Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-009

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 December 4, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Patricia Paterson, Chief of Nursing
- Arpan Aulakh, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- Deborah Wofford, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary

Office of the Corrections Ombuds (OCO)

- 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: 1963 (61-years-old).

Date of Incarceration: July 2019.

Date of Death: June 2025.

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

The cause of death is atherosclerotic and hypertensive cardiovascular disease. The manner of death is natural.

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

One Day Prior to Death	Event
9:39 – 9:56 hours	• The decedent is last observed on video surveillance.
Day of Death	**Event**
6:20 hours	• Formal count is conducted.
11:42 – 3:28 hours	• Hourly tier checks are conducted.
3:45 – 3:48 hours	• Formal count is conducted. • At 3:48 hours, a custody officer observes the decedent lying on their bed and attempts to gain a response from them.
3:50 – 3:53 hours	• Custody officers initiate a radio notification for a medical emergency and began life-saving measures, including Narcan administration. • Community Emergency Medical Services (EMS) is requested.
3:54 hours	• DOC medical staff arrive on scene and assume care.
4:13 hours	• Community EMS arrive on scene and assume care.
4:20 hours	• The decedent is declared deceased by the community EMS medical director.

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 corrective action.

A. The MRC reviewed the medical record and antecedent care delivered and provided the following findings.

    1. The MRC found:

        a. The decedent's antecedent medical history included diabetes, atrial fibrillation, iron deficiency anemia, and high cholesterol.

            i. At the time of death, recommended screenings and immunizations were current and the decedent's diabetes and blood pressure were controlled.

        b. The decedent's visits with DOC's primary care team were intermittent; however, their medications were continued during these times.

            i. Approximately four months before death, the decedent reported to their primary care provider that they were feeling well and attempting lifestyle changes including exercise.

        c. During the medical emergency response, a DOC nurse did not follow Basic Life Support (BLS) standards or DOC nursing protocols when they administered an EpiPen.

            i. The CIR noted that responding nurses did not recall having received specific medical emergency response training.

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

        a. DOC's Director of Nursing will follow up with facility nursing leadership regarding the process and status of emergency response training for all nurses.

        b. Facility leadership will ensure completion of the Brief Nurse Orientation checklist for all new nursing staff to ensure they have received DOC's Emergency Response Training and are prepared to respond to a medical emergency.

        c. DOC's Director of Nursing and clinical nurse educators will develop a plan to provide additional education and clinical guidance for nursing staff regarding appropriate use of EpiPens.

d. DOC will initiate systematic annual primary care visits.

B. 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 due to natural causes in their cell.

2. No contributing, causal, or non-causal factors to the decedent's death were identified within the scope of the CIR.

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

1. Medical emergency response.

a. The UFR committee reviewed the medical emergency response, including the inappropriate administration of an EpiPen. The committee supported adding a visual aid or algorithm to the emergency response bag to enhance decision-making for responding DOC staff during medical emergencies. Members also noted that custody officers waited for DOC medical staff to arrive before beginning lifesaving measures, due to concerns about moving the decedent off the top bunk.

b. Facility-wide emergency drills are currently underway at the facility where this incident occurred. These drills aim to better educate and support staff responding to medical emergencies.

2. Annual primary care visits.

a. UFR members reviewed recent updates to DOC's population health report, which will flag an incarcerated individual if they have not had an annual primary care visit within the last year and track whether an individual accepts or denies the visit.

3. Tier checks.

a. During tier checks, the decedent appeared to be sleeping on the top bunk while custody officers were observed stopping to look into the cell. DOC is currently examining tier check processes and guidelines to establish benchmarks, reinforcing its commitment to improving quality and consistency of these checks.

4. Delayed Resilience Support Team (RST) deployment.

a. The UFR committee noted a delay in the deployment of RST to the facility. Available documentation was also unclear about whether DOC's mental health team followed up with incarcerated individuals in the unit after this incident. To ensure that staff and

incarcerated individuals receive necessary resources and support, DOC is now clearly documenting both mental health and RST deployment in all subsequent reports.

UFR Committee Findings

The decedent died of atherosclerotic and hypertensive cardiovascular disease. The manner of death is natural.

UFR Committee Recommendations

The UFR committee did not issue 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. Include a visual aid or algorithm with the emergency response bag to enhance decision-making for responding DOC staff during medical emergencies.
2. Evaluate tier check processes and refine guidance to promote consistency and strengthen overall quality of procedure.
3. DOC's Director of Nursing will confirm completion status of emergency response training for all nurses with facility leadership.
4. DOC's Director of Nursing will ensure all new nurses complete the Brief Nurse Orientation checklist, verifying emergency response readiness.
5. The Director of Nursing and clinical nurse educators will develop and deliver additional training on appropriate EpiPen use.
6. DOC will continue to develop systemic annual primary care visits to strengthen continuity and preventive health management.