Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-028

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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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 7
Committee Recommendations 7

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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 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 March 19, 2026:

DOC Health Services

- Dr. Frank Longago, Interim Chief Medical Officer
- Alexis Telles, Chief of Nursing
- Dr. Eric Rainey-Gibson, Director – Behavioral Health
- Dr. Ashley Espitia, Suicide Prevention Specialist
- Justin Wozab, Registered Nurse
- Arpan Aulakh, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- Deborah Wofford, Deputy Assistant Secretary
- Charles Anderson, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- Rochelle Stephens, Men's Prisons Project Manager

DOC Risk Mitigation

- Elisabeth Kingsbury, Litigation Administrator

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. Heather Schultz, Associate Medical Director

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

Fatality Summary

Date of Birth: 1956 (69-years-old).

Date of Incarceration: July 2014.

Date of Death: October 2025.

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

The cause of death is multiorgan failure and uncontrolled type 2 diabetes, with hypertension, coronary artery disease, congestive heart failure, anemia, hyperlipidemia, cerebral vascular accident, and non-compliance of medical treatment identified as contributing conditions. The manner of death is natural.

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

13 Days Prior to Death	Event
10:00 – 14:05 hours	• The decedent tells DOC nursing staff that they are feeling unwell; an assessment is completed and the decedent is sent to the Health Services Building (HSB) via wheelchair for further evaluation. However, the HSB provider was unable to discuss a plan of care with the decedent, as the decedent left the appointment early to return to their unit.
7 Days Prior to Death	**Event**
12:20 hours	• DOC nursing staff prepare to transport the decedent to a medical appointment; however, the decedent declines and states that they do not want to leave their unit.
5 Days Prior to Death	**Event**
12:20 hours	• The decedent is reassessed after missing their medical appointment two days prior, and follow-up is scheduled for the next day.
17:25 hours	• The decedent is found sweaty and lethargic; they are assessed, treated, and observed before being cleared to return to their unit.
18:13 – 23:31 hours	• Tier checks and facility counts are conducted.
4 Days Prior to Death	**Event**
00:50 – 01:09 hours	• The decedent is found on the floor of their cell, and a medical emergency is declared; DOC nursing staff assess, treat, observe, and clear the decedent to return to their unit.

01:45 – 06:21 hours	• Tier checks and a facility count are conducted.
07:15 hours	• The decedent is transferred to a community hospital's emergency department for treatment and evaluation, and a Seriously Ill Notification (SIN) is submitted.
2 Days Prior to Death	**Event**
10:04 – 12:05 hours	• The decedent is discharged from the community hospital after declining treatment and admitted to the Intensive Patient Unit (IPU) at WSP for end-of-life/comfort care measures at their request.
1 Day Prior to Death	**Event**
09:07 hours	• The decedent is assessed by DOC medical staff and comfort care measures are continued.
Day of Death	**Event**
7:25 – 7:35 hours	• A Registered Nurse (RN) observes the decedent through the IPU window and notes that he is alert and responsive. • The same RN finds the decedent unresponsive in their IPU room and assesses the decedent for signs of life. No signs of life are noted and the RN requests additional DOC medical response.
7:42 hours	• The decedent is assessed again and declared deceased.

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 corrective action.

A. The MRC reviewed the medical record and antecedent care delivered and provided the following findings.

1. The MRC found:

    a. The decedent's medical history included uncontrolled diabetes-type 2, congestive heart failure, chronic pain, chronic lung disease, traumatic brain injury, stroke, hypertension, and chronic kidney disease. The decedent had a well-documented history of declining medication and care recommendations from DOC's medical team and community hospitals.

    b. Approximately two months prior to death, the decedent interacted with DOC's medical team several times and reported experiencing medical issues, including shortness of breath, cough, and congestion. However, the decedent continued to decline their medical teams' recommendations and scheduled appointments.

c. Five days prior to death, the decedent was found lethargic and sweating at 17:25 hours; they were assessed, treated, and cleared to return to their unit by DOC medical staff.

d. Four days prior to death, a medical emergency was declared at 00:50 hours during which the decedent was assessed, treated, and cleared to return to their unit.

   i. Later that same day, the decedent was found on their bed moaning and mumbling with a decreased level of consciousness. The decedent was transported to a community hospital's emergency department and, while at the hospital, the decedent declined care and told hospital staff that they wished to return to their DOC facility.

e. Two days prior to death, the decedent was discharged from the community hospital and admitted to WSP's IPU for comfort care measures at their request. They died two days later.

f. The decedent would intermittently decline care and the MRC noted that their primary care team was effective in managing the decedent's chronic medical conditions when the decedent would engage with them.

g. During their final hospital admission, the Facility Medical Director appropriately notified and communicated with the decedent's family and their Durable Power of Attorney (DPOA).

   i. While treating the decedent, the community hospital contacted DOC to obtain consent to deactivate their defibrillator. The MRC emphasized that DOC cannot act as an individual's DPOA and make care decisions; however, this remains a common misconception among community hospitals. Here, the MRC noted that DOC staff appropriately reminded the community hospital to follow its internal policies and contact the decedent's DPOA regarding care decisions and as appropriate.

2. The MRC did not identify any care gaps or recommendations for improvement.

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 found:

   a. Approximately 11 years prior to death, the decedent was readmitted to DOC with a documented history of declining their recommended care plan and prescribed medications.

   b. Approximately two months prior to death, the decedent was assessed by DOC medical staff several times during sick call and emergency declarations for various complaints.

   c. Four days prior to death, the decedent was sent to a community hospital's emergency department where they declined care and requested to return to WSP on comfort care measures.

   d. Two days prior to death, the decedent was discharged from the community hospital and admitted to the WSP IPU for comfort care measures at their request; they died two days later.

2. No contributing, causal, or non-causal factors were identified within the scope of the CIR.

C. The UFR committee reviewed the unexpected fatality and additional details related to the decedent's care and treatment prior to death. UFR members did not identify any opportunities for improvement.

UFR Committee Findings

The decedent died of multiorgan failure and uncontrolled type 2 diabetes, with hypertension, coronary artery disease, congestive heart failure, anemia, hyperlipidemia, cerebral vascular accident, and non-compliance of medical treatment identified as contributing conditions. The manner of death is natural.

UFR Committee Recommendations

The UFR committee did not identify any corrective actions.