Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-018

Report to the Legislature

As required by RCW 72.09.770

December 31, 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 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 11, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Eric Rainey-Gibson, Director – Behavioral Health
- Mark Eliason, Deputy Assistant Secretary
- Dr. Rae Simpson, Director – Quality Systems
- Justin Wozab, Clinical Nurse Specialist (for Director of Nursing)
- 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 Person Centered Services

- Megan Pirie, Director

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, Deputy 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. Christopher Chen, Associate Medical Director

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

Fatality Summary

Date of Birth: 1985 (40-years-old).

Date of Incarceration: December 2019.

Date of Death: September 2025.

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

The cause of death is the toxic effects of methamphetamine, with hypertensive cardiovascular disease identified as a significant contributing condition. The manner of death is accidental.

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

One Day Prior to Death	Event
11:00 – 11:58 hours	• Tier checks and formal count are conducted.
Day of Death	**Event**
12:47 – 12:51 hours	• Custody staff respond to the decedent's cell, initiate a radio notification at 12:48 hours, and enter the cell to begin rendering aid, including Cardiopulmonary Resuscitation (CPR) and administration of Narcan.
12:52 hours	• DOC medical staff arrive on scene and assume care.
01:09 hours	• Community Emergency Medical Services (EMS) arrives on scene and assumes care.
01:10 – 01:31 hours	• Community EMS staff administer medications, briefly regain a pulse, and transport the decedent to a community hospital.
02:47 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. 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, high blood pressure, Substance Use Disorder (SUD), and chronic pain. Care provided was appropriate and no gaps were identified.

b. The decedent frequently communicated with their DOC primary care team and intermittently interacted with their DOC mental health team.

c. The decedent reported a history of methamphetamine and marijuana use and completed SUD treatment during a previous incarceration. There was no evidence of SUD treatment during their final incarceration or follow-up after a positive urinalysis was conducted by custody staff.

    i. DOC's SUD harm reduction strategies include an intake screening pilot program currently underway at DOC's reception center to better identify and support individuals with SUD.

d. During the medical emergency response, an oxygen mask was used instead of an AMBU bag, leading to a delay in delivery of rescue breaths. Additionally, emergency response record documentation was incomplete, and video evidence did not match written reports.

    i. These concerns have been referred to facility leadership for individual staff remediation. A DOC emergency response interdisciplinary workgroup is also underway.

e. All responding DOC Health Services' staff were current with Basic Life Support (BLS) certification.

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

    a. Evaluate the results of the reception facility SUD screening pilot program and consider incorporating similar SUD screening upon facility transfers.

    b. Evaluate DOC screening forms 13-421 *Intrasystem Intake Screening*, 13-432 *Nursing Assessment of Patient Placed in Restrictive Housing*, and 13-349 *Intersystem/Restrictive Housing Mental Health Screening* to include screening questions regarding possible substance withdrawal.

B. Independent of the mortality review, 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 factors to the decedent's death:

    a. When the CIR was conducted, the autopsy and toxicology reports were not yet available

for review. Preliminary results from the coroner indicated that methamphetamine use and possible health conditions contributed to the decedent's death; as a result, access to methamphetamine was identified as a contributing factor to the decedent's death.

2. The CIR identified the following potential causal factors to the decedent's death:

    a. The decedent had access to illicit substances in prison, which impacted their health and disciplinary behavior.

        i. Funding and support are required to help prevent the introduction of illicit substances into DOC facilities, including implementation of body scanners and digital mail processing. Current efforts are ongoing to identify and obtain the resources needed, but funding continues to be a barrier.

3. The CIR identified the following non-causal concerns to the decedent's death:

    a. It was unclear whether required urinalysis as part of an infraction sanction was completed, as the facility could not provide documentation of completion and there was no information on a clear process for urinalysis sanction follow-up.

    b. The officer taking photos of the crime scene was relatively new and photo backers were incomplete for crime scene documentation. When processing the Incident Management Reporting System (IMRS) packet, the Shift Lieutenant did not notice that the photo backers were incomplete.

        i. This concern has been relayed to the facility for remedial training for new staff and Shift Lieutenants.

4. The CIR identified the following opportunity for improvement:

    a. Identify and provide the process details for urinalysis sanction follow-up to ensure that urinalyses are conducted as required and recorded in OMNI.

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

1. Illicit substances in prison facilities.

    a. The introduction of illicit substances into prison facilities remains a complex challenge. DOC has identified and implemented multiple strategies to detect and prevent the entry of illicit substances, including the implementation of a contraband mitigation workgroup. The workgroup is analyzing the methods used to introduce illicit substances into DOC facilities and developing additional mitigation strategies.

2. Prevalence of SUD in the Native American population.

a. The UFR committee discussed that the decedent was of Native American heritage and the higher prevalence of SUD in the Native American population. UFR members supported a review of data by DOC and development of targeted harm reduction strategies to better support Native Americans in DOC's custody.

3. Support programs in prison facilities.

   a. UFR members reviewed the sobriety support programs available in DOC prison facilities. The committee emphasized the importance of incarcerated individuals finding and maintaining community and supported an analysis of available programs that support sobriety and foster engagement.

4. Sanctions resulting from positive urinalysis.

   a. The UFR committee discussed the possible impacts of disciplinary sanctions resulting from illicit substance use or possession of related contraband. DOC balances the impact of privilege restrictions with the responsibility of maintaining the safety of all incarcerated individuals and continues to prioritize supporting recovery in a safe and humane way. UFR members supported a staff referral to and tracking engagement with SUD treatment services following a positive drug screen.

   b. UFR members voiced support for DOC's expanded SUD screening tool, which is currently piloted at DOC's reception center. The screening tool supports early identification and connection of individuals who are at greater risk for illicit substance use to sobriety support programs and treatment services.

   c. UFR members also discussed delayed infraction hearings statewide, administrative segregation situations, and the impacts of delayed hearings on individuals struggling with addiction.

UFR Committee Findings

The decedent died of the toxic effects of methamphetamine, with hypertensive cardiovascular disease identified as a significant contributing condition. The manner of death is accidental.

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. Evaluate the results of the reception facility SUD screening pilot program and consider incorporating similar SUD screening for intersystem facility transfers.

2. Evaluate and update DOC screening forms 13-421 *Intrasystem Intake Screening*, 13-432 *Nursing Assessment of Patient Placed in Restrictive Housing*, and 13-349 *Intersystem/Restrictive Housing Mental Health Screening* to include screening questions regarding possible substance withdrawal.
3. Identify and provide the process details for urinalysis sanction follow-up to ensure that urinalyses are conducted as required and recorded in OMNI, including referral to and tracking of engagement with treatment services following a positive urinalysis.
4. Conduct a data review and develop targeted harm reduction strategies to better support DOC's Native American population.
5. Evaluate available sobriety support programs in DOC prison facilities to ensure all incarcerated individuals have access to relevant support programs and community.
6. Explore feasibility of assigning restocking of emergency red bags to a job position.