Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-024

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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Table of Contents

Table of Contents 1
Legislative Directive and Governance 2
Disclosure of Protected Health Information 2
UFR Committee Members 3
Fatality Summary 4
UFR Committee Discussion 5
UFR Committee Findings 12
UFR Committee Recommendations 12
Consultative remarks that do not directly correlate to cause of death, but may be considered for review by the Department of Corrections: 13

Unexpected Fatality Review Committee Report

UFR-25-024 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 March 5, 2026:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Eric Rainey-Gibson, Director – Mental Health
- Dr. Ashley Espitia, Suicide Prevention Specialist
- Dr. Bhinna Park, Chief of Psychiatry
- Arpan Aulakh, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- Deborah Wofford, Deputy Assistant Secretary
- Charles Anderson, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- Rochelle Stephens, Men's Prisons Project Manager
- Paige Perkinson, Correctional Relations Manager

DOC Community Corrections Division

- Kelly Miller, Administrator – Graduated Reentry

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

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

Fatality Summary

Date of Birth: 1996 (29-years-old).

Date of Incarceration: June 2020.

Date of Death: November 2025.

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

The cause of death is asphyxia due to ligature hanging. The manner of death is suicide.

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

Days Prior to Death	Event
216 – 160	• The decedent attempts suicide by hanging. • The decedent is subsequently admitted to the Close Observation Area (COA) where an assessment is completed, and the decedent is approved for a Residential Treatment Unit (RTU)-level of care. The decedent interacted daily with DOC's mental health and nursing teams, and medication compliance was closely monitored.
157 – 63	• After discharging from the COA, the decedent is found on the floor with a blanket and string around their neck. • The decedent is readmitted to and remains in the COA. DOC's mental health team evaluated the decedent the day after the suicide attempt and new care recommendations were implemented, including daily mental health and nursing visits, psychiatric review of involuntary medication administration, and structured supportive therapy and safety planning.
62 – 4	• The decedent is discharged from the COA with an updated safety and treatment plan. • The decedent worked with their primary therapist, participated in mental health group sessions, and is seen for a mental health crisis appointment and a mental health case management appointment.
2	• The decedent is observed on video reentering their cell at 18:12 hours. • Staff conducted formal count and tier checks with and without the use of flashlights; no noticeable movement within the decedent's cell is documented.
1	• Staff conducted formal count and tier checks with and without the use of

<table>
<tr><td></td><td>flashlights; no noticeable movement within the decedent’s cell is documented. Officers are observed walking by the decedent’s cell without stopping to inspect the interior of the cell.
• Tier doors are opened and closed; video surveillance shows the decedent remained inside their cell.</td></tr>
<tr><th>Day of Death</th><th>Event</th></tr>
<tr><td>00:29 – 05:28 hours</td><td>• Tier checks are conducted with the use of flashlights.</td></tr>
<tr><td>06:17 – 10:57 hours</td><td>• Tier doors are opened and closed; video surveillance shows the decedent remained inside their cell.
• Formal counts and tier checks are conducted without the use of flashlights. Officers are observed walking by the decedent’s cell without stopping to inspect the interior of the cell.</td></tr>
<tr><td>10:59 – 12:18 hours</td><td>• Video surveillance shows an incarcerated individual looking into the decedent’s cell window and then returning to their assigned cell, where they use the intercom in their cell to contact the unit booth officer to request a check on the decedent.
• The booth officer attempts to contact the decedent through the intercom system but does not receive a response; the officer then radios the unit sergeant to request a wellness check.</td></tr>
<tr><td>12:19 – 12:35 hours</td><td>• The unit sergeant, a custody officer, and a Registered Nurse enter the decedent’s cell.
• The sergeant moved a sheet hanging by the cell door where he discovered the decedent suspended by a ligature secured to a ventilation grate.
• Staff initiate a radio request for a medical emergency response, including community Emergency Medical Services (EMS).
• Additional DOC staff arrive on scene, remove the ligature and begin rendering aid.</td></tr>
<tr><td>12:31 – 12:35 hours</td><td>• DOC’s mental health team and community EMS arrive on scene.</td></tr>
<tr><td>12:36 hours</td><td>• The decedent is declared deceased by community EMS.</td></tr>
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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 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. The decedent died by suicide while housed in a single-person cell within a DOC RTU.

        i. During a wellness check, DOC staff discovered the decedent concealed behind a sheet and suspended by a ligature that was secured around their neck and tied to a small ventilation grate in their cell. The decedent had positioned items on their bed to give the appearance of a person resting and darkened the cell interior by covering the window and lights.

