Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-020

Report to the Legislature

As required by RCW 72.09.770

January 23, 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 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 December 11, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Justin Wozab, Chief Nursing Officer – Interim
- Dr. Eric Rainey-Gibson, Director – Behavioral Health
- 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

- James Key, Deputy Assistant Secretary
- Rochelle Stephens, Men's Prisons Project Manager
- Paige Perkinson, Correctional Operations Program Manager

DOC Risk Mitigation

- Michael Pettersen, Director

DOC Person Centered Services

- Megan Pirie, Director

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, Deputy Director
- 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. Christopher Chen, Associate Medical Director

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

Fatality Summary

Date of Birth: 1954 (70-years-old).

Date of Incarceration: December 2024.

Date of Death: September 2025.

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

The cause of death is complications of penetrating trauma of the head. The manner of death is homicide.

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

Days Prior to Death	Event
30	• The decedent, cellmate A, and cellmate B are assigned to the same cell.
Days Prior to Death	**Event**
Day 29 - 19:35 hours	• Cellmate B entered the shared cell and reported observing cellmate A choking the decedent. • Cellmate B reported grabbing a cane and striking cellmate A in an attempt to stop the assault.
Day 29 - 19:36 hours	• Cellmate A exited the cell and walked toward the restroom. Cellmate B followed cellmate A and a physical altercation between the two ensued. • The decedent was observed moving to the cell door and sitting in the doorway.
Day 29 - 19:37 hours	• Custody staff made a radio notification of a fight and requested DOC medical staff and additional custody staff. • Cellmate A and cellmate B were separated and escorted out of the area by custody staff.
Day 29 - 19:38 hours	• Severe trauma to the decedent's eye socket was observed, a request for community Emergency Medical Services (EMS) was made, and staff began rendering aid.
Day 29 - 19:43 hours	• DOC medical staff arrived on scene and assumed care.
Day 29 - 19:59 – 20:28 hours	• Community EMS arrived on scene, assumed care, and transported the decedent to a local community hospital.

Days Prior to Death	Event
28 – 1	• The decedent received extensive hospital care for his injuries.
0	• The decedent is pronounced deceased by community hospital staff.

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).

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. Approximately one month before death, the decedent was assaulted in their cell. They were transported via community emergency medical services to a community hospital for care. Despite extensive treatment, the decedent died from the injuries sustained during the assault.

2. The CIR identified the following potential causal factors to the decedent's death:

   a. The individual who assaulted the decedent was mistakenly awarded programming points during months when they were ineligible which placed them in a lower level of custody for housing.

      i. The CIR noted DOC Policy 350.100 Earned Release Time may create confusion for staff when calculating custody scores.

   b. The CIR identified the following non-causal concerns to the decedent's death:

      i. The cellmate who assaulted the decedent did not receive urinalysis after this incident as required by DOC policy. The Shift Lieutenant was unaware of the DOC policy requirement.

      ii. Several DOC staff members did not complete Incident Reports after this incident as required by DOC policy, as a directive was given to facility staff that they did not need to complete an Incident Report if they only had minimal involvement in an incident.

      iii. Mental health rounds were not completed with incarcerated individuals on the unit after this incident which is a preferred clinical practice. The facility has put a plan in place to ensure future unit mental health rounds after a significant incident.

3. The CIR recommended:

    a. The Headquarters Classification Unit provides policy language clarification and instructs classification staff to confirm calculation accuracy within the custody facility plan.

    b. Include conducting a urine drug screening after involvement in violent behavior as a discussion topic for the next Superintendent meeting.

    c. Send an all-staff communication regarding the policy-driven requirement of completing an incident report regardless of staff's level of involvement.

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 was receiving ongoing care for their chronic medical conditions and was up to date on recommended screening exams and immunizations.

        b. The decedent suffered a penetrating injury of the brain during an assault.

            i. During the subsequent hospitalization, the decedent underwent multiple surgeries and developed several complications including a heart attack, a blood clot in the lung, pneumonia, gastrointestinal bleeding, and a stroke.

        c. The decedent was transitioned to comfort care after discussions with their family and were declared deceased on day 29 of hospitalization.

    2. No care gaps or opportunities for improvement were identified by the MRC.

C. The UFR Committee reviewed the unexpected fatality, and the following topics were discussed.

    1. Mental health rounds.

        a. The UFR committee discussed that mental rounding in the unit after a significant incident is an important support for other impacted incarcerated individuals. Committee recommends that communication be sent to DOC facility leaders to ensure mental health rounds is the standard response after a traumatic event.

    2. Custody level calculation.

        a. UFR members reviewed the miscalculation of the cellmate's custody level and acknowledged the process may be confusing for the classification staff. The UFR committee discussed that the HQ classification unit is conducting a process review and plans to provide clarification and additional guidance to the classification counselors responsible for calculating an individual's custody level.

3. Peer memorial services.

    a. The UFR committee discussed some facilities allow incarcerated peers to hold a memorial service. Committee members propose DOC develop a universal process for incarcerated individuals to hold a memorial service after the death of a peer.

UFR Committee Findings

The decedent died of complications of penetrating trauma of the head. The manner of death is homicide.

UFR Committee Recommendations

Table 1 presents the UFR Committee's recommendations to prevent similar fatalities and further strengthen safety and health protections for incarcerated individuals. As required, the DOC will develop, publish, and implement an associated corrective action plan within 10 days following the publishing of this report.

Table 1. UFR Committee Recommendations
1. DOC's classification unit complete a review of the current custody level calculation process and provide clarification and additional guidance to the classification counselors responsible for calculating an individual's custody level.

Consultative remarks that do not directly correlate to cause of death, but may be considered for review by the Department of Corrections:

1. Include conducting a urine drug screen after an incarcerated individual exhibits violent behavior as a discussion topic for the next Superintendent meeting.
2. Send an all-staff communication to reinforce the policy-driven requirement of completing an incident report regardless of their level of involvement in an incident.
3. Explore creation of a universal process for incarcerated individuals to hold a memorial service after the death of a peer.