



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-002 Report to the Legislature

As required by RCW 72.09.770

February 20, 2026

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 UFR 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. Within ten days of the publication of this report, DOC must publish an associated corrective action plan. DOC will then have 120 days to implement that plan.

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 January 22, 2026:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Justin Wozab, Interim Chief of Nursing
- Dr. Eric Rainey-Gibson, Director – Behavioral Health
- Dr. Ashley Espitia, Suicide Risk Reduction
- Mark Eliason, Deputy Assistant Secretary
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- Deborah Wofford, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- Lorne Spooner, Correctional Operations Program Manager
- Rochelle Stephens, Men’s Prisons Project Manager
- Paige Perkinson, Correctional Operations Program Manager

DOC Community Corrections Division

- Kristine Skipworth, Regional Administrator

DOC Risk Mitigation

- Michael Pettersen, Director

DOC Person Centered Services

- Megan Pirie, Director

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, Acting 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. Heather Schultz, Associate Medical Director

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

Fatality Summary

Date of Birth: 1967 (57-years-old).

Date of Incarceration: January 2025.

Date of Death: February 2025.

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

The cause of death is undetermined. The manner of death is undetermined.

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

3 to 2 Days Prior to Death	Event
-	<ul style="list-style-type: none"> The decedent was arrested by a community police department on a DOC Secretary’s Warrant and transported to a contracted jail facility. DOC’s Nurse Desk and Community Corrections staff were not notified or involved in the medical or mental health triage of the decedent prior to their admittance to the jail facility. Documentation revealed two incidents of the decedent defecating on themselves after arrival at the jail facility, resulting in multiple cell transfers.
1 Day Prior to Death	Event
18:01 hours	<ul style="list-style-type: none"> The decedent refuses their meal.
21:22 hours	<ul style="list-style-type: none"> Jail staff submit a referral for mental health consultation for the decedent.
06:44 hours	<ul style="list-style-type: none"> The decedent refuses their meal.
Day of Death	Event
07:44 – 08:45 hours	<ul style="list-style-type: none"> An Advanced Registered Nurse Practitioner (ARNP) ordered one dose of medication and a Licensed Practical Nurse (LPN) attempted to administer the medication to the decedent.
11:13 hours	<ul style="list-style-type: none"> A cell check is conducted including a custody officer communicating through and knocking on the cell door.
11:31 – 11:32 hours	<ul style="list-style-type: none"> An LPN conducted an assessment and documented that the decedent would not lift their head for medication. A meal tray and hand soap are delivered to the decedent.

13:05 hours	<ul style="list-style-type: none"> • A cell check is conducted; no direct communication with the decedent is documented.
14:06 hours	<ul style="list-style-type: none"> • The decedent is found unresponsive in their cell.
14:09 hours	<ul style="list-style-type: none"> • Custody officers began lifesaving measures, including Cardiopulmonary Resuscitation (CPR).
14:21 – 14:46 hours	<ul style="list-style-type: none"> • Community Emergency Medical Services (EMS) arrive on scene and assume care. • The decedent is declared deceased by community EMS at 14:46 hours.

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. 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. Three days prior to death, the decedent was arrested by a community police department on a DOC Secretary’s Warrant for failure to report for supervision. He was admitted to a community jail contracted with DOC to house individuals pending supervision sanction hearings. The decedent died while in the jail’s custody.
 - b. Available documentation revealed that an intake was not completed by medical or custody staff upon the decedent’s arrival at the jail facility. The CIR noted that mental health care could have been initiated sooner.
 2. No contributing, causal, or non-causal factors were identified within the scope of the CIR.
- B. Independent of the CIR, the MRC reviewed the available medical records and antecedent care delivered. The MRC provided the following findings.
 1. The MRC found:
 - a. The decedent was never incarcerated in a DOC prison facility and the records available for review were limited.
 - b. The decedent’s medical history included schizoaffective disorder-bipolar type, alcohol use disorder, stimulant use disorder, vitamin D deficiency, obesity, high cholesterol and triglyceride levels, and high blood pressure.

