Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-012

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.

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 September 4, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Patricia Paterson, Chief of Nursing
- Dr. Ashley Espitia, Suicide Prevention Specialist
- Dr. Zainab Ghazal, Administrator
- Mark Eliason, Deputy Assistant Secretary
- 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
- James Key, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Rochelle Stephens, Men's Prisons Project Manager
- Paige Perkinson, Correctional Operations Program Manager

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, Acting Director
- Madison Vinson, Assistant Corrections Ombuds – Policy

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: 1961 (63-years-old)

Date of Incarceration: January 1999

Date of Death: March 2025

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

The cause of death is acute septic thromboembolic infarct of the right middle cerebral artery due to infective endocarditis due to degenerative valvular disease of the heart (i.e. stroke on the right side of the brain caused by an infected blood clot that was spreading infection). The manner of death is natural.

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

6 Days Prior to Death	Event
11:32 hours	• The decedent received their medications during pill line and was observed to be unsteady during this interaction.
12:02 – 12:11 hours	• The decedent returned to their cell and spoke with their cellmate and custody staff.
12:18 – 12:21 hours	• The decedent's cellmate is observed entering and exiting the cell.
12:35 – 12:49 hours	• A tier check is conducted at 12:35 hours. • The cellmate is observed looking into the cell before entering at 12:49 hours.
12:50 – 12:51 hours	• The cellmate exits the cell and signals for a custody officer, who responds and enters the cell.
12:54 – 13:02 hours	• DOC medical staff responds to the scene and transports the decedent to onsite Medical.
13:03 – 13:32 hours	• Community Emergency Medical Services (EMS) arrives on scene, assumes care, and transports the decedent to a local community hospital.
17:15 hours	• The decedent is transferred to a referral hospital via air ambulance for specialty care.
Day of Death	**Event**
18:53 hours	• The decedent is pronounced deceased 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 and provided the following findings:

    1. The MRC found:

        a. The decedent received appropriate care for their chronic medical conditions. No care gaps were identified.

            i. Primary Care visit notes documented a heart examination was within normal limits, with no signs or symptoms to indicate an infection.

            ii. Approximately three months before death, the decedent reported transient right-sided weakness that resolved. A follow-up Magnetic Resonance Imaging (MRI) did not reveal a cause for these symptoms and they did not recur in the interim.

        b. Six days before death, the decedent was found unresponsive in their cell. The decedent became responsive during emergency treatment and reported to staff and community EMS that they had fallen in their cell.

        c. The decedent was transported to a local community hospital where it was determined that they needed additional specialty care. The decedent was then transported by air ambulance to the referral hospital.

        d. Despite treatment, the decedent's condition deteriorated. Artificial life support was discontinued in accordance with the decedent's expressed wishes and in consultation with their family.

    2. The MRC did not identify any opportunities for improvement.

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. The decedent experienced a medical incident resulting in a medical emergency response and subsequent hospitalization.

        b. The decedent reported experiencing dizziness upon standing, causing them to fall and injure their head.

c. Due to the injuries sustained, the possibility of an assault was investigated by DOC.

i. An internal review of the incident and further testing by the medical examiner's office determined that the decedent's death was due to natural causes and was not deemed suspicious.

2. The CIR did not identify any contributing factors to the decedent's death and no causal or non-causal concerns were identified.

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

1. Community EMS Response

a. During this incident, there was more than one medical emergency requiring ambulance transportation at the prison facility.

b. UFR committee members discussed community EMS triage protocols and prioritization procedures when there are multiple individuals requiring ambulance transportation simultaneously.

UFR Committee Findings

The decedent died of acute septic thromboembolic infarct of the right middle cerebral artery due to infective endocarditis due to degenerative valvular disease of the heart (i.e. stroke on the right side of the brain caused by an infected blood clot that was spreading infection). The manner of death is natural.

UFR Committee Recommendations

The UFR committee did not issue any recommendations for corrective action.