Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-025

Report to the Legislature

As required by RCW 72.09.770

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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
Committee Discussion 5
Committee Findings 8
Committee Recommendations 8
Consultative remarks that do not directly correlate to cause of death, but should be considered for review by the Department of Corrections: 8

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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
- Darren Chlipala, Health Services Administrator
- 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
- Rochelle Stephens, Men's Prisons Project Manager
- Paige Perkinson, Correctional Relations Manager

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: 1997 (28-years-old).

Date of Incarceration: December 2019.

Date of Death: November 2025.

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

The cause of death is hypertensive and atherosclerotic cardiovascular disease. The manner of death is natural.

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

Days Prior to Death	Event
1	• The decedent received a custody promotion and is transferred to a new DOC prison facility.
Day of Death	**Event**
18:52 hours	• The decedent is observed entering their assigned cell while appearing to stumble and has difficulty closing the cell door.
19:14 hours	• A tier check is conducted, and a custody officer is observed glancing into the decedent's darkened cell.
19:27 hours	• The decedent's insulin pump stops recording data due to a "failed sensor."
19:59 hours	• The decedent's cellmate is observed entering the cell.
20:02 – 20:03 hours	• The cellmate notifies a custody officer that the decedent is unresponsive in their cell. • Custody officers initiate a radio notification, enter the cell, and request DOC medical response.
20:04 – 20:16 hours	• The decedent is moved out of the cell to accommodate lifesaving measures and custody officers begin rendering aid, including Cardiopulmonary Resuscitation (CPR), Narcan administration, and Automated External Defibrillator (AED) placement. • DOC medical staff arrive on scene, and custody officers continue to rotate through providing chest compressions.
20:27 hours	• Community Emergency Medical Services (EMS) arrives on scene and assumes care.

20:45 hours	• The decedent is declared deceased by a community EMS staff physician.

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.

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 type 1 diabetes diagnosed at age 10 and a self-reported history of illicit substance use including stimulants.

      b. The decedent was appropriately prescribed a statin (a medication which lowers cholesterol and reduces the risk of heart disease and stroke) and their blood pressure was controlled at the time of death.

      c. The decedent had a documented history of challenges with diabetes management; they interacted often with their primary care team and used an insulin pump to assist with blood sugar level regulation.

      d. Approximately one month before death, the decedent sustained an injury and underwent surgery shortly after to repair a fracture. The decedent was housed in the facility's Inpatient Unit (IPU) during recovery and was discharged the day before transferring to a new prison facility due to a planned custody promotion.

         i. Upon intake to the new prison facility, the decedent reported no medical concerns aside from pain from their injury and surgery and was issued a new cartridge for their insulin pump.

      e. The MRC reinforced DOC's continued focus on Atherosclerotic Cardiovascular Disease (ASCVD) risk reduction through appropriate and effective use of statins.

      f. MRC members discussed blood clot prevention for IPU patients through deep vein thrombosis (DVT) prophylaxis. Here, the decedent was ambulatory while housed in the IPU and there was, therefore, little risk of blood clot; however, consideration of DVT prophylaxis was not documented in their care plan.

      g. The MRC noted that the decedent's prescribed type of insulin was not readily available in the IPU urgent stock and was dispensed from another facility pill room.

h. Emergency medical response documentation incorrectly stated that the decedent had a "compromised airway." Rather, the decedent's airway was uncompromised, and the issue was that they were not breathing.

   i. The MRC noted that DOC Form 13-459 *Infirmary/Extended Observation Unit Nursing Assessment* does not prompt for a blood pressure check or have a location for such documentation, and that vital signs are documented on a separate flow sheet.

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

   a. DOC Health Services will continue to focus on ASCVD risk reduction through appropriate and effective use of statins.

   b. Reinforce consideration, assessment, and documentation of DVT prophylaxis in an individual's care plan.

   c. Ensure appropriate insulin and related supplies are readily stocked and available for individuals in the IPU.

   d. Provide further clarification on compromised airways to DOC nursing staff.

   e. Review and update DOC Form 13-459 *Infirmary/Extended Observation Unit Nursing Assessment* to require and document a blood pressure check.

