Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-019

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 October 30, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Eric Rainey-Gibson, Director of Behavioral Health
- Dr. Ashley Espitia, Psychologist 4
- Patricia Paterson, Chief of Nursing
- Dr. Zainab Ghazal, Health Services Administrator
- Arpan Aulakh, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Charles Anderson, 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: 1979 (46-years-old).

Date of Incarceration: February 2023.

Date of Death: August 2025.

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

The cause of death is acute bupropion, levetiracetam, olanzapine, fluoxetine, hydroxyzine and propranolol intoxication. The manner of death is suicide.

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

1 Day Prior to Death	Event
19:19	The decedent is observed entering their cell.
21:00	Formal count is conducted.
22:30	A tier check is conducted.
23:39	The decedent is found unresponsive in their cell during formal count.
23:40 – 23:50	A medical emergency radio call is made. Custody staff begin lifesaving measures. DOC medical staff arrive on scene and assume care at 23:43 hours. Community Emergency Medical Services (EMS) arrives on scene and assumes care at 23:50 hours.
Day of Death	**Event**
00:19	The decedent is pronounced deceased by community EMS.

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. No contributing or causal factors related to the decedent's death were identified within the scope of the CIR and there were no recommendations for corrective action.

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

    a. DOC staff were concerned for the mental wellbeing of other incarcerated individuals in the unit and moved the decedent's body back into the cell after they were declared deceased. This is not a recommended practice according to crime scene security and preservation standards.

    b. The unit video surveillance system produced a timestamp that was not in real-time and was inconsistent with other video timestamps across the facility. The CIR noted that video surveillance upgrades require additional funding and resources.

    c. The facility preemptively identified and remedied gaps in pill line supervision by custody staff prior to the CIR team's arrival at the facility.

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

1. The decedent's antecedent medical history included anoxic brain injury, Lance-Adams Syndrome, pacemaker placement, anemia, alcohol use disorder, prediabetes, migraines, hypertension, and scoliosis. They were not a frequent utilizer of DOC's primary care services but were seen by nursing staff several times during the last year of their life. No care gaps were identified.

2. Their mental health history included prior suicide attempts, depression, anxiety, major depressive disorder, traumatic brain injury, Post Traumatic Stress Disorder (PTSD) and ingesting foreign bodies.

    a. The decedent interacted with DOC's mental health team and had a follow-up appointment scheduled with their primary therapist at the time of their death. They denied suicidal ideation to both DOC medical and mental health staff prior to their death.

3. The decedent died by suicide using prescribed medications.

    a. Their medications were appropriately prescribed and administered to the decedent through pill line. It is unknown how they compiled the amount of medication needed to cause their death. The MRC noted that there are no medications free from overdose potential and that implementation of a "high-risk" pill line in conjunction with custody staff could decrease incarcerated individuals' ability to hide medication.

4. 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.

b. Develop a proposal for a "high-risk" pill line to be submitted for augmented staffing in decision packages to provide an enhanced safety net for individuals at high risk of suicide or after a "near miss" medication event.

c. Encourage prescriber use of the DOC Health Services polypharmacy dashboard to assist with identification and management of individuals with multiple medications and prescribers.

d. Explore creation of an alert system with closed-loop communication for individuals who are determined to be at high risk of suicide, including possibly joining the Falcon-based suicide risk reduction effort.

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

1. Medication management and a "high-risk" pill line.

   a. UFR members reviewed DOC's medication management process, including implementation of follow-up and monitoring plans after a care plan is established and availability of clinical pharmacists at each facility who assist and support incarcerated individuals who are prescribed multiple medications. The UFR committee supported exploration of a "high-risk" pill line to better identify and support those at high risk of suicide or after a "near miss" medication event.

2. 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 reversed the effects of the medications ingested; however, DOC is committed to ensuring that Narcan administration is a routine part of emergency medical response.

UFR Committee Findings

The cause of death is acute bupropion, levetiracetam, olanzapine, fluoxetine, hydroxyzine and propranolol intoxication. The manner of death is suicide.

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. Establish standardized annual primary care visits.
2. Develop a proposal for a “high-risk” pill line to be submitted for augmented staffing in decision packages to provide an enhanced safety net for individuals at high risk of suicide or after a “near miss” medication event.
3. Encourage prescriber use of the DOC Health Services polypharmacy dashboard to assist with identification and management of individuals with multiple medications and prescribers.
4. Explore creation of an alert system with closed-loop communication for individuals who are determined to be at high risk of suicide, including possibly joining the Falcon-based suicide risk reduction effort.
5. Reinforce the administration of Narcan during a medical emergency when the individual is unresponsive.