Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-007

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 October 16, 2025:

DOC Health Services

- Dr. Poonam Bhagia, Deputy Chief Medical Officer
- Patricia Paterson, Chief of Nursing
- Zainab Ghazal, Health Services Administrator
- Mark Eliason, Deputy Assistant Secretary
- 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, Correctional Operations Program Manager
- Rochelle Stephens, Men's Prisons Project Manager
- Paige Perkinson, Correctional Operations Program Manager

DOC Risk Mitigation

- Michael Pettersen, Director

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. Heather Schultz, Associate Medical Director

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

Fatality Summary

Date of Birth: 1975 (49-years-old)

Date of Incarceration: February 2006

Date of Death: April 2025

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

The cause of death is acute methamphetamine toxicity. The manner of death is accidental.

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

Days Prior to Death	Event
5	• The decedent is transferred to a Restrictive Housing Unit (RHU) for protective housing at their request.
4	• The decedent is transferred to the Close Observation Area (COA) for 15-minute observations after exhibiting decompensation behaviors and voicing suicidal thoughts.
1	• The decedent is released from the COA and transferred back to the RHU. • Hourly tier checks are conducted. • Formal count is conducted, and the decedent is last observed through their cell window at 16:22 hours. • Nursing staff were unaware that the decedent was prescribed evening medications and did not administer the prescribed dose. • Formal count is conducted, and the decedent is found unresponsive at 23:11 hours. • Custody staff make a radio notification, enter the decedent's cell, and begin rendering aid.
	• DOC medical staff arrive on scene, assume care, and continue rendering aid at 23:25 hours.
	• Community Emergency Medical Services (EMS) arrives on scene and assumes care at 23:37 hours.
0	• The decedent is declared deceased by community EMS at 00:01 hours.

UFR Committee Discussion

The UFR committee met to discuss the findings and recommendations from the DOC Critical Incident Review (CIR) and the DOC Mortality Review Committee (MRC).

A. 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 identified the following contributing and potentially causal factors:

        a. Four days prior to death, the decedent was transferred to the COA for 15-minute observations after exhibiting signs of behavioral decompensation and reporting suicidal thoughts. Custody staff did not follow DOC Policy 423.310 *Searches of Incarcerated Individuals*, as the decedent was not strip searched before or after the transfer.

        b. Video footage from the decedent's COA cell captures them ingesting an item identified as contraband. A plastic wrapper is seen on the floor that is consistent with material recovered from their body during the autopsy.

            i. While strip searches mitigate one common method of contraband concealment, it does not eliminate all concealment risks.

        c. Consistent with agency policy, personnel matters are referred to the appointing authority and DOC Human Resources for appropriate follow-up.

    2. The CIR identified the following non-causal concerns:

        a. Supervisory review and acknowledgment of post orders by sergeants and higher-level staff were not documented. As a result, tier walkthroughs and tier checks leading up to the incident did not meet policy standards.

            i. This concern has been referred to the appointing authority and DOC Human Resources for appropriate follow-up.

        b. A segregated housing nursing assessment was not completed upon the decedent's arrival to the RHU, which contributed to the decedent not being identified as needing evening medication on the day of this incident.

            i. This concern is noted as a missed opportunity and did not impact the outcome of this incident.

        c. There was a delay in emergency response, as the Shift Lieutenant and onsite medical staff do not have scanning capabilities to hear radio calls for medical emergencies in one of the units.

i. This delay in response would not have impacted the outcome of this incident.

3. The CIR recommended:

   a. Enable Shift Lieutenants and onsite DOC medical staff on third shift to scan radio channels, ensuring an emergency response broadcast is immediately received and response initiated.

B. The DOC MRC reviewed the medical record and the antecedent care delivered, and provided the following findings:

1. The decedent was incarcerated in 2006 with an Earned Release Date (ERD) of 2099.

2. They had a known history of Substance Use Disorder (SUD) and died from methamphetamine toxicity, likely related to a retained foreign body in their intestinal tract. The decedent did not receive addiction care services during their incarceration.

3. The decedent was not actively or consistently engaged in care with DOC's primary care team. They maintained ongoing contacts with DOC's psychiatric services team and received case management services spanning several years.

4. The decedent's COA placement four days prior to death appears to have been precautionary based on observed behavior, rather than a direct response to any suicidal ideation, plan, or intent.

5. While not contributory to the cause of the decedent's death, the MRC identified the following opportunities for improvement:

   a. Establish standardized annual primary care visits including a defined follow-up process if an individual declines the visit.

   b. Explore utilization of the population health dashboard under development to identify individuals requiring an annual visit.

   c. Explore the feasibility of using tablets during emergency responses to enable real time completion of documentation and immediate access to emergency response checklists and related forms.

   d. Train nursing staff to designate a scribe during emergency responses to ensure timely and accurate completion of required documentation.

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

1. SUD treatment.

a. UFR members reviewed DOC's SUD treatment options and services for incarcerated individuals serving long sentences. The committee noted that increased funding is needed to expand addiction care availability to those with long periods of incarceration.

2. COA housing and transfer communications.

    a. UFR committee members examined the observation levels for close observation housing and noted that the decedent was placed on 15-minute observations and not one-to-one direct observation. As a result, the decedent had the opportunity to discreetly ingest contraband. The committee also discussed the missed medication dose when the decedent transferred from the COA to the RHU and supported improvements to the housing transfer process to ensure continuity of prescribed medications.

3. Tier checks.

    a. Enhancing the quality of and accountability for tier checks remains a priority and area of improvement focus for DOC.

UFR Committee Findings

The decedent died of acute methamphetamine toxicity. The manner of death is accidental.

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. Enable Shift Lieutenants and onsite DOC medical staff on third shift to scan radio channels, ensuring an emergency response broadcast is immediately received and response initiated.

2. Establish standardized annual primary care visits including a defined follow-up process if an individual declines the visit.

3. Explore utilization of the population health dashboard under development to identify individuals requiring an annual visit.

4. Explore the feasibility of using tablets during emergency responses to enable real time completion of documentation and immediate access to emergency response checklists and related forms.

5. Train nursing staff to designate a scribe during emergency responses to ensure timely and accurate completion of required documentation.

6. Review and update nursing protocols to ensure continuity of prescribed medications when housing transfers occur outside of scheduled pill line times.