Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-016

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 30, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Poonam Bhagia, Deputy Chief Medical Officer
- Patricia Paterson, Chief of Nursing
- Dr. Eric Rainey-Gibson, Director – Behavioral Health
- Dr. Ashley Espitia, Suicide Prevention Specialist
- Dr. Zainab Ghazal, Health Services Administrator
- Arpan Aulakh, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- Charles Anderson, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- 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. Sophie Miller, Medical Officer

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

Fatality Summary

Date of Birth: 1997 (28-years-old).

Date of Incarceration: May 2025.

Date of Death: August 2025.

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

The cause of death is acute methadone intoxication and probable additive effects of clobazam. The manner of death is accidental.

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

Day of Death	Event
8:09	The decedent's cellmate notifies a custody officer that the decedent is unresponsive in their cell.
8:10	Custody staff enter the cell and administer two doses of Narcan.
8:13	The decedent is removed from the cell and lifesaving measures are initiated.
8:14	DOC medical staff arrive on scene and assume care.
8:27 – 8:56	Community Emergency Medical Services (EMS) arrive on scene, assume care, and transport the decedent to a community hospital where they are later pronounced deceased.

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 found:

        a. At the time the CIR was conducted, the autopsy and toxicology reports were not yet finalized and available for review and it was presumed that the decedent had medical conditions that resulted in their death.

b. After the decedent's death, a search of their cell revealed a large amount of bright orange powder and the decedent's prescribed Keep On Person (KOP) medications.

2. No contributing, causal, or non-causal factors were identified within the scope of the CIR, and no corrective actions were recommended.

B. Independent of the CIR, the MRC reviewed the medical record and antecedent care delivered and provided the following findings:

1. The MRC found:

a. The decedent arrived at the prison facility in May 2025, with an Earned Release Date (ERD) of August 2025. They were preparing for transition to the community at the time of their death.

b. No gaps in care were identified.

c. The decedent's medical history included intractable epilepsy, Substance Use Disorder (SUD), and chronic pain.

i. They did not attend a scheduled visit with their primary care provider in July 2025.

ii. The decedent's prescribed medications include clobazam.

d. Documentation from a community provider outlined a history of mental health diagnoses; however, the decedent denied this history and any symptoms during their mental health intake screening.

e. The MRC explored how the decedent may have obtained the methadone found in their system, including possible diversion by their cellmate who was prescribed methadone. However, it is unknown how the decedent obtained the methadone and no evidence of diversion by the cellmate was found.

i. DOC is evaluating its current methadone tablet distribution process, including exploring whether liquid methadone is a viable alternative to decrease the likelihood of diversion.

2. While not contributory to the cause of death, the MRC identified the following opportunity for improvement:

a. Continue evaluation of DOC's current methadone tablet distribution process, including exploring whether liquid methadone is a viable alternative.

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

1. Methadone administration.

    a. UFR members reviewed DOC's current methadone administration process and supported a review that includes evaluation of alternate methadone delivery and administration methods.

    b. Committee members acknowledged that the use of liquid methadone creates challenges to maintaining accurate and consistent records that comply with legal and regulatory requirements.

UFR Committee Findings

The decedent died of acute methadone intoxication and probable additive effects of clobazam. The manner of death is accidental.

UFR Committee Recommendations

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

Consultative remarks that do not directly correlate to cause of death, but may be considered for review by the Department of Corrections:

1. Continue evaluating DOC's current methadone tablet distribution process, including exploring whether liquid methadone is a viable alternative.