



# Unexpected Fatality Review Committee Report

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## Unexpected Fatality UFR-25-026 Report to the Legislature

*As required by RCW 72.09.770*

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UFR-25-026 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.

## **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. Bhinna Park, Chief of Psychiatry
- Dr. Eric Rainey-Gibson, Director – Mental Health
- Dr. Ashley Espitia, Suicide Prevention Specialist
- 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 Operations Program Manager

### DOC Risk Mitigation

- Michael Pettersen, Director
- Elisabeth Kingsbury, Litigation Administrator

### DOC Community Corrections Division

- Kelly Miller, Administrator – Graduated Reentry

### 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: 1986 (39-years-old).

Date of Incarceration: October 2019.

Date of Death: November 2025.

At the time of death, the decedent was participating in DOC’s Graduated Reentry (GRE) program.

The cause of death is blunt force trauma to the head, neck, torso and legs due to a motorcycle accident. The manner of death is accidental.

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

Days Prior to Death	Event
226	<ul style="list-style-type: none"> <li>The decedent transfers to the GRE program and completes intake and orientation, as well as a drug screening with negative results.</li> <li>The decedent is transported to approved transitional housing.</li> </ul>
220 – 150	<ul style="list-style-type: none"> <li>The decedent successfully completes the Decision Points program and secures employment.</li> <li>A Corrections Specialist (CS) conducts several visits to the decedent’s place of employment and residence. The visits include drug and alcohol screenings which return negative results and no issues are reported.</li> </ul>
136	<ul style="list-style-type: none"> <li>The decedent moves from the approved transitional housing to their own apartment. The assigned CS did not complete a home investigation or visit the new residence.</li> </ul>
122 – 119	<ul style="list-style-type: none"> <li>A CS conducts field visits and telephone contacts with the decedent’s place of employment/supervisor. All drug and alcohol screenings return negative results and no issues are reported.</li> </ul>
Day of Death	Event
–	<ul style="list-style-type: none"> <li>The decedent leaves their residence at 16:34 hours and did not return by 21:00 hours. It was determined they had lost control of their motorcycle while driving at a high rate of speed and collided with a tree. The decedent was declared deceased at the scene of the accident.</li> </ul>
Days after Death	Event

1	<ul style="list-style-type: none"> <li>• A CS reviews alerts from the previous day and notes the decedent’s failure to return; DOC staff attempt to contact the decedent via text and phone but receive no response.</li> <li>• While initiating escape procedures, DOC staff are notified of a motorcycle accident involving an individual wearing an ankle monitor.</li> <li>• At 13:15 hours, DOC staff received confirmation from the county medical examiner that the individual involved in the accident was the decedent and that they were declared deceased at the scene of the accident the day before.</li> </ul>
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## 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 information from both reviews.

A. The MRC reviewed the medical record and antecedent care delivered and provided the following findings.

1. The MRC found:

- a. During their final prison admission, the decedent received problem-focused care including treatment for latent tuberculosis infection.
- b. During their initial physical exam, the decedent self-reported methamphetamine use weekly for ten years and prior completion of chemical dependency treatment.
- c. Approximately ten months prior to death, the decedent successfully completed intensive outpatient substance use treatment with a recommendation of continued care in the community.
- d. The decedent did not have chronic care needs nor require facilitated care coordination when they transferred to the community. An Affordable Care Act (ACA) application was completed, and Apple Health benefits were in place at the time of their transfer to GRE.

2. The MRC did not identify any care gaps or opportunities for improvement.

B. Independent of the mortality review, 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, the decedent lost control of their motorcycle while driving at a high

rate of speed and crashed into a tree.

- b. Upon intake to the GRE program, DOC staff did not review the decedent's SUD treatment discharge summary to determine if further treatment and follow-up were required. Therefore, the decedent's treatment needs were not assessed, and they were not referred to treatment.
  - c. A CS failed to complete a home investigation or visit the decedent's new residence to verify that they were residing there and determine whether the residence met DOC requirements. Therefore, it is unknown whether the new residence met DOC's standards for approval.
  - d. While the CIR identified and remedied procedural concerns, no contributing factors to the decedent's death were identified within the scope of the CIR.
2. The CIR identified the following recommendations for improvement:
- a. Upon transfer to the GRE program, a CS will review an individual's treatment discharge summary to determine any treatment needs or requirements and, if necessary, refer to them an appropriate provider.
  - b. A CS will conduct a home investigation and a home visit when a GRE participant moves to a new residence.
- C. The UFR committee reviewed the unexpected fatality and, after brief discussion, voiced support for the recommendations identified by the CIR.

### **UFR Committee Findings**

The decedent died of blunt force trauma to the head, neck, torso and legs due to a motorcycle accident. 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. Upon transfer to the GRE program, a CS will review an individual's treatment discharge summary to determine any treatment needs or requirements and, if necessary, refer to them an appropriate provider.
2. A CS will conduct a home investigation and a home visit when a GRE participant moves to a new residence.