Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-003

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. Within ten days of the publication of this report, DOC must publish an associated corrective action plan. 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.

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

DOC Prisons

- Melissa Andrewjeski, Assistant Secretary – Women's Division
- Deborah Wofford, Deputy Assistant Secretary – Women's Division
- James Key, Deputy Assistant Secretary – Men's Division
- Susan Leavell, Senior Administrator - Women's Division
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Program Manager

DOC Reentry Division

- Michelle Eller-Doughty, Reentry Center Operations Administrator

DOC Risk Mitigation

- Michael Pettersen, 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: 1996 (28-years-old)

Date of Incarceration: October 2024

Date of Death: February 2025

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

The cause of death is asphyxiation due to ligature strangulation. The manner of death is suicide.

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

12 Days Prior to Death	Event
	• The decedent is moved to the Close Observation Area (COA) after reporting suicidal ideation.
1 Day Prior to Death	**Event**
17:10 hours	• The decedent is released from the COA to a housing unit.
18:41 – 22:46 hours	• The decedent is seen in the unit dayroom and interacting with staff, or movement is seen in their cell.
22:16 hours	• A tier check is conducted.
23:08 hours	• A tier check is conducted.
23:11 hours	• Custody staff speak with the decedent about the overhead light in the cell.
Day of Death	**Event**
00:17 hours	• The decedent is found unresponsive in their cell during count. • Custody staff make a radio notification of a self-harm medical emergency and request a ligature removal device.
00:19 hours	• Community Emergency Medical Services (EMS) is requested. • The initial attempt to cut the ligature is unsuccessful. Custody staff reduce tension in the ligature by repositioning the decedent and remove the ligature manually. • Cardiopulmonary Resuscitation (CPR) is initiated.
00:26 hours	• On-site medical staff arrive on scene and resuscitation efforts

	continue.
00:36 hours	• Community EMS arrives on scene and assumes care.
00:58 hours	• Community EMS pronounce the death of the decedent.

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 for corrective action.

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

    1. The MRC found:

        a. The decedent received appropriate care for all medical and mental health concerns.

        b. Available records revealed inconsistency between the decedent verbalizing that they were "okay" but quickly destabilizing and becoming suicidal. The decedent's self-harm attempts and expression of thoughts of self-harm led to multiple stays in the COA.

            i. The decedent was determined to be stable for discharge from the COA with an appropriate safety and care plan in place a few hours before the completed suicide.

            ii. There was ineffective interdisciplinary communication regarding the decedent's history and safety plan prior to their discharge from the COA to the housing unit.

                1. Mental health and living unit staff exchanged emails regarding the safety plan, but unit officers on shift at the time of the COA discharge were not included.

    2. The MRC identified the following opportunity for improvement:

        a. Revise DOC Policy 320.265 Close Observation Areas and associated mental health protocols to establish standardized guidance for patient transfers out of the COA, ensuring interdisciplinary communication and comprehensive safety and aftercare planning.

B. Independent of the mortality review, DOC conducted a Critical Incident Review (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 completed suicide after discharge from the COA to a housing unit. They had known suicide risk factors, including previous attempts of self-harm and being housed without a cellmate.

b. There is no formal process for discharge from the COA, which impacted coordination and interdisciplinary communication of risk mitigation strategies for the decedent.

c. Coordinated and ongoing emergency response training for Health Services and/or Health Services and Custody is not consistent. This was not causal to the decedent's death.

d. The pace of cell front inspections hindered effective observation and assessment of in-cell activity. This was not causal to the decedent's death.

e. Designated storage locations in the housing unit for the Automated External Defibrillator (AED) and ligature removal device hindered timely deployment during the emergency. This was not causal to the decedent's death.

2. The CIR recommended:

a. Establish and document a uniform process to effectively communicate safety plans and risk mitigation processes with all disciplines involved in the safety and security of the individual releasing from the COA.

b. Utilize Sergeants, classification staff, and other unit supervisors to develop a plan to ensure unit tier checks and visual cell front inspections are completed with intention to determine in-cell activity.

c. Determine a location within each wing or pod for the storage of emergency response equipment.

d. Custody and Health Services staff must develop a robust plan for interoperability, including frequent mandatory, physical response scenarios using role players or mannequins that provide for the deployment and use of medical equipment, transport devices, restraints, and the modification of such devices which are designed to enhance rendered care.

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

1. Residential Treatment Unit (RTU) history and discharge.

a. The UFR committee discussed the decedent's history of RTU placement as well as concerns about their move from the COA to restrictive housing, instead of returning to the RTU level of care.

b. The OCO requested updates about the pending DOC RTU policy, which is related to a previous UFR Corrective Action Plan (CAP). The OCO also recommended the policy be finalized and language included to make explicit the need for DOC to request state mental health records when reviewing patients for admission to an RTU.

2. COA placement and discharge.

    a. UFR committee members reviewed DOC's enhanced COA placement and discharge procedures and discussed concerns about missed opportunities for clear communication with unit staff for ongoing monitoring needs and post-COA discharge plans, particularly in restrictive housing settings.

3. Ligature removal devices.

    a. DOC is evaluating ligature removal devices to ensure that the most effective tools are available for use during self-harm events.

4. Response to mental health crises.

    a. DOC conducts annual staff training focused on reducing suicide risk, responding to mental health crises and is nearing completion of efforts to ensure that all incarcerated individuals have access to the 988 mental health hotline.

5. Tier checks.

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

UFR Committee Findings

The decedent died of asphyxiation due to ligature strangulation. The manner of death is suicide.

UFR Committee Recommendations

Table 1 presents the UFR Committee's recommendations to prevent similar fatalities and further strengthen safety and health protections for incarcerated individuals. As required, the DOC will develop, publish, and implement an associated corrective action plan within 10 days following the publishing of this report.

Table 1. ***UFR Committee Recommendations***
1. Review DOC 320.265 Close Observation Areas and establish a standard communication protocol for transfers out of the COA. The protocol should support timely interdisciplinary communication of necessary aftercare needs and ensure safe management of the individual in their assigned housing unit.

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

1. Develop and implement a plan to ensure unit tier checks and visual cell front inspections are conducted with intention to assess in-cell activity and well-being.
2. Identify and designate a secure location within each wing or pod for the storage of emergency response equipment to support timely deployment during critical incidents.
3. Develop and execute a series of drills and training to equip custody and medical staff with the skills and confidence to effectively respond in the event of an emergency.
4. Include guidance in the pending RTU policy for DOC to request and review state mental health records when reviewing a patient for RTU placement.