Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-013

Report to the Legislature

As required by RCW 72.09.770

December 19, 2025

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 UFR 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 and presents recommendations. Within ten days of the publication of this report, DOC must publish an associated corrective action plan. DOC will then have 120 days to implement that plan.

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 November 13, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Patricia Paterson, Director of Nursing
- Dr. Eric Rainey-Gibson, Director – Behavioral Health
- Mark Eliason, Deputy Assistant Secretary
- 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. Judy Zerzan, Medical Director

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

Fatality Summary

Date of Birth: 1973 (52-years-old).

Date of Incarceration: November 2005.

Date of Death: June 2025.

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

The cause of death is ligature strangulation. The manner of death is suicide.

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

Day of Death	Event
10:54 hours	• The decedent's cellmate was transported for a medical emergency after a fall in their cell.
13:42 hours	• Suspected narcotics were discovered in the decedent's cell during a search by custody staff. On-site testing returned a presumptive positive result.
14:50 hours	• The decedent was transferred to the Restrictive Housing Unit (RHU) pending a disciplinary investigation and was unable to provide a urine sample for drug screening.
15:00 – 18:05 hours	• Routine tier checks, formal count, and meal tray pick-up are conducted.
18:23 hours	• Custody staff walk by the decedent's cell while escorting another individual.
18:24 hours	• Custody staff return to the decedent's cell after completing the escort and immediately initiate a radio call for assistance.
18:25 – 18:35 hours	• Custody staff initiate Cardiopulmonary Resuscitation (CPR). • DOC medical staff arrive on scene and assume care, including placing an Automated External Defibrillator (AED).
18:36 hours	• Community Emergency Medical Services (EMS) arrives on scene and assumes care.
18:53 hours	• The decedent is declared deceased by community EMS.

UFR Committee Discussion

The UFR committee met to discuss the findings and recommendations from the DOC Mortality Review (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 high blood pressure, diabetes, and chronic pain limiting their mobility.

        b. The decedent died by suicide. Postmortem toxicology documented positive results for amphetamine and methamphetamine.

            i. The decedent denied having a history of illicit substance use during their Health Services intake process and did not communicate any ongoing use of illicit substances or relapse to Health Services staff.

                a. At the time the decedent entered the DOC prison system, Substance Use Disorder (SUD) screening was not universal nor targeted based on personal history.

        c. DOC's needs assessment tool (WA ONE) contained documentation of polysubstance use prior to the decedent's incarceration.

            i. Currently, WA ONE is not integrated into DOC's Health Services intake or assessment workflows.

        d. There was no indication from available documentation that the decedent was continuing to use or had relapsed other than mechanical falls, the cause of which was confounded by their other medical needs.

            i. The MRC noted that there may have been an opportunity to inquire about recent substance use and conduct urinalysis drug screening after the decedent suffered a fall with injury approximately two months before death.

        e. It is unclear whether the decedent would have accepted addiction care if their history prior to incarceration had been integrated into discussions with DOC Health Services.

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

a. Integrate individuals admitted to DOC prior to the implementation of universal SUD screening into addiction care services and consider periodic re-screening to better identify relapses and ongoing use patterns.

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 was a 52-year-old male with complex medical issues and no known history of serious mental illness, suicidal ideation, or suicide attempts.

b. They were housed in an Americans with Disabilities Act (ADA)-compliant cell due to limited mobility.

c. The decedent died by suicide, using an exposed conduit from the television shelf as a ligature anchor point. The shelf had previously been enclosed with plexiglass, which contributed to the monitor overheating and impaired audio transmission. As a result, the plexiglass was removed, leaving the conduit exposed.

2. The CIR noted that, if the decedent had a known history of serious mental illness, suicidal ideation, or suicide attempts, they would have been placed in a Close Observation Area (COA) cell rather than the RHU.

3. No operational, procedural, or causal factors were identified as contributing to the decedent's cause of death within the scope of the CIR.

4. The CIR recommended:

a. Removing or concealing the exposed conduits in the ADA-compliant cells.

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

1. Transfer to the RHU.

a. UFR committee members reviewed DOC's transfer process, including medical and mental health screening before an individual is moved to the RHU. The UFR committee supported a review of the screening process used by clinical staff to determine if transfer to the RHU is appropriate.

2. Prevalence of SUD in the Native American population.

a. The UFR committee discussed that both the decedent and their cellmate were of Native American heritage and the higher prevalence of SUD in the Native American population.

3. Ligature Point Assessment.

    a. The UFR committee supported a statewide assessment of possible ligature points in DOC's RHUs and infirmaries.

4. Narcan administration.

    a. The UFR committee noted that Narcan was not administered during the medical emergency response as required by DOC policy and supported further staff education regarding the appropriate use of Narcan. Here, Narcan administration would not have changed the outcome of this incident; however, DOC is committed to ensuring that Narcan administration is a routine part of emergency medical response.

UFR Committee Findings

The decedent died of ligature strangulation. The manner of death is suicide.

UFR Committee Recommendations

Table 1 presents the UFR Committee's recommendations to prevent similar fatalities and further strengthen safety and health protections for incarcerated individuals. As required, the DOC will develop, publish, and implement an associated corrective action plan within 10 days following the publishing of this report.

Table 1. ***UFR Committee Recommendations***
1. Remove or conceal the exposed conduits in the RHU ADA-compliant cells.
2. Complete a statewide assessment of possible ligature points in DOC's RHUs and infirmaries.

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

1. Incorporate individuals admitted prior to universal SUD screenings into structured addiction services, with periodic rescreening protocols to detect relapse and evolving use patterns.

2. Review and refine clinical screening processes using clear criteria, decision support tools, and peer oversight to ensure transfers to the RHU are clinically appropriate and consistently applied.

3. Strengthen staff training and emergency response drills to ensure Narcan is administered promptly when an individual is unresponsive, supported by accessible kits and clear documentation requirements.