



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-021 Report to the Legislature

As required by RCW 72.09.770

February 24, 2026

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Tim Lang, Secretary
tim.lang@doc1.wa.gov

Table of Contents

Table of Contents	1
Legislative Directive and Governance.....	2
Disclosure of Protected Health Information.....	2
UFR Committee Members	3
Fatality Summary.....	4
UFR Committee Discussion.....	5
UFR Committee Findings	8
UFR Committee Recommendations	8
Consultative remarks that do not directly correlate to cause of death, but may be considered for review by the Department of Corrections:	8

Unexpected Fatality Review Committee Report

UFR-25-021 Report to the Legislature–600-SR001

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 and presents recommendations.

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 January 8, 2026:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Eric Rainey-Gibson, Director – Mental Health
- Mark Eliason, Deputy Assistant Secretary
- Dr. Rae Simpson, Director – Quality Systems
- 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
- Charles Anderson, Deputy Assistant Secretary
- Lorne Spooner, Correctional Operations Program Manager
- Paige Perkinson, Correctional Operations Program Manager

DOC Person Centered Services

- Megan Pirie, Director

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, Acting Director
- Ollie Webb, Assistant Corrections Ombuds – Investigations
- Madison Vinson, 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: 1986 (39-years-old).

Date of Incarceration: April 2015.

Date of Death: October 2025.

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

The cause of death is multiple bilateral pulmonary thromboemboli, with deep venous thromboses of lower extremities, decreased mobility, and schizophrenia complicated by catatonia identified as contributing conditions. The manner of death is natural.

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

12 Days Prior to Death	Event
19:00 hours	<ul style="list-style-type: none">After noting that the decedent had not attended pill line for two days, DOC nursing staff assessed the decedent in their housing unit. The decedent was subsequently admitted to the Inpatient Unit (IPU) for further evaluation, treatment, and observation.
6 Days Prior to Death	Event
09:40 hours	<ul style="list-style-type: none">The decedent’s IPU admission acuity level is increased to intermediate care, as their condition was not improving.
1 Day Prior to Death	Event
16:00 hours	<ul style="list-style-type: none">The decedent’s condition continues to decline, and a DOC practitioner orders labs and imaging. However, the decedent declined the lab draw.
Day of Death	Event
10:30 hours	<ul style="list-style-type: none">The decedent is assessed by a DOC practitioner who reorders labs and imaging and adds a new medication. The lab draw is completed and sent to the lab.
11:48 hours	<ul style="list-style-type: none">As DOC staff arrive to prepare the decedent for imaging, the decedent is overheard groaning and observed attempting to get out of bed. Additional staff assistance is requested.
11:50 – 11:52 hours	<ul style="list-style-type: none">Cardiopulmonary Resuscitation (CPR) is initiated, and the decedent is moved to the trauma room.

11:58 hours	<ul style="list-style-type: none"> An Automated External Defibrillator (AED) is placed.
12:03 hours	<ul style="list-style-type: none"> Community Emergency Medical Services (EMS) arrives on scene and assumes care.
12:23 hours	<ul style="list-style-type: none"> 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 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 health history included schizophrenia with features of psychosis, schizoid personality disorder, depression, and catatonia.
 - b. The decedent also had a history of prescribed force-feeding and involuntary medication administration, including olanzapine and duloxetine. After nearly a year and a half of involuntary treatment, they showed signs of improvement including stability in their presentation and improved trends of their self-directed care and overall condition. As a result, the involuntary medication administration order was allowed to expire approximately ten months before death.
 - i. The decedent voluntarily complied with their medication orders until approximately one month before death, when they asked to stop the olanzapine due to concerns of weight gain. After discontinuing the olanzapine, the decedent continued with duloxetine therapy up until a week before they were admitted to the IPU.
 - c. Approximately twelve days before death, the decedent’s condition deteriorated, and they were assessed by DOC nursing staff in their unit; they were subsequently admitted to the IPU. While in the IPU, the decedent was largely non-verbal and immobile and communicated via head movements.
 - i. The MRC noted that the care plan completed six days before death addressed bathing and eating but did not address interventions for decreased or absent mobility or deep vein thrombosis (DVT) prophylaxis.
 - ii. DVT was suspected the day before death and further testing was ordered and completed on the day of death.

