



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-023 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 February 19, 2026:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Alexis Telles, Director of Nursing
- Dr. Eric Rainey-Gibson, Director – Behavioral Health
- Mark Eliason, Deputy Assistant Secretary
- Darren Chlipala, Administrator
- 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
- Rochelle Stephens, Men’s Prisons Project Manager
- Paige Perkinson, Correctional Relations Manager

DOC Community Corrections Division

- Kristine Skipworth, Administrator – East Region
- Kelly Miller, Administrator – Graduated Reentry

DOC Person Centered Services

- Megan Pirie, Director

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. Judy Zerzan, Medical Director

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

Fatality Summary

Date of Birth: 1983 (41-years-old).

Date of Incarceration: January 2025.

Date of Death: November 2025.

At the time of death, the decedent was participating in DOC’s Graduated Reentry (GRE) program.

The cause of death is acute combined drug intoxication including fentanyl and methamphetamine, with atherosclerotic 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:

Days Prior to Death	Event
98	<ul style="list-style-type: none"> The decedent transfers to the GRE program where an intake and orientation are conducted, including drug screening which returned negative results. The decedent is given a Narcan kit and transported to their approved residence.
84 – 79	<ul style="list-style-type: none"> The decedent meets with a DOC Community Specialist (CS) at their residence and completes drug screening which returned negative results. A CS received confirmation of the decedent’s scheduled substance use disorder (SUD) assessment appointment from the treatment provider.
70 – 10	<ul style="list-style-type: none"> A CS conducts drug screening on six different occasions, and all return negative results.
8	<ul style="list-style-type: none"> A CS conducts a home visit with the decedent and no issues are reported.
Day of Death	Event
–	<ul style="list-style-type: none"> At approximately 9:00 AM, residents in the decedent’s transitional house find the decedent unresponsive in their room; they administer Narcan, initiate Cardiopulmonary Resuscitation (CPR), and call 911 to request community Emergency Medical Services (EMS) response. DOC is notified of the suspected overdose by the transitional house manager and responds to the residence. The decedent is declared deceased at 9:30 AM 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. 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. Prior to death, the decedent was successfully participating in DOC's GRE program and preparing for release to the community.
 - b. On the day of death, the decedent was found unresponsive in their room by other residents of the transitional house and resuscitation efforts were unsuccessful.
 - i. Community EMS, community law enforcement and the county medical examiner responded to the scene and informed DOC staff that they suspected the decedent's death was due to a fentanyl overdose.
 - ii. The autopsy report later confirmed that the decedent's death was due to an acute combined drug intoxication including fentanyl and methamphetamine.
 2. No contributing, causal, or non-causal factors were identified within the scope of the CIR.
- B. Independent of the CIR, the MRC reviewed the medical record and antecedent care delivered and provided the following findings.
 1. The MRC found:
 - a. Approximately ten months before death, the decedent was readmitted to prison with a well-documented history of illicit substance use.
 - i. The decedent self-reported consuming social levels of alcohol and illicit substances including fentanyl in the months preceding their incarceration. They also disclosed using heroin weekly for the last four years.
 - b. Approximately seven months prior to death, DOC custody staff referred the decedent to DOC medical due to concerns that the decedent was intoxicated in the unit. The decedent did not confirm use of any substances, and a drug screen returned negative results.
 - i. The decedent had no subsequent contact with DOC's medical or nursing teams prior to transferring to the GRE program.

- c. The decedent successfully participated in and completed psychosocial SUD treatment prior to transfer.
 - d. The decedent was not started on Medication for Opioid Use Disorder (MOUD) before transferring to GRE, as notification to DOC's Medication Assisted Treatment (MAT) team occurred one week prior to transfer, which is not enough time to start an individual on medication.
 - i. However, the MAT coordinator sent the decedent a kiosk message inquiring into their interest in receiving MOUD and an email to the supervising GRE specialist offering the assistance of the MAT team in setting up treatment services, if needed.
 - ii. The decedent did not respond to the kiosk message and responded "no" to the question of whether he was interested in the MOUD program on their *Release/Transfer Needs Survey (07-053)* completed the day before transfer.
 - e. At the time of death, the decedent was employed, residing in transitional housing which offered sobriety support, and enrolled in SUD treatment in the community.
2. The MRC discussed DOC's ongoing improvement efforts, including:
- a. Efforts underway to improve the screening process for partial confinement settings, including earlier collaboration on screening for addiction and notification to DOC's addiction medicine team prior to transfer.
 - b. Ongoing work by DOC's MAT team to refine their outreach process with the intent of increasing in-person connections with incarcerated individuals prior to transfer for a more patient-centered case management approach.
 - c. DOC's ongoing research project to trial a new shared decision-making model of nursing-led MOUD discussions with incarcerated individuals. The project aims to determine if this collaborative approach increases uptake of medication treatment for individuals with opioid use disorder prior to release.
3. While not contributory to the decedent's death, the MRC identified the following improvement opportunities:
- a. Update DOC Form 13-303 *History and Physical* by relocating questions regarding illicit substance use from the social history section to the medical history section, which will help reinforce addiction as a medical condition.
 - b. Assess DOC's approach when an individual reports actively using illicit substances to better ensure individuals needing treatment services are identified and supported.

- C. The UFR committee reviewed the unexpected fatality, and the following topics were discussed:
1. SUD treatment efforts.
 - a. The UFR committee reviewed DOC's ongoing efforts to improve its engagement with and support for individuals carrying SUDs.
 - b. Members discussed possible collaboration with the Health Care Authority's ScalaNW program ([ScalaNW | Better care for patients who use drugs](#)) to augment DOC's harm reduction efforts through additional support and access to care for individuals with SUDs.

UFR Committee Findings

The decedent died of an acute combined drug intoxication including fentanyl and methamphetamine, with atherosclerotic cardiovascular disease identified as a significant contributing condition. The manner of death is accidental.

UFR Committee Recommendations

The UFR committee did not issue any 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. Update DOC Form 13-303 *History and Physical* by relocating questions regarding illicit substance use from the social history section to the medical history section, which will help reinforce addiction as a medical condition.
2. Assess DOC's approach when an individual reports actively using illicit substances to better ensure individuals needing treatment services are identified and supported.