        ii. The decedent was last observed alive speaking with a staff member in the evening two days before they were found. However, the county medical examiner was unable to determine the decedent's exact time of death.

    b. Following this incident, the DOC Correctional Mental Health Unit Supervisor and DOC mental health staff conducted rounds to provide crisis intervention for affected incarcerated individuals; these rounds continued daily for the following week. The Resilience Support Team (RST) deployed the same day to provide staff support.

    c. The CIR identified the following contributing factors to the decedent's death:

        i. The decedent had a history of prior suicide attempts and was housed without a roommate.

        ii. The decedent's authorized property created access to a lethal means of self-harm.

        iii. Substandard tier checks reduced the possibility of early detection and intervention of suicidal behavior.

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

        i. DOC Policy 420.150 *Counts* was not followed.

            1. During a formal count on third shift, custody staff did not require the decedent to physically present themselves as required by DOC policy.

            2. Seven formal counts were conducted between the decedent's last known alive status and the discovery of their body; during these intervals, staff did not verify the decedent's well-being as mandated.

        ii. DOC Policy 420.370 *Security Inspections* was not followed.

1. Custody officers were observed conducting tier checks at a pace that did not allow for adequate observation of the unit's cells and their occupants. Additionally, custody officers did not adequately look into the cells during tier checks to assess the condition and activity of each cell's occupants as specified in DOC's Security Inspection Matrix. Therefore, tier checks prior to this incident were ineffective.

    a. This matter is under review by DOC's Appointing Authorities and Human Resources. On December 9, 2025, a statewide directive was issued requiring facility management to participate in tier checks alongside custody staff to ensure compliance.

e. The CIR identified the following non-causal concerns regarding the decedent's death:

   i. DOC Policy 420.320 *Searches of Facilities* was not followed.

      1. Unit staff were conducting cell inspections monthly rather than daily. The documentation required use of an obsolete form from a facility Operational Memorandum (OM) that did not require documentation of daily cell inspections.

   ii. DOC Policy 420.370 *Security Inspections* was not followed.

      1. A required tier check was not conducted during the two-hour period preceding the discovery of the decedent. While the CIR noted that the timing of this check may not have directly impacted the outcome, it identified a concern regarding the consistency and thoroughness of visual inspections as a potential contributing factor.

      2. This matter has been referred to the DOC's Appointing Authority and Human Resources for further administrative review.

   iii. The facility OM 420.155 *Movement in Prisons* was not followed.

      1. DOC staff did not attempt to verify the decedent's location following a missed scheduled callout. This is contrary to established movement protocols, which require custody staff to contact an individual's living unit to locate them when they do not report for a scheduled callout or appointment.

   iv. The DOC Mental Health Transfer Committee reviewed the decedent's case and determined that an RTU level of care was required. A transfer to an appropriate RTU was subsequently recommended and completed.

      1. The decedent had a history of suicide attempts and was placed in a single-person cell after transfer which is the standard housing configuration within the RTU.

a. To further strengthen suicide risk reduction within DOC, the Department is developing a formalized process to incorporate individualized housing considerations for individuals who have a history of suicide attempts and/or self-harm.

v. A review of the emergency response identified that radio transmissions were vague and confusing, which contributed to a delay in the arrival of responding staff. Post incident interviews indicated a delay in the initiation of Cardiopulmonary Resuscitation (CPR) by some custody staff upon observing the physical condition of the decedent's body showing early signs of decomposition.

vi. The Medical Administration Records (MAR) indicates the decedent received medications on the day prior to the discovery of their body. However, a review of facility records and video surveillance footage could not verify a medication delivery to the cell or that the decedent left the cell to receive it.

1. This matter has been referred to the DOC Appointing Authority and Human Resources for further administrative review.

2. The CIR recommended:

a. Update the facility's OM 420.320 *Searches of Facilities* and relevant post orders to incorporate a standardized daily cell inspection form and clearly define staff responsibilities for these inspections.

b. Incorporate specific accountability and oversight measures into DOC's current tier check improvement plan to promote policy compliance.

c. Add a Place Safety Muster topic for accountability of missed callouts per the facility's OM 420.155 *Movement in Prisons*.

i. Formally submit a recommendation to the owner of DOC Policy 420.155 *Movement in Prisons* to include a requirement for documented verification of an individual's location following a missed callout.

d. Share feedback with the owner of DOC Policy 420.370 *Security Inspections* to consider increasing tier checks in Close Custody RTUs to every 30 minutes instead of hourly.

e. The DOC should evaluate the Washington State Department of Health's *2024 BLS/ILS Protocol Guidance* for withholding or terminating resuscitation efforts when clinical signs of irreversible death are present to determine if internal resuscitation protocols require updates. This review should specifically focus on criteria for withholding or terminating life-saving efforts when clinical signs of irreversible death are present.

