Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-027

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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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.

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 July 23, 2026:

DOC Health Services

- Dr. Frank Longano, Interim Chief Medical Officer
- Alexis Telles, Chief of Nursing
- Ronna Cole, Deputy Assistant Secretary
- Dr. Ashley Espitia, Suicide Prevention Specialist
- Dr. Ryan Quirk, Chief of Forensic Psychology
- Rachel Lusk, Health Services Administrator
- Dr. Rae Simpson, Director – Quality Systems
- Mary Beth Flygare, Sentinel Event Program Manager

DOC Prisons Division

- Jason Bennett, Senior Director – Correctional Operations
- Rochelle Stephens, Men's Prisons Project Manager
- Paige Perkinson, Correctional Operations Program Manager

DOC Risk Mitigation

- Michael Pettersen, Director
- Elisabeth Kingsbury, Litigation Administrator

DOC Person Centered Services

- Megan Pirie, Director

Office of the Corrections Ombuds (OCO)

- Heather Bates, Interim Director
- Ollie Webb, Assistant Corrections Ombuds – Investigations
- Madison Vinson, Assistant Corrections Ombuds – Policy

Department of Health (DOH)

- Kirstin McFarland, Injury and Violence Prevention Manager

Health Care Authority (HCA)

- Dr. Heather Schultz, Associate Medical Director
- Jessica Blanchard, Health Care Program Manager

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

Fatality Summary

Date of Birth: May 1979 (46-years-old).

Date of Incarceration: December 2023.

Date of Death: December 2025.

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

The cause of death is ligature hanging. The manner of death is suicide.

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

Days Prior to Death	Event
19 days	The decedent was found in their assigned cell with a ligature secured around their neck. DOC staff rendered aid until community emergency medical services arrived to transport the decedent to the hospital. The decedent was placed in the close observation area on a 1:1 watch for safety after they returned from the hospital.
18 - 14 days	The decedent was continued on a 1:1 safety watch. A DOC Psychology Associate met with the decedent and updated safety watch conditions daily.
13 days	During a crisis assessment, the decedent denied current suicidal thoughts. Safety watch conditions were updated to 15-minute checks.
12 days	The decedent was released from close observation and transferred back to their assigned living unit.
11 - 1 days	The decedent was seen for three follow-up visits with a Psychology Associate and continued to deny current suicidal thoughts.
Day of Death	**Event**
00:35 – 05:00 hours	Tier checks were conducted. Custody staff observed signs of life within the decedent's cell during the 05:00 tier check.
05:45 – 05:47 hours	During a routine tier check, the decedent was found unresponsive and suspended from a ligature.

	Custody staff made radio notification of a medical emergency, requested community emergency medical services (EMS) response and began rendering aid.
05:48 – 06:12 hours	DOC medical staff arrived and assumed life-saving efforts.
06:13 – 06:25 hours	Community EMS arrived and assumed life-saving efforts. The decedent's death was pronounced by EMS 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). The UFR committee considered the information from both reviews in formulating recommendations.

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

    1. The decedent's antecedent medical history included hereditary neuropathy, major depressive disorder, generalized anxiety disorder and previous suicide attempts.
    2. At the time of death, the decedent was housed in a general population unit without a cellmate after their cellmate's request for a housing move was granted.
    3. DOC Policy 320.265 *Close Observation Areas* (COA) and Behavioral Health protocol BH113.001 *Suicide Assessment Protocol* were not followed during the decedent's placement in the Close Observation Area:
        a. The suicide risk assessments and safety plans required for both admission to and release from the COA were either incomplete or inconsistent.

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. No contributing or causal factors were identified within the scope of the CIR.
    2. The following non-causal factors were identified:
        a. The required evaluation by the primary mental health provider was omitted prior to the decedent's transfer from the COA to their assigned living unit.
        b. The current DOC electronic case management system lacks visual indicators necessary to identify individuals who would have been recommended for shared housing.
        c. There is no standardized or formal notification system, outside of email, to ensure housing unit staff receive the aftercare plan following an individual's discharge from COA.

C. The UFR committee reviewed the unexpected fatality, the mortality review committee recommendations, and discussed the following:

2. Suicide Risk Detection:

    a. DOC mental health staff proactively conduct screening interviews to identify potential suicidality upon admission to DOC, placement in a restrictive housing unit, and during scheduled appointments.

    b. When there are indicators for potential suicidality, DOC requires a suicide risk assessment (SRA) to determine the current level of risk and document the plan to address the risk factors.

    c. Individuals who are assessed to be an imminent danger to themselves are placed on an observation/safety watch in the COA.

3. Aftercare:

    a. Once the individual is assessed for discharge from the COA, mental health staff and the individual collaboratively develop an individualized safety plan. This plan details specific steps the individual can take to manage symptoms and maintain safety, as well as instructions on how to alert staff if they feel unable to stay safe. The individual is provided with a copy of the safety plan, and a copy is filed in their health record.

    b. The mental health provider also establishes an aftercare plan and notifies the Shift Commander and the individual's Correctional Unit Supervisor (CUS) of any specific details necessary for continued care during their transition back to their living unit, which may include recommending a cellmate.

    While not directly causal to the fatality, the UFR Committee recommends DOC:

        i. Implement a form to standardize and document the communication of the Mental Health Aftercare Plan to housing unit personnel when an individual is discharged from the close observation area, and

        ii. Add a distinct visual indicator within the DOC electronic case management system to identify individuals who have been recommended for shared housing as a protective factor for suicide.

UFR Committee Findings

The decedent died as a result of ligature hanging. The manner of death is suicide.

UFR Committee Recommendations

The UFR committee did not issue any recommendations for corrective action.

Consultative remarks that do not directly correlate to the cause of death, that are being implemented by the Department of Corrections:

1. Implement a form to standardize and document the communication of the Mental Health Aftercare Plan to housing unit personnel when an individual is discharged from the close observation area.
2. Add a distinct visual indicator within the electronic case management system to identify individuals who have been recommended for shared housing as a protective factor for suicide.