Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-008

Report to the Legislature

As required by RCW 72.09.770

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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 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 August 21, 2025:

DOC Health Services

- Dr. Mary Colter, Facility Medical Director (for Chief Medical Officer)
- Patricia Paterson, Director 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

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, and recommendations.

Fatality Summary

Date of Birth: 1984 (41-years-old)

Date of Incarceration: September 2023

Date of Death: May 2025

At the time of death, the decedent was participating in DOC's Graduated Reentry program while residing in a support home for those in recovery from a substance use disorder.

The cause of death is multiorgan failure following cardiac arrest due to acute stimulant intoxication. The manner of death is undetermined.

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

Days Prior to Death	Event
26	• The decedent transferred to DOC's Graduated Reentry (GRE) program, where intake was completed, including a negative urine drug screen.
21 to 13	• A DOC Community Specialist (CS) communicated with the decedent on multiple occasions and conducted two visits to the decedent's place of employment. • All drug screens returned negative, and no significant issues or concerns were noted.
12	• The CS received notification that the decedent tested positive for drug use and was subsequently terminated from both employment and housing support programs. • The decedent made multiple phone calls to their CS, who instructed them to remain at their current residence while efforts were made to secure new housing. • After identifying a new housing option and while on route to the decedent's residence, the CS was informed that the decedent had fled from their residence. • The decedent could not be located, and a Secretary's Warrant was requested.
8	• The decedent fell from a third story window while under the influence of stimulants and was admitted to a community hospital for treatment of injuries.
Day of Death	**Event**

0	• The decedent was pronounced deceased while receiving care in the community hospital.

UFR Committee Discussion

The UFR committee met to discuss the findings and opportunities for improvement from the DOC Mortality Review Committee (MRC) and the DOC Critical Incident Review (CIR). The UFR committee considered the information from both reviews and did not issue recommendations for corrective action.

A. The DOC MRC reviewed the medical record and 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 received appropriate care for their medical issues.

            i. A substance use assessment was completed and the decedent was diagnosed with polysubstance use disorder. The decedent successfully completed residential therapeutic treatment before transferring to the GRE program and was discharged with a recommendation of a relapse prevention treatment program after transitioning to the community.

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

        a. Continue enhancing DOC's addiction care system to ensure each incarcerated individual's recovery and wellness are supported through personalized evaluation and treatment.

        b. Consider expanding the role of DOC Reentry Nurses to improve communication and care hand-offs with community partners.

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 did not identify any causal or non-causal factors contributing to the decedent's death and no corrective actions were identified.

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

    1. DOC's addiction care.

        a. UFR members reviewed the unique challenges that a correctional environment poses to both an incarcerated individual's recovery and the delivery of addiction care. DOC remains committed to enhancing its addiction care services to ensure that each incarcerated

individual receives a personalized evaluation and an individualized treatment plan, including care handoffs when an individual reenters the community.

i. Currently, substance use treatment records are not included in the DOC medical record. DOC plans to integrate substance use treatment records into the DOC medical record as part of the transition to an Electronic Health Record (EHR).

UFR Committee Findings

The decedent died of multiorgan failure following cardiac arrest due to acute stimulant intoxication. The manner of death is undetermined.

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. Continue enhancing DOC's addiction care system to ensure each incarcerated individual's recovery and wellness are supported through personalized evaluation and treatment.
2. Consider expanding the role of DOC Reentry Nurses to improve communication and care hand-offs with community partners.
3. Integrate substance use treatment records into DOC's medical records through EHR updates.