B. Independent of the CIR, the MRC reviewed the medical record and antecedent care delivered and provided the following findings and recommendations.

1. The MRC found:

    a. The decedent's antecedent medical history included psychotic paranoid delusional disorder, schizoaffective disorder, bipolar disorder, major depressive disorder with psychotic symptoms, anxiety disorder, PTSD, impulse disorder, seizure disorder related to a traumatic brain injury, insomnia, and substance use disorder (SUD).

    b. The decedent had over 32 contacts with DOC's mental health staff, including a combination of staff rounds, case management, crisis support, and psychoeducational and support group meetings during the 60 days preceding the death.

    c. The decedent had a documented history of multiple suicide attempts, and most were connected to a persistent and paranoid psychotic delusion beginning as a teenager.

        i. The decedent did not engage in routinely scheduled counseling or psychiatric health services outside of the COA but did have a current Mental Health Update and active Mental Health Treatment Plan and would initiate contact with mental health staff when they needed support.

    d. DOC's psychiatric team strongly recommended antipsychotic medications to the decedent, but they consistently declined.

        i. Approximately three months prior to death, a hearing was initiated to determine if involuntary antipsychotic medication administration was appropriate in this case. However, it was determined that the decedent did not meet the criteria for involuntary medication administration at that time.

    e. The decedent actively denied suicidal ideation prior to death. Notwithstanding, the decedent tended to underreport their mental health symptoms, only intermittently took prescribed psychotropic medication, and appeared to be struggling emotionally.

    f. The MRC discussed the difficulties in caring for and managing individuals with persistent paranoid delusions, particularly when they have decisional capacity and decline medication to assist with management of their symptoms.

    g. The MRC reviewed the RTU's common practice of housing individuals in single-cells and noted that, while there are a few two-person cells available, they are not commonly used due to difficulties with cellmate screening and matching.

        i. DOC's Suicide Risk Reduction workgroup is developing a protocol to prioritize multi-

occupancy housing in the RTU when clinically appropriate. The COA aftercare plan has been updated to include recommendations for housing with a cellmate to mitigate isolation. To support these efforts, DOC's electronic case management system will be updated in April 2026 to expand R-codes, enhancing the communication of an individual's risk for future acts of self-harm and/or suicide across multi-disciplinary teams.

h. The MRC discussed a kite from the decedent requesting a medication change dated five days prior to death. The kite was stamped "Received" by a DOC clinician one day after the decedent's death. However, MRC members were unable to determine when the kite was actually submitted by the decedent.

2. While not contributory to the cause of death, the MRC identified the following improvement opportunities:

   a. Monitor DOC's electronic case management system to ensure R-codes are updated as planned.

   b. Continue efforts of DOC's Suicide Risk Reduction workgroup to develop a screening form which will consider housing individuals in the RTU with a cellmate, where appropriate.

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

1. DOC suicide risk reduction efforts.

   a. In addition to the expansion of R-codes for improved risk identification, UFR committee members reviewed DOC's suicide risk reduction efforts including an update to DOC Policy 420.140 *Housing and Cell/Room Assignment* to incorporate criteria for consideration of housing with a cellmate. Additionally, a standardized aftercare plan will be implemented in conjunction with an individual's personal safety plan. This integrated approach ensures increased visibility and multi-disciplinary communication with staff to better support individuals transitioning out of the COA.

   b. DOC has secured funding to replace sheets in its RTUs with specialized, high-durability bedding designed to enhance safety within the living environment. The bedding is difficult to cut, shred or tear, which will decrease a person's ability to use the bedding to construct a ligature device. Similarly, a workgroup is also evaluating best shoe options without laces for individuals housed in an RTU.

2. Consideration of video monitoring in RTU cells.

   a. The UFR committee reviewed the possibility of using video to monitor the wellbeing of individuals housed in the RTU. However, the Prison Rape Elimination Act (PREA) and other

personal privacy protections would be limiting factors for effective use of in-cell video monitoring, and this endeavor would require significant capital expenditure and special legislative funding for implementation.

3. RTU policy.

   a. Currently, DOC's RTUs do not have a governance policy; however, development of a comprehensive policy is underway, and the draft policy is presently being reviewed by DOC's Assistant Secretary of Health Services. UFR members emphasized the need for RTU-specific policy implementation as soon as possible.

