



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-029 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 virtual meeting held on April 16, 2026:

DOC Health Services

- Dr. Poonam Bhagia, Deputy Chief Medical Officer
- Kellett Sayre, Interim Assistant Secretary
- Mark Eliason, Deputy Assistant Secretary
- Kristen Stowers, Registered Nurse 4
- Dr. Catherine Smith, Director – Addiction Medicine
- Dr. Cynthia Mason, Chief of Psychology
- Dr. Zainab Ghazal, Administrator
- Dr. Rae Simpson, Director - Quality Systems
- Arpan Aulakh, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Rochelle Stephens, Men’s Prisons project Manager

DOC Risk Mitigation

- Michael Pettersen, Director
- Elisabeth Kingsbury, Litigation Administrator

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 3 – 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

Year of Birth: 1951 (74-years-old)

Date of Incarceration: March 2024

Date of Death: October 2025

At the time of death, the decedent was housed in a prison facility and receiving care in a community hospital.

The cause of death is subacute myocardial infarct due to atherosclerotic cardiovascular disease. The manner of death is natural.

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

Day Prior to Death	Event
Day 28	<ul style="list-style-type: none">The decedent was seen during sick call for shortness of breath with increasing cough and prescribed medication.
Day 25	<ul style="list-style-type: none">The decedent was seen by their primary provider for follow-up. Medications were adjusted and they were advised to notify staff for any worsening of their condition.
Day 24	<ul style="list-style-type: none">The decedent advised DOC staff that they were having increased difficulty breathing, a medical emergency was declared, and they were transported to a community hospital.
Day 20	<ul style="list-style-type: none">The decedent required an enhanced level of care and was transported to a larger community hospital and admitted to the critical care unit.A seriously ill notification was completed.
Days 19 – 1	<ul style="list-style-type: none">The decedent’s condition continued to decline and they developed multiple complications.
Day 0	<ul style="list-style-type: none">The decedent was transitioned to comfort care per the wishes of their family.The decedent was declared deceased by a community hospital provider.

UFR Committee Discussion

The UFR committee met to discuss the findings and recommendations from the DOC Mortality Review Committee and the DOC Critical Incident Review. The UFR committee considered the information from both reviews in formulating recommendations.

- A. The DOC Mortality Review Committee (MRC) reviewed the medical record and the antecedent care delivered, and provided the following findings:
 - a. The decedent's medical history includes pre-existing cardiovascular disease and hyperlipidemia.
 - b. The decedent received appropriate problem-focused clinical care and was up to date on all recommended health screenings and routine exams.
 - c. Nursing staff provided the decedent with generalized fluid intake education. The MRC noted that clinical recommendations should be tailored to meet the needs of older adults.
 - d. The MRC reviewed a report regarding a brief delay in operational coordination between nursing and custody staff during the community hospital transport process and confirmed that the transport timelines had no causal relationship to the fatality.
 - e. No clinical care gaps were identified.
- B. While not contributory to the cause of the decedent's death, the MRC identified the following opportunities for improvement and recommended:
 1. DOC should provide additional clinical guidance and education to enhance staff competence and facilitate the personalization of fluid intake recommendations for older adults.
 2. DOC should conduct a facility-level review of the hospital transport request process to identify potential improvements.
- C. 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. No contributing, causal or non-causal factors were identified within the scope of the CIR were found.
- D. The committee reviewed the unexpected fatality, the MRC recommendations and discussed

the following:

1. Documentation the Seriously Ill Notification (SIN):
 - a. A committee member inquired if the family of the decedent was notified of their seriously ill notification status because the space on DOC Health Services form 13-109 *Seriously Ill Notification* was left blank.
 1. DOC confirmed the decedent's family was notified of the seriously ill status and the family was actively in communication with the community hospital physicians.
 - b. Pursuant to DOC policy 610.600 *Infirmatory/Special Needs Unit Care*, the facility Superintendent, Religious Coordinator or their designee is responsible to notify an individual's family when they are seriously ill.
 - c. The UFR Committee noted that the form used for SIN documentation is a Health Services form that is filed within an individual's protected health record and is not accessible to staff in other DOC departments.
 - d. Committee members recommend DOC review the administrative workflow for SIN documentation to ensure consistent, accurate record-keeping.

Committee Findings

The decedent died of a subacute myocardial infarct due to atherosclerotic cardiovascular disease. The manner of death is natural.

Committee Recommendations

The UFR committee did not issue any recommendations for 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. DOC should provide additional clinical guidance and education to enhance staff competence and facilitate the personalization of fluid intake recommendations for older adults.
2. DOC should conduct a facility-level review of the hospital transport request process to identify potential improvements.