- c. Medical and mental health services at the jail are provided by a contracted medical provider.
- d. The decedent was deemed “aggressive” on transport to the jail facility and, while housed there, demonstrated concerning behaviors, including defecating and urinating on themselves and smearing their person and cell with feces, leading to several cell changes.
 - i. Upon intake to the jail facility, a medical assessment was not completed, and the DOC Nurse Desk was not contacted.
- e. Jail staff submitted an urgent mental health referral the day before the decedent’s death.
 - i. The jail’s medical staff were not aware of the decedent’s arrival to the jail prior to receiving the mental health referral the following morning.
 - ii. On the day of death, an on-duty LPN conducted a wellness check and observed the decedent lying on the floor of their cell, covered in feces. The LPN contacted the covering ARNP provider via Teams, who ordered medication.
 - 1. The LPN attempted to administer the medication to the decedent but was unable to do so, as the decedent did not respond to verbal prompts and would not lift their head.
 - 2. The jail’s mental health team responded to the referral on the day of death but was unable to assess the decedent as resuscitative efforts were underway.
 - 3. Resuscitation was unsuccessful and the decedent was pronounced deceased by community EMS personnel.
 - iii. The MRC noted that the community jail changed its contracted healthcare provider after this incident.
- f. The MRC recognized that there was no opportunity for DOC staff to intervene and request hospital clearance prior to the decedent’s death.
- g. MRC members noted the limited records available for review and expressed concern regarding the jail staff’s apparent non-responsiveness from the day the decedent was admitted to their day of death, including:
 - i. No medical intake, assessment, or rounds appear to have been conducted while the decedent was housed at the facility, despite the decedent’s concerning behavior.
 - ii. No urgent access to a mental health consultation despite facility corrections officers requesting several times.

- iii. No transport to a community hospital or call to DOC's Nurse Desk for support when jail nursing staff determined that the decedent needed an evaluation by the designated mental health crisis responder including possible transport to Western State Hospital.
 2. The MRC recommended:
 - a. DOC's Chief Medical Officer (CMO), Director of Quality and Chief Nursing Officer (CNO) review and elevate this case to the DOC Secretary, DOC Deputy Secretary and DOC Assistant Secretaries of Health Services and Community Corrections to ensure that those under DOC's jurisdiction are receiving appropriate and timely medical care and treatment while housed in a community jail on behalf of DOC.
- C. Additionally, DOC's leadership identified the following improvement opportunities:
 1. Ensure the DOC Nurse Desk is contacted and provided the opportunity to triage individuals under DOC's jurisdiction prior to admittance to a community jail when they are being held on behalf of DOC.
 2. DOC's CMO and Director of Quality will brief the community jail's leadership and the jail's current contracted medical provider on DOC's concerns and highlight the quality and timeliness of care delivered.
- D. The UFR committee reviewed the unexpected fatality, and the following topics were discussed:
 1. Health information sharing and communication between contracted community jails and DOC.
 - a. DOC Policy 610.040 *Health Screenings and Assessments* requires community supervision violators to be pre-screened through DOC's Nurse Desk prior to intake at a DOC prison facility. UFR members noted that there is no equivalent requirement for contracted community jails or community law enforcement when an individual is arrested on a DOC Secretary's Warrant.
 - b. DOC does not participate in nor receive results from any internal reviews or quality improvement initiatives that the community jail may have undertaken after this incident. The UFR committee identified significant procedural delays in obtaining medical records from the community jail. The coroner also requested additional medical records that the community jail failed to provide. These delays postponed the coroner's death investigation and the UFR committee's review by several months.
 2. Coroner's death investigation.

- a. The UFR committee reviewed autopsy findings, noting that while the manner of death remains “undetermined,” the coroner also concluded that a classification of homicide could be considered under Title 72 and RCW 9A.42.010(2) if it is established that neglect, specifically the failure to provide medically necessary care or hygiene, caused or contributed to the death.
 - b. The county coroner indicated that, should additional clarifying information arise, the cause and manner of death as well as the autopsy report may be amended.
3. Quality and timeliness of care provided by the community jail.
- a. UFR committee members expressed concern with the quality and timeliness of care that the community jail provided to the decedent.
 - i. UFR members raised concerns about the fact that individuals under DOC jurisdiction make up 50% of some community jail populations and the need for DOC to ensure they are receiving proper medical care.
 - ii. UFR members concurred with the findings and recommendations identified by the DOC MRC and DOC leadership.
 - iii. UFR members recommended considering alternative community facilities which may be used to house individuals on behalf of DOC by reviewing the existing contracts and determining if the partnerships remain appropriate.

UFR Committee Findings

The cause of the decedent’s death is undetermined. The manner of death is undetermined.

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 leadership will conduct a debrief with the community jail’s leadership and medical staff to share identified concerns regarding the quality and timeliness of care in this case.

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

1. The UFR committee may reconvene on this case if additional information regarding the circumstances of this individual's death becomes available.
2. DOC will assess whether its jail housing contracts should be updated to require a medical intake screening within 16 hours of an individual's arrival at a community facility. Additionally, the UFR committee recommends reviewing this jail contract to address the limited records that were provided by the jail, which hindered the completion of both the autopsy and the unexpected fatality review.
3. DOC leadership will convene a workgroup to develop communication tools and outreach strategies for contracted jails, emphasizing use of the DOC's Nurse Desk as a critical resource for triaging individuals between jail admission and hospital care.