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 non-causal concerns to the decedent's death:

      a. The custody officer who conducted the tier check prior to the decedent being found unresponsive in their cell did not follow current tier check requirements, as the officer did not use a flashlight and their walking speed prevented adequate visualization of the cell interior.

         i. Following this incident, a directive was distributed to all DOC Prisons staff requiring refamiliarization with and adherence to all posted local and department-wide memoranda regarding tier checks. This matter was also referred to DOC's Appointing Authorities and Human Resources for further remediation.

      b. Two medical emergency response bags were used during the emergency response, as the initial emergency response bag did not contain the amount of Narcan doses needed and the Ambu bag mask seal (used to deliver rescue breaths) was deflated. The CIR noted that DOC may consider increasing the number of Narcan doses per emergency response bag.

c. During CIR interviews, staff reported that the emergency response felt chaotic, which invites the opportunity for additional interdisciplinary hands-on drills with a focus on role delegation and coordination during a medical emergency response.

d. The decedent's cellmate had to leave the unit pod to find a custody officer when reporting the medical emergency, as a unit sergeant was not assigned to the unit at the time of this incident. Therefore, the unit custody officer was performing duties typically assigned to a unit sergeant outside of their assigned pod during this incident. The CIR noted that facilities facing long-term absences of unit sergeants should consider assigning a temporary replacement.

2. No contributing or causal factors related to the decedent's death were identified within the scope of the CIR.

3. The CIR identified the following recommendation for improvement:

    a. DOC Health Services and Custody should conduct join emergency response drills with a focus on role-delegation during an emergency response.

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

1. Emergency response drills.

    a. Interdisciplinary drills are currently underway throughout DOC facilities and DOC has implemented the following exercise policy changes:

        i. Monthly tabletop exercises, which are conducted during each Place Safety Muster on all three shifts (nine per quarter).

        ii. Monthly functional drills, which rotate between first, second, and third shifts (three 3 per quarter).

    b. Additionally, DOC's Emergency Management Center reviews exercise evaluations, documents process improvements, and produces a Quarterly Exercise Summary Report. During the second quarter after implementation, the Quarterly Exercise Summary Report revealed that facilities have made great strides in adhering to the new exercise policy and reporting process.

2. DOC's Population Health Management.

    a. The UFR committee reviewed DOC's use of the Population Health Report, which flags and identifies individuals who are at increased risk for heart disease. Additionally, DOC's primary care providers are partnering with clinical pharmacists to help identify individuals at increased risk of heart disease and assess whether a statin would be beneficial.

3. Tier checks.
    a. Inconsistent or inadequate tier checks have been noted in previous UFR committee discussions. DOC has taken additional action to improve this process, including:
        i. DOC leadership and Correctional Unit Supervisors are conducting tier checks alongside custody officers and emphasizing best and expected practices, including flashlight use, walking pace, and visual observation.
        ii. Finalizing a training video for DOC's CORE academy, which features personal accounts from previous staff members of an event where an individual died, and tier checks were missed. By exploring these circumstances and gaps in safety observation protocols, these peer accounts will provide essential learning for DOC staff.
4. Communication and care handoffs.
    a. DOC Health Services is utilizing its Population Health Report to prompt discussion at the weekly Facility Medical Director transfer conference call to better ensure warm handoffs and communication before and during an individual's transfer to a new facility.
        i. Here, the decedent was screened upon intake at the facility and DOC staff confirmed that they had all appropriate medical devices and supplies. However, the UFR committee noted that any kind of transfer or move may be stressful for incarcerated individuals.
5. Use of restraints.
    a. During the emergency response, staff were unable to place an IV due to the decedent being restrained at the wrist. UFR committee members supported a DOC review of the use of restraints when staff are performing lifesaving measures, including CPR and AED placement.

UFR Committee Findings

The decedent died of hypertensive and atherosclerotic cardiovascular disease. 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. Continue focus on ASCVD risk reduction through appropriate and effective use of statins.
2. Reinforce consideration, assessment, and documentation of DVT prophylaxis in an individual's care plan.
3. Ensure appropriate insulin and related supplies are readily stocked and available for individuals in the IPU.
4. Provide further clarification on compromised airways to DOC nursing staff.
5. Review and update DOC Form 13-459 *Infirmary/Extended Observation Unit Nursing Assessment* to require and document a blood pressure check
6. DOC Health Services and Custody should conduct join emergency response drills with a focus on role-delegation during an emergency response.
7. Incorporate specific accountability and oversight measures into DOC's current tier check improvement plan to promote policy compliance.
8. Review the use of restraints when DOC staff are performing lifesaving measures, including CPR and IV and AED placement.