Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-014

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 October 2, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Poonam Bhagia, Deputy Chief Medical Officer
- Patricia Paterson, Chief of Nursing
- Dr. Ashley Espitia, Suicide Prevention Specialist
- Arpan Aulakh, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Rochelle Stephens, Men's Prisons Project Manager
- Paige Perkinson, Correctional Operations Program Manager

DOC Reentry Division

- Danielle Armbruster, Assistant Secretary
- Paul Daniel, Reentry Center Administrator

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Karen Pastori, Health Services Consultant – Prevention and Community Health

Health Care Authority (HCA)

- Dr. Charissa Fotinos, Director – Medicaid

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

Fatality Summary

Date of Birth: 1983 (41-years-old)

Date of Incarceration: August 2024

Date of Death: June 2025

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

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

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

2 Days Prior to Death	Event
12:49 hours	• The decedent is observed on the phone in the unit.
13:09 hours	• A tier check is conducted.
13:53 – 14:14 hours	• The decedent and their cellmate are observed entering and exiting their cell.
14:16 – 14:18 hours	• A custody officer observed the decedent through their cell door and initiated a radio call. • A ligature removal device and additional staff response are requested.
14:19 – 14:22 hours	• Cardiopulmonary Resuscitation (CPR) is initiated. • Onsite medical staff arrive on scene at 14:20 hours. • Community Emergency Medical Services (EMS) is requested and Narcan is administered.
14:29 hours	• Community EMS arrive on scene and assume care.
14:51 – 15:33 hours	• The decedent is transported to a community hospital via air ambulance.
Day of Death	**Event**
11:54 hours	• The decedent is declared deceased at the community hospital.

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 improvement.

A. Independent of the mortality review, the 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 died by suicide between tier checks.

        b. While procedural concerns were identified, no contributing or causal factors related to the decedent's death were identified within the scope of the CIR. The CIR identified the following non-causal factors to the decedent's death:

            i. DOC *Policy 630.500 Mental Health Services* does not clearly identify who the author or recipient is for form 13-420 Request for Mental Health Assessment, leading to confusion about the process, particularly during after-hours operations.

            ii. Approximately one month before the decedent's death, unit staff notified nursing staff after overhearing the decedent make suicidal statements. Nursing staff evaluated the decedent and contacted the Mental Health Duty Officer who determined that the decedent could return to their unit with a follow-up appointment scheduled for the next day. However, form 13-420 Request for Mental Health Assessment was not completed as required by DOC *Policy 630.500 Mental Health Services.*

    2. The CIR recommended:

        a. Clarify the designated staff responsible for completing form 13-420 Request for Mental Health Assessment and initiating any required clinical follow-up.

        b. Develop and disseminate standardized messaging to all staff clarifying the processes, roles, and responsibilities outlined in form 13-420 Request for Mental Health Assessment.

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

    1. The MRC found:

        a. The decedent was receiving appropriate care for their medical issues. No care gaps were identified.

b. A review of available records indicated multiple signs of Substance Use Disorder (SUD). However, variations in the decedent's self-reporting impacted the SUD diagnoses across various DOC teams.

c. The decedent was appropriately prescribed Sublocade (an extended-release injectable form of buprenorphine used for the treatment of Opioid Use Disorder (OUD)) while in the DOC violator unit.

    i. Records from the DOC violator units are not integrated into the main DOC medical record when an individual's community custody is revoked and they are returned to full confinement.

    ii. The Sublocade injections were discontinued following the revocation of the decedent's community custody, as their prison sentence exceeded 12 months. Current DOC criteria for Medication for Opioid Use Disorder (MOUD) requires individuals have a sentence of less than 12 months from prison intake to community release.

d. After a referral from unit staff who overhead the decedent making suicidal statements, the decedent was evaluated by a DOC nurse who contacted the Mental Health Duty Officer.

    i. The Mental Health Duty Officer determined that the decedent could return to their unit with a follow-up appointment scheduled for the next day. However, the follow-up appointment was cancelled due to the primary therapist being out of office.

    ii. The decedent was seen for a follow-up appointment by a mental clinician approximately two weeks later and denied any suicidal ideation, intent, or plan.

    iii. Form 13-420 Request for Mental Health assessment was not completed as required by DOC *Policy 630.500 Mental Health Services.*

e. The decedent had a history of previous suicide attempts. Their risk of suicide increased after the onset of divorce proceedings shortly after their appeal of community custody board revocation was denied in 2025.

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

    a. Update form 13-420 to include appropriate referral, follow-up, and documentation guidelines for urgent requests and provide staff education and training.

    b. Review and update relevant DOC policy to ensure consistency and provide guidance on the use of form 13-420 Request for Mental Health Assessment.

c. Explore options to integrate records from DOC's violator units into the DOC medical record when an individual's community custody is revoked and they are returned to full confinement.

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

1. Form 13-420 Request for Mental Health Assessment and mental health follow-up.

   a. UFR members discussed the delay in mental health follow-up and the inconsistent use of form 13-420 Request for Mental Health Assessment. The UFR committee supports review of relevant DOC policy and updates to the process of referring and documenting urgent requests for mental health care to support timely evaluation and follow-up.

2. DOC MOUD protocol.

   a. UFR committee members reviewed DOC's eligibility criteria and the process of tapering individuals off certain medications when they are reincarcerated and their sentence is greater than one year due to funding constraints. Here, the decedent was appropriately tapered off Sublocade upon return to full confinement.

   b. DOC has requested additional funding to support the continued expansion of addiction care including the provision of certain medications.

3. Integration of DOC violator unit records.

   a. UFR members support exploration of options to integrate records from DOC's violator units into DOC's main medical record to better support incarcerated individuals.

4. Use of Artificial Intelligence (AI) to process DOC data.

   a. The UFR committee discussed the possible use of AI processing of unstructured data across various DOC applications to better identify individuals needing targeted support and services.

UFR Committee Findings

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

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. Review relevant DOC policy to ensure consistency and provide guidance on the use of form 13-420 Request for Mental Health Assessment.

2. Update form 13-420 to include appropriate referral, follow-up, and documentation guidelines for urgent requests and provide staff education and training.

3. Explore options to integrate records from DOC's violator units into the main DOC medical record when an individual's community custody is revoked and they are returned to full confinement.

    a. Explore the use of AI to help process DOC's unstructured data to identify individuals needing targeted support and services.