c. Track compliance rates in the HS linked metrics venue to ensure all nursing staff complete emergency response training.

B. Independent of the mortality review, the DOC conducted a CIR to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operational procedures.

1. 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.

    a. The decedent completed suicide between tier checks.

        i. There was one hour and 14 minutes between unit tier checks.

    b. Due to a scoring error during a compatibility housing review, the decedent was approved to house with a preferred cellmate. Prior to the housing move, the error was discovered, and the approval was rescinded.

    c. The initial radio transmission announced a "medical emergency" but did not identify the nature of the emergency (i.e. unresponsive individual).

    d. The Ambu bag for rescue breathing was used ineffectively during the response.

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

1. Response to a mental health crisis.

    a. DOC conducts annual staff training focused on reducing suicide risk and responding to mental health crises. The training encompasses the identification of warning signs and the procedures for effectively communicating with and referring individuals to mental health providers when concerns arise.

    b. DOC is nearing completion of efforts to ensure that all incarcerated individuals have free access to the 988 mental health hotline.

2. DOC housing review process.

3. Patient education on medication interactions.

    a. Health Services providers consistently communicate information about potential risks, benefits, and interactions before prescribing new medications, enabling incarcerated individuals to make informed decisions about their care options.

4. Tier Checks.

    a. DOC is working to improve the quality and consistency of tier checks through establishing benchmarks, sharing lessons learned, and opportunities for improvement from previous reviews.

UFR Committee Findings

The decedent died of asphyxia due to hanging. The manner of death was suicide.

UFR Committee Recommendations

The UFR Committee endorsed actions taken by DOC to identify and respond to a mental health crisis and reduce suicide risk. They did not offer additional 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. Submit a proposal to improve CPR team synchronization.
2. Track compliance rates for nursing emergency response training.
3. Establish tier check benchmarks and reinforce consistency.