



# Unexpected Fatality Review Committee Report

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## Unexpected Fatality UFR-25-017 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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UFR-25-017 Report to the Legislature—600-SR001

## 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. 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 Prevention Specialist
- 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 Relations 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, Interim 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: 1971 (54-years-old).

Date of Incarceration: July 2019.

Date of Death: August 2025.

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

The cause of death is asphyxia due to strangulation. The manner of death is homicide.

Explanatory Notes
<ul style="list-style-type: none"><li>• Currently, there is an ongoing community law enforcement investigation into this incident.</li><li>• Each Incarcerated Individual (I/I) who may have been involved in this incident is referred to numerically (01-08) for clarity while protecting the integrity and confidentiality of the ongoing criminal investigation.</li></ul>

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

Day of Death	Event
11:36 hours	<ul style="list-style-type: none"><li>• The decedent is last observed in their cell.</li></ul>
12:09 – 14:40 hours	<ul style="list-style-type: none"><li>• Hourly tier checks are conducted.</li></ul>
15:00 – 15:02 hours	<ul style="list-style-type: none"><li>• I/I 06 is observed speaking with the unit floor officers at the officer’s station and obstructing the officers’ view of the unit.</li><li>• I/I 01 is allowed into the decedent’s cell for cleaning, and the cell door is resecured after they enter the cell.</li><li>• I/I 08 is observed leaving the unit pod and entering a small conference room.</li></ul>
15:03 – 15:08 hours	<ul style="list-style-type: none"><li>• I/I 07 is observed crossing the dayroom and entering the unit’s pantry room as I/I 06 leaves the officer’s station doorway.</li><li>• Floor officers are observed walking to the small conference room where I/I 08 is located and then returning to the officer’s station without conducting a required tier check.</li></ul>
15:14 – 15:20 hours	<ul style="list-style-type: none"><li>• I/Is 07 and 08 are observed moving between the small conference room and the pantry while appearing to deliver the unit commissary orders.</li></ul>

15:23 – 15:26 hours	<ul style="list-style-type: none"> <li>• I/I 01 uses the intercom button in the decedent’s cell, exits the cell, and remains at the cell entrance where they wave at the booth officer to resecure the cell door.</li> <li>• I/I 01 is observed walking across the dayroom carrying two items and entering the pantry where I/Is 07 and 08 are located.</li> <li>• I/I 01 is observed exiting the pantry carrying only one item and entering the small conference room, where they are joined by I/I 08 and they begin sorting through items.</li> <li>• I/I 01 is observed exiting the small conference room emptyhanded and entering the pantry.</li> <li>• I/I 08 is also observed exiting the small conference room, while I/I 07 is observed waiting by the door.</li> </ul>
15:28 hours	<ul style="list-style-type: none"> <li>• I/I 01 is observed exiting the pantry while carrying a clear garbage bag.</li> </ul>
16:00 – 16:04 hours	<ul style="list-style-type: none"> <li>• Formal count is initiated.</li> <li>• Custody officers arrive at the decedent’s cell and find the decedent unresponsive; officers initiate a radio notification requesting additional assistance.</li> </ul>
16:05 – 16:07 hours	<ul style="list-style-type: none"> <li>• Custody officers enter the cell and find the decedent with what appeared to be a charging cord tied around their neck. Cardiopulmonary Resuscitation (CPR) is initiated and a request made for an Automated External Defibrillator (AED) and community Emergency Medical Services (EMS) response.</li> </ul>
16:08 hours	<ul style="list-style-type: none"> <li>• DOC medical staff arrive on scene and assume care.</li> </ul>
16:22 hours	<ul style="list-style-type: none"> <li>• Community EMS arrive on scene and assumes care.</li> </ul>
16:43 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 DOC Mortality Review Committee (MRC). 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 identified the following contributing factors to the decedent’s death:

a. The unit booth officer was new to their position and believed the decedent’s cell was empty; the officer, therefore, allowed I/I 01, who worked as a unit porter, to enter the decedent’s

cell for cleaning on an unscheduled day while the decedent was present in the cell.

