Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-005

Report to the Legislature

As required by RCW 72.09.770

September 8, 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-25-005 Committee 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 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 (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 and presents recommendations. 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 21, 2025:

DOC Health Services

- Dr. Mary Colter, Facility Medical Director (Designee for Chief Medical Officer)
- Patricia Paterson, Chief of Nursing
- Dr. Eric Rainey-Gibson, Director – Behavioral Health
- Dr. Zainab Ghazal, Health Services Administrator
- Dr. Rae Simpson, Director – Quality Systems
- Paul French, Administrator – Substance Abuse Recovery Unit
- Arpan Aulakh, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- Charles Anderson, Deputy Assistant Secretary, Men's Prisons
- James Key, Deputy Assistant Secretary, Men's Prisons
- Susan Leavell, Senior Administrator, Women's Prisons
- Lorne Spooner, Correctional Operations Program Manager
- Rochelle Stephens, Men's Prisons Project Manager

DOC Community Corrections

- Kristine Skipworth, Regional Administrator

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. Judy Zerzan, Medical Director

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

Fatality Summary

Date of Birth: 1969 (55-years-old)

Date of Incarceration: February 2025

Date of Death: March 2025

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

The cause of death is ligature strangulation. The manner of death is suicide.

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

Days Prior to Death	Event
12	• The decedent is readmitted to prison and Health Services' intake screenings are completed.
6	• The decedent submits a kite to Health Services with a medication question. • A written response to the kite is issued one day later indicating an appointment would be scheduled.
3	• The decedent submits a kite to Health Services indicating they are feeling unsafe and inquiring into medication. • A response is issued one day later indicating an appointment would be scheduled.
Day of Death	**Event**
03:21 hours	• Tier check is conducted.
04:15 hours	• Tier check of lower deck begins.
04:17 hours	• Custody staff discover the decedent with a ligature around their neck and make a radio notification of a self-harm medical emergency. • Custody Quick Response Strike Team (QRST) and on-site medical staff are deployed. • A request for Community Emergency Medical Services (EMS) is made.
04:20 hours	• Custody staff enter the cell and initiate Cardiopulmonary Resuscitation (CPR).
04:24 hours	• Medical staff arrive on scene and apply an Automated External

	Defibrillator (AED).
04:32 hours	• Community EMS arrive on scene and assume medical care.
05:04 hours	• The decedent is declared deceased by a community EMS physician.

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, the antecedent care provided by DOC, and provided the following findings.

    1. The MRC found:

        a. The decedent was appropriately screened by nursing and mental health staff during intake on the day of arrival.

            i. The decedent disclosed a history of hypertension, depression, anxiety, and substance use. They denied a previous history of suicidal ideation or self-harm attempts.

        b. After arrival at the prison facility, the decedent's prescribed medications were continued based on records received from the county jail.

        c. The decedent submitted three kites to Health Services requesting that his medications be adjusted and included language indicating feelings of being unsafe.

            i. Health Services staff did not follow the established guidelines for kite triage and response. As a result, the response did not appropriately address the decedent's safety concerns or initiate an urgent clinical evaluation.

    2. The MRC recommended:

        a. Strengthening DOC's kite triage system to ensure timely identification, appropriate escalation to qualified personnel, and consistent response to safety-related concerns.

B. Independent of the mortality review, 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. Health Services kites were not triaged adequately, and a same-day wellness check did not

occur after concerning kites were received.

b. There is no formal policy or operational memorandum establishing procedures for Health Services kite management.

2. The CIR recommended:

a. Develop and implement policy language establishing standardized procedures for Health Services kite management, including triage protocols, escalation criteria, and documentation requirements.

b. Establish a statewide nursing protocol that requires a Registered Nurse 2 (RN2) license or higher, to triage incoming Health Services kites to ensure clinical appropriateness and consistency.

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

1. Kite management and processing.

a. UFR committee members reviewed the initial kite triage process and emphasized the importance of responding timely and elevating kites containing safety-related language to qualified clinical personnel.

b. Health Services has implemented standardized procedures and training to support consistent evaluation and auditing of kite triage and response practices.

i. Urgent requests or safety-related concerns can be addressed quickly with a same-day evaluation by nursing staff.

ii. Non-urgent requests requiring an appointment are forwarded to designated scheduling personnel, and kite responses include an estimated timeframe for follow-up.

2. Subsequent outreach.

a. The Resilience Support Team (RST) was deployed to provide support to staff and incarcerated individuals affected by this incident, consistent with DOC's post-incident response protocols.

3. Communication between shifts.

a. UFR members discussed the importance of effective communication between staff when an incident bridges shifts.

UFR Committee Findings

The decedent died of 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, 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. Strengthen the Health Services kite triage process by implementing standardized criteria to ensure kite response is timely and appropriate.