



# Unexpected Fatality Review Committee Report

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## Unexpected Fatality UFR-25-022 Report to the Legislature

*As required by RCW 72.09.770*

May 5, 2026

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

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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 April 16, 2026:

### DOC Health Services

- Dr. Poonam Bhagia, Deputy Chief Medical Officer
- Kristen Stowers, Registered Nurse 4 for Chief of Nursing
- Dr. Cynthia Mason, Chief of Psychology for Director of Behavioral Health
- Mark Eliason, Deputy Assistant Secretary
- Dr. Rae Simpson, Director – Quality Systems
- Dr. Catherine Smith, Director – Addiction Medicine
- Dr. Zainab Ghazal, Health Services Administrator
- 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 – 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: 1975 (50-years-old).

Date of Incarceration: February 2018.

Date of Death: November 2025.

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

The cause of death is acute methamphetamine, hydroxyzine, PINACA 3, 3-dimethylbutanoic acid, and MDMB-4-en-PINACA intoxication. The manner of death is accidental.

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

1 Day Prior to Death	Event
19:31 hours	<ul style="list-style-type: none"><li>The decedent is observed entering their cell.</li></ul>
19:48 – 21:05 hours	<ul style="list-style-type: none"><li>Tier checks and formal counts are conducted.</li></ul>
21:42 – 22:26 hours	<ul style="list-style-type: none"><li>Video surveillance depicts movement in the decedent’s cell and their cell light turning on and off.</li></ul>
22:30 – 23:46 hours	<ul style="list-style-type: none"><li>A tier check and formal count are conducted.</li><li>The cell light within the decedent’s cell is observed turning on and off.</li></ul>
Day of Death	Event
00:32 – 00:37 hours	<ul style="list-style-type: none"><li>A tier check is initiated; a custody officer arrives at the decedent’s cell front at 00:36 hours and finds the decedent unresponsive in their cell.</li><li>DOC staff initiate an emergency call for an unresponsive individual.</li></ul>
00:38 – 00:39 hours	<ul style="list-style-type: none"><li>Additional DOC staff response, including medical staff, arrive on scene.</li></ul>
00:40 hours	<ul style="list-style-type: none"><li>The decedent’s cell door is opened, and lifesaving measures are initiated.</li></ul>
00:54 hours	<ul style="list-style-type: none"><li>Community Emergency Medical Services (EMS) arrives on scene and assumes care.</li></ul>
1:10 hours	<ul style="list-style-type: none"><li>The decedent is declared deceased by community EMS.</li></ul>

## UFR Committee Discussion

The UFR committee met to discuss the findings and recommendations from the DOC Critical Incident

Review (CIR) and the DOC Mortality Review Committee (MRC). 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. On the day of death, a custody officer conducting a tier check discovered the decedent unresponsive in their cell.
    - i. Lifesaving measures were initiated by DOC staff and continued by community EMS; however, the decedent was declared deceased at 1:10 hours by community EMS.
  - b. DOC's Resilience Support Team (RST) was deployed the same day to speak with affected DOC staff and mental health rounds in the unit were completed the following day.
  - c. The CIR noted that a tier check between the 21:00 and 22:00 hours was not conducted as required by DOC policy 420.370 *Security Inspections* due to a shift change between third and first shift. However, video surveillance revealed that the decedent was alive during this time, as their cell light was observed turning on and off and movement within the cell was visible. Therefore, the delayed tier check does not appear to have contributed to this incident.
2. No contributing, causal, or non-causal factors to the decedent's death 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. The decedent's antecedent medical history included high blood pressure, prediabetes, complex chronic pain, asthma, multiple substance use disorders (SUD), unspecified personality disorder, anxiety, and post-traumatic stress disorder (PTSD).
- b. The decedent interacted consistently with their DOC care team and self-reported illicit substance use prior to incarceration and ongoing illicit buprenorphine use while incarcerated to their mental health provider. The decedent was diagnosed with multiple SUDs but was not referred for a formal substance use assessment or to their primary care provider for additional care planning.
- c. The decedent requested psychosocial SUD treatment through their mental health provider and medication to treat opioid use disorder (MOUD) and chronic pain through their primary

care provider.

- i. A referral to DOC's Care Review Committee (CRC) was placed for consideration of suboxone for the decedent. The CRC deferred to DOC's addiction medicine team; however, at the time of the CRC deferral, there was no formal process for addiction medicine consultations or referrals, and an addiction medicine consultation was not completed.
  - d. The MRC discussed the importance of collaboration and communication between DOC's mental health, psychiatric, addiction medicine, and primary care providers for complex individuals, as well as the potential benefits of incorporating clinical urine drug screening as part of an individual's care plan.
2. While not directly causal to the decedent's death, the MRC recommended:
- a. Continue enhancing DOC's addiction medicine services to ensure each incarcerated individual's recovery and wellness are supported.
  - b. Reinforce the importance of multidisciplinary collaboration and communication between DOC care team members.
  - c. Consider incorporating clinical urine drug screening into primary care encounters as part of an individual's ongoing treatment.
- C. The UFR committee reviewed the unexpected fatality, and the following topics were discussed:
1. Process for referring an individual to DOC's addiction medicine team.
    - a. The UFR committee discussed the decedent's incomplete referrals to DOC's addiction medicine team and reviewed the measures and education which have since been implemented to ensure consultations are completed.
  2. Initiation of lifesaving measures.
    - a. UFR committee members reviewed custody staff's brief delay in entering the decedent's cell to begin lifesaving measures, as custody officers were working to secure the scene and completing a safety assessment before entering.

## **UFR Committee Findings**

The decedent died of acute methamphetamine, hydroxyzine, PINACA 3, 3-dimethylbutanoic acid, and MDMB-4-en-PINACA intoxication. The manner of death is accidental.

## **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 enhancing DOC's addiction medicine services to ensure each incarcerated individual's recovery and wellness are supported.
2. Reinforce the importance of multidisciplinary collaboration and communication between DOC care team members.
3. Consider incorporating clinical urine drug screening into primary care encounters as part of an individual's ongoing treatment.