Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-011

Report to the Legislature

As required by RCW 72.09.770

August 26, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

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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 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.

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 August 7, 2025:

DOC Health Services

- Dr. Poonam Bhagia, Deputy Chief Medical Officer
- Dr. Eric Rainey-Gibson, Director – Behavioral Health
- Dr. Ashley Espitia, Suicide Prevention Specialist
- Patricia Paterson, Chief of Nursing
- Dr. Rae Simpson, Director – Quality Systems
- Arpan Aulakh, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- Melissa Andrewjeski, Assistant Secretary
- Deborah Wofford, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- Susan Leavell, Senior Administrator
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Project Manager

DOC Reentry Division

- Michelle Eller-Doughty, Reentry Center Operations Administrator

DOC Risk Mitigation

- Michael Petterson, Director

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

Health Care Authority (HCA)

- Dr. Heather Schultz, Associate Medical Director

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

Fatality Summary

Date of Birth: 1974 (51-years-old)

Date of Incarceration: January 2024

Date of Death: February 2025

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

The cause of death is hypertensive and atherosclerotic cardiovascular disease. The manner of death is natural.

A brief timeline of events on the day of death:

Time	Event
13:10 hours	• After a brief period of exercising in the outdoor yard, the decedent sat down in their wheelchair and became unresponsive.
13:11 hours	• The decedent's assigned peer therapy aid/wheelchair pusher attempts to rouse them. The therapy aid then notified custody staff that the decedent is unresponsive.
13:12 – 13:29 hours	• Custody staff initiated a medical emergency response and then used the wheelchair to move the decedent closer to medical responders. • The decedent is removed from the wheelchair, placed on the ground, and staff began lifesaving efforts. • A request for community Emergency Medical Services (EMS) is made.
13:30 – 14:05 hours	• Community EMS arrive on scene and assumed care.
14:06 hours	• The decedent's death is pronounced by community EMS.

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.

A. The MRC reviewed the medical record and the antecedent care delivered by DOC and provided the following findings. The MRC did not identify any additional recommendations to prevent a similar fatality in the future.

1. The MRC found:

    a. The decedent was receiving appropriate care and treatment for several medical conditions. Recommended health screenings were up to date and the decedent was seen regularly by primary care.

    b. The decedent was under the care of a community cardiologist. Documentation indicates a cardiology appointment occurred approximately one week prior to death, during which the decedent's care plan had been reviewed and updated.

    c. Available records did not indicate that the decedent was counseled on the potential cardiovascular risks associated with exercise.

2. While not contributory to the cause of death, the MRC identified the following opportunities:

    a. Enhance medical emergency response readiness through standardized staff training, drills, and quality control inspections of Health Services emergency response (Red) bags to ensure equipment availability and functionality.

    b. Evaluate the feasibility of implementing predictive analytics and AI solutions to proactively identify medically complex individuals who may benefit from targeted outreach and care coordination offered by DOC's Nurse Care Managers.

B. Independent of the MRC, 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 found:

    a. The decedent had a documented history of multiple chronic health conditions.

    b. The Ambu-bag mask was not present in the Health Services emergency response (Red) bag. The Ambu-bag was not needed in the response and was not contributory to the decedent's death.

    c. Review of applicable policy, procedure and staff performance did not identify any contributing factors to the decedent's cause of death within the scope of a CIR.

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

1. Emergency response training and staff readiness.

    a. DOC's nursing emergency response training has been updated to include standardized requirements for restocking and auditing emergency response supplies, hands-on instruction, and practical application assessments to evaluate employee performance on effective use of equipment.

b. UFR Committee Members also reviewed improvements that are currently underway statewide to ensure all DOC staff are trained to appropriately respond to a medical emergency.

2. Peer Support

   a. DOC is expanding its peer support programs to include training for therapy aids and wellness support groups.

3. Nursing care management team.

   a. Individuals can be connected to and treated by nurse care managers after referral from their primary care provider, through a multidisciplinary team meeting, or by direct outreach from a nurse care manager when appropriate.

UFR Committee Findings

The decedent died of hypertensive and atherosclerotic cardiovascular disease. The manner of death is natural.

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. Sustain and expand efforts to strengthen medical emergency response readiness through standardized staff training, scenario-based drills, and routine inspections of emergency medical supplies to ensure availability and functionality.

2. Explore feasibility of implementing use of predictive modeling and AI solutions to assist with identifying medically complex individuals who may benefit from enhanced care coordination.