4. Tier checks.

   a. Inconsistent or inadequate tier checks have been noted in previous UFR committee discussions, and, in this instance, there were also problems noted with the unit count process. DOC has taken additional action to improve this process:

      i. DOC leadership and Correctional Unit Supervisors are conducting tier checks alongside custody officers and emphasizing the use of flashlights to properly visualize cell interiors even if it inadvertently awakens an individual.

      ii. Finalizing a training video for the CORE academy and annual suicide prevention training, which features previous staffs' personal accounts of an event where an individual died by suicide during missed tier checks. By exploring the circumstances and gaps in safety observation protocols, these peer accounts will provide essential learning for DOC staff.

5. Unit staffing.

   a. UFR members reviewed custody staff assignments, as the sergeant on duty during this incident was relatively new and not permanently assigned to the unit. The facility where this incident occurred has a staff model in place where staff may be offered temporary assignments when they are available and there are additional unit sergeants on duty to provide coverage and assistance when needed.

6. Communication and care handoffs.

   a. The UFR committee requested an overview of the care-hand-off process when an individual discharges from the COA or is identified as being at increased risk during and/or after transfers between facilities. Individuals currently have a targeted safety plan in place. As part of a systemic improvement initiative, the DOC is developing an aftercare plan. This plan incorporates specific clinical triggers and contextual information to improve communication between DOC clinical and custody staff, ensuring a comprehensive support structure for individuals transitioning out of the COA.

7. Involuntary antipsychotic medication administration.

   a. DOC recognizes that involuntary medication administration is a temporary removal of an individual's rights and, therefore, utilizes due process and the principles of medical ethics to govern all decision-making.

   b. UFR members requested additional information regarding the decedent's involuntary antipsychotic medication hearing held approximately three months before death. During this hearing, the decedent presented as lucid and coherent and they denied suicidal ideation or delusions and committed to continue taking a prescribed antidepressant. As a result, the hearing panel determined that the decedent had decisional capacity, was not gravely disabled, did not present a danger to themselves or others, and denied suicidal ideation; therefore, the decedent did not meet the criteria for involuntary medication administration at that time. The panel recommendation was for immediate reconsideration if imminent risk of self-harm or evidence of decompensation became apparent.

   c. The UFR committee noted that the process for communicating next steps when involuntary medication administration is determined to be inappropriate is unclear.

8. Kite handling process.

   a. At the time of this incident, the kite handling process was highly variable. As part of DOC's Patient-Centered Medical Home initiative, a statewide standard work process for kite triage and handling was developed and approved.

UFR Committee Findings

The cause of death is asphyxia due to ligature hanging. The manner of death is suicide.

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. Finalize and implement a DOC Residential Treatment Unit policy.
2. Finalize and implement a screening form to consider housing individuals in the Residential Treatment Unit with a cellmate, where appropriate.
3. DOC will 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.

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

1. Update the facility OM 420.320 *Searches of Facilities* and relevant post orders to incorporate a standardized daily cell inspection form and clearly define staff responsibilities for these inspections.
2. Incorporate specific accountability and oversight measures into DOC's current tier check improvement plan to promote policy compliance.
3. Add a Place Safety Muster topic for accountability of missed callouts per the facility's OM 420.155 *Movements in Prisons*.
    1. Formally submit a recommendation to the owner of DOC Policy 420.155 *Movement in Prisons* to include a requirement for documented verification of an individual's location following a missed callout.
4. Share feedback with the owner of DOC Policy 420.370 *Security Inspections* to consider increasing tier checks in Close Custody RTUs to every 30 minutes instead of hourly.
5. The DOC should evaluate the Washington State Department of Health's *2024 BLS/ILS Protocol Guidance* for withholding or terminating resuscitation efforts when clinical signs of irreversible death are present to determine if internal resuscitation protocols require updates. This review should specifically focus on criteria for withholding or terminating life-saving efforts when clinical signs of irreversible death are present.
6. Monitor DOC's electronic case management system to ensure R-codes are updated as planned.
7. Continue efforts of DOC's Suicide Risk Reduction workgroup to develop a screening form which will consider housing individuals in the RTU with a cellmate, where appropriate.
8. Continue development of an aftercare plan including specific triggers and contextual information, which will improve communication between DOC clinical and custody staff and provide necessary support to incarcerated individuals
9. Ensure the standard work process for Health Services kite triage and handling is implemented at each facility.
10. Develop a process for communicating recommended next steps after an involuntary antipsychotic hearing panel determines that an individual does not meet criteria.