- b. Simultaneously, unit floor officers were gathered in the officer's station and distracted by conversation with I/I 06 who was standing in the doorway. The conversation eliminated officer presence on the unit floor, obscured officer view of unit activity, and delayed initiation of the required hourly tier check, which was ultimately missed.
  2. The CIR identified the following potential causal factors to the decedent's death:
    - a. The new unit booth officer had limited training and information available on the unit schedule, roster, and empty vs. occupied cells, and a post order manual outlining unit operations and officer responsibilities was not easily accessible to the officer.
    - b. A tier check in the 15:00 hour was not conducted in accordance with DOC policy.
      - i. This matter was forwarded to line staff supervisors for remediation prior to the CIR teams' arrival and the facility will continue to carry out DOC's recently developed plan to improve tier check compliance and remedy identified process gaps.
    - c. Officers were not present on the unit floor while I/I 01 was in the decedent's cell, as all floor officers were collected in the officer's station speaking to an I/I and other I/Is were observed moving freely in and out of the unit's small conference room and pantry unsupervised.
      - i. The CIR noted that adding a third officer or a roving officer to match other units' staffing models may be beneficial.
  3. The CIR identified the following non-causal concerns to the decedent's death:
    - a. Oxygen cannisters are not stored in the living units due to safety and security concerns and, therefore, was not immediately available for use during an emergency response.
      - i. The CIR recommended that DOC Health Services and Prisons develop a recommendation to make oxygen cannisters immediately available for emergency response in units.
  4. The CIR identified the following recommendations for improvement:
    - a. Print and post the unit schedule in the unit control booth.
    - b. Disseminate a directive to unit supervisors to ensure custody officer presence in unit dayrooms when incarcerated individuals are present.
- 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 mixed personality disorder, severe lower extremity vascular insufficiency, and chronic pain.
    - i. Care was appropriate and no gaps were identified by the MRC.
  - b. After admission to DOC in 2019, the decedent declined most of their intake assessment and any recommendations to evaluate or treat their right lower extremity during the three years following admission to DOC. As a result, the decedent developed gangrene and osteomyelitis (a bone infection) in their right foot. Due to the persistence of the decedent's care team, the decedent received a below-knee amputation in 2022.
  - c. The decedent had a history of declining to communicate verbally and instead relied on written communication with health care providers. Available documentation also revealed that the decedent had poor compliance with their care team's recommendations and treatment.
  - d. The MRC reviewed and discussed the CIR recommendation of oxygen cannister storage in living units to ensure availability during an emergency response and agreed that it is unlikely oxygen administration would have impacted the outcome of this incident.
2. The MRC did not identify any opportunities for improvement.
- C. The UFR committee reviewed the unexpected fatality, and the following topics were discussed:
1. Tier checks and officer presence.
    - a. Inconsistent or inadequate tier checks have been noted in previous UFR committee discussions. DOC leadership has taken additional action to improve this process including facility leadership and Correctional Unit Supervisors conducting tier checks alongside unit officers to emphasize agency expectations and best practices. Additionally, unit supervisors have been directed to ensure there is officer presence in unit dayrooms and tiers.
  2. Housing and job assignments.
    - a. UFR members reviewed the housing and job assignment processes in DOC facilities and that, before placement in a unit, a multidisciplinary team evaluates each individual's support needs, behavior history, and safety considerations.
    - b. UFR committee members noted that this incident occurred in a unit which house both individuals receiving residential mental health treatment and individuals who are in protective custody. An Office of the Corrections Ombuds (OCO) representative reported that the OCO received a report that this incident was the result of a "security threat group hit" and voiced concern regarding the safety of housing these two populations in the same unit.

3. Community law enforcement investigation.
  - a. The OCO representative requested DOC share the results of the law enforcement investigation with UFR committee members and supported reconvening of the UFR committee to assess new relevant information, if appropriate.

### UFR Committee Findings

The decedent died of asphyxia due to strangulation. 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.

<b>Table 1. UFR Committee Recommendations</b>
1. Complete a value stream mapping of the unit tier check process and provide a report with recommended changes and compliance metrics to support monitoring changes for effectiveness.
2. Print and post the unit schedule in the unit control booth.
3. Disseminate a directive to unit supervisors to ensure custody officer presence in unit dayrooms when incarcerated individuals are present.
4. Disseminate a directive requiring unit booth officers verify cell occupancy prior to allowing a unit porter or other incarcerated individual to enter a cell for cleaning.

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

1. Assess the feasibility of storing oxygen cannisters in living units while considering the safety and security of incarcerated individuals and DOC staff.