- d. The MRC reviewed clinical decision points throughout the decedent's care, specifically examining DVT prophylaxis protocols for catatonia. The interdisciplinary team demonstrated clear, collaborative consensus in their decision-making process.
 - i. However, the record does not establish whether DVT prophylaxis was clinically indicated or if its administration would have changed the decedent's outcome.
 - e. MRC members also reviewed the discontinuation of the decedent's involuntary medications approximately ten months before death and that allowing a 180-day involuntary order to expire is a typical decision psychiatric providers consider over the course of long-term involuntary antipsychotic therapy.
 - f. The goal with this decision is to balance the least restrictive option of treatment by fostering and promoting patient autonomy within a decisional capacity frame versus weighing the risks for patient refusal which may lead to decompensation.
 - i. The MRC endorsed the primary care team's approach to medication management in this case.
2. The MRC recommended:
- a. DOC's Chief of Psychiatry will perform a systematic literature review of management of patients with catatonia (specifically regarding DVT prophylaxis), make necessary changes to DOC's clinical guidelines as indicated by the literature review, and provide education to DOC's psychiatry and inpatient teams on DOC's updated practices.
 - i. DOC's Chief Medical Officer and Chief of Psychiatry will brief the Chief Medical Officers at Eastern State Hospital and Western State Hospital on this case, literature review findings, and opportunities for reviewing and updating of their protocols regarding DVT prophylaxis in individuals evidencing catatonia.
 - b. DOC's nursing team will review the assessment forms used in the IPU and make recommended revisions to include nursing assessment tools to help identify those at risk for DVT and prompt a request for DVT prophylaxis orders, where appropriate.
 - c. Consider creation of and formalize policy for a multidisciplinary team meeting to discuss cases at the onset of formal discontinuation of an antipsychotic treatment.
- 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. Approximately three years prior to death, the decedent was transferred to their current

prison facility and admitted to the IPU for healthcare needs. During this admission, DOC's mental health team ordered involuntary medications and the decedent's condition improved.

- i. Upon discharge from the IPU, the decedent was placed in the Residential Treatment Unit and continued to slowly make progress.
 - b. Approximately ten months before death, the decedent's involuntary medication order was discontinued, as they were showing improved overall recovery including stability in their living unit and willingness to voluntarily continue medication.
 - i. A review of Medication Administration Records (MARs) completed in September 2025 revealed that the decedent was compliant with all prescribed medications.
 - c. Approximately twelve days before death, the decedent was admitted to the IPU, where their health declined; the decedent struggled with eating and drinking and was generally nonverbal and immobile. The individual mainly communicated by nodding or shaking their head to answer questions.
 2. The CIR identified the following contributing factor to the decedent's death:
 - a. The decedent's inability or unwillingness to communicate verbally inhibited their ability to describe any urgent or emergent changes in the way they were feeling.
 - i. The CIR noted that the decedent's cause of death had not yet been determined at the time the CIR was completed.
 3. No potential causal or non-causal factors were identified within the scope of the CIR.
- C. The UFR committee reviewed the unexpected fatality, and the following topics were discussed:
1. Catatonia and DVT.
 - a. UFR members expressed concern regarding DOC clinicians' focus on the decedent's history of catatonia and overlooking consideration of other possible causes for the decedent's symptoms and their risk of blood clot formation. The UFR committee supported enhancing clinical curiosity through education on differential diagnosis, updating relevant protocols, and integrating prompts into documentation templates to support staff decision-making.
 2. Decisional capacity and communication with incarcerated individuals' families.
 - a. The UFR committee discussed use of a multidisciplinary team to review decisional capacity and, if necessary, establish a surrogate decision maker. Members recommend routinely assessing decisional capacity for non-verbal individuals admitted to the IPU and contacting a

proxy decision-maker as soon as possible.

- b. UFR committee members voiced support for notification to an incarcerated individual's family when they become acutely ill and are admitted to the IPU. Currently, DOC notifies the individual's designated contact when they are determined to be seriously ill.
3. UFR members noted that the autopsy report was not finalized and available for review at the time the UFR meeting was held; however, the death certificate, including the decedent's cause of death, was available for the UFR committee's consideration and review.

UFR Committee Findings

The decedent died of multiple bilateral pulmonary thromboemboli, with deep venous thromboses of lower extremities, decreased mobility, and schizophrenia complicated by catatonia identified as contributing conditions. The manner of death is natural.

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. DOC's Chief of Psychiatry will perform a systematic literature review of management of patients with catatonia (specifically regarding DVT prophylaxis), make necessary changes to DOC's clinical guidelines as indicated by the literature review, and provide education to DOC's psychiatry and inpatient teams on DOC's updated practices.
 - a. DOC's Chief Medical Officer and Chief of Psychiatry will brief the Chief Medical Officers at Eastern State Hospital and Western State Hospital on this case, literature review findings, and opportunities for reviewing and updating of their protocols regarding DVT prophylaxis in individuals evidencing catatonia.
2. DOC's nursing team will review the assessment forms used in the IPU and make recommended revisions to include nursing assessment tools to help identify those at risk for DVT and prompt a request for DVT prophylaxis orders, where appropriate.
3. The DOC Clinical Services Board (CSB) will review to establish a formal protocol outlining and standardizing the process when multidisciplinary team consultations are to be held upon the formal discontinuation of antipsychotic treatment.
4. The DOC CSB will review to establish a formal protocol for assessing decisional capacity in non-verbal IPU admissions and identifying proxy decision-makers.