



Unexpected Fatality Review

Pierce County Sheriff's Office

2025 UNEXPECTED FATALITY INCIDENT # 2534502168

REPORT TO THE LEGISLATURE

AS REQUIRED BY RCW 70.48.510

DATE OF CRITICAL INCIDENT 12/11/2025

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LEGISLATIVE DIRECTIVE PER ESSB 5119 (2021)

A city or county department of corrections or chief law enforcement officer responsible for the operation of a jail must conduct an unexpected fatality review when a person confined in the jail dies unexpectedly.

The city or county department of corrections or chief law enforcement officer must issue a report on the results of the review within 120 days of the fatality, unless an extension has been granted by the chief executive, or if appropriate, the county legislative authority of the governing unit with primary responsibility for the operation of the jail. Reports must be distributed to the governing unit with primary responsibility for the operation of the jail and appropriate committees of the Legislature.

The Department of Health must create a public website where reports must be posted and maintained. Reports are subject to public disclosure and confidential information may be redacted by the city or county department of corrections or chief law enforcement officer consistent with applicable state and federal laws. No provision of this act may be interpreted to require a jail to disclose any information in a report that would, as determined by the jail, reveal security information about the jail.

Unexpected fatality review is defined as a review of any death that was not the result of a diagnosed or documented terminal illness or other debilitating or deteriorating illness or condition where the death was anticipated and includes the death of any person under the care and custody of the city or county department of corrections or chief local enforcement officer, regardless of where the death actually occurred. A review must include an analysis of the root cause or causes of the expected fatality, and an associated corrective action plan for the jail to address identified root causes and recommendations made by the unexpected fatality review team.

DISCLOSURE OF INFORMATION RCW 70.48.510

(1)(d) Upon conclusion of an unexpected fatality review required pursuant to this section, the city or county department of corrections or chief law enforcement officer shall, within 120 days following the fatality, issue a report on the results of the review, unless an extension has been granted by the chief executive or, if appropriate, the county legislative authority of the governing unit with primary responsibility for the operation of the jail. Reports must be distributed to the governing unit with primary responsibility for the operation of the jail and appropriate committees of the legislature, and the department of health shall create a public website where all unexpected fatality review reports required under this section must be posted and maintained.

An unexpected fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the department of health public website, except that confidential information may be redacted by the city or county department of corrections or chief law enforcement officer consistent with the requirements of applicable state and federal laws.

(2)(4) No provision of this section may be interpreted to require a jail to disclose any information in a report that would, as determined by the jail, reveal security information about the jail.

UFR COMMITTEE MEETING INFORMATION (CRITICAL INCIDENT REVIEW)

Meeting date: 12/18/2025

COMMITTEE MEMBERS IN ATTENDANCE**Facilitator / Coordinator**

Theresa Stiltner	Assistant to the Chief	Corrections Bureau
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Medical / Mental Health Team

Dr. Miguel Balderrama	Medical Director	Corrections Bureau
Angela Sinclair	Health Services Administrator	Naphcare
Victoria Kraus	Director of Nursing	Naphcare
Marty Shurtz	RN	Naphcare
Lucy McConnell	RN	Naphcare
Priti Singh	LPN	Naphcare

Command Staff

Douglas Watkins	Chief	Corrections Bureau
Matthew Dobson	Major	Corrections Bureau
Forest Ake	Major	Corrections Bureau

Operations Leadership

Michele Graham	Clinic Liaison Lieutenant	Corrections Bureau
Russ Allen	Facility Lieutenant	Corrections Bureau
Gianni Falzone	Facility Sergeant	Corrections Bureau
Steve Buchanan	Classifications Sergeant	Corrections Bureau

Operations Deputies

Keila Medero	Corrections Deputy	Corrections Bureau
John Theodorson	Corrections Deputy	Corrections Bureau
Jason Smith	Corrections Deputy	Corrections Bureau
Davon Miller	Corrections Deputy	Corrections Bureau
Joshua Mount	Corrections Deputy	Corrections Bureau
Click here to enter text.		Corrections Bureau

FATALITY SUMMARY

AGE: 31-YEARS OLD

DATE OF INCARCERATION: 12/10/2025

DATE OF DEATH: 12/11/2025

The deceased individual was a 31-year-old who was booked in the Pierce County Jail by the Puyallup Police Department at 14:53 hours on December 10, 2025. The defendant was held on DWLS/DWLR; OPER VEH W/O VAL CERT OF OWNER; UICD and IDENT THFT 2. On December 11, 2025, the deceased was found unresponsive in the cell by custody staff.

INCIDENT OVERVIEW

On 12/11/25, at approximately 21:33, a custody staff member was working in 5 West conducting medication pass in the B Unit. When the staff member approached the cell door, they observed through the window that the inmate had a sheet wrapped around their neck and the other end was tied to the bunk. Medical emergency was immediately called on the radio. The staff member entered the cell and the inmate was taken down to the floor. CPR was administered. Other staff members and medical staff arrived and took turns performing CPR. Narcan was administered with negative results. AED pads were placed on the inmate and three shocks were delivered. Tacoma Fire Department arrived and took over life-saving measures.

COMMITTEE DISCUSSION**THE SCOPE OF REVIEW INCLUDED:**

- Defendants complete booking file
- Defendants current and historical jail medical records
- Facility logs related to the defendant and/or incident
- All internal reports and notes related to the incident
- Detectives investigative report
- Medical Examiner's report and autopsy results

THE POTENTIAL FACTORS REVIEWED INCLUDE:

- A. Structural
 - a. Risk factors present in design or environment
 - b. Broken or altered fixtures or furnishings

- B. Clinical
 - a. Relevant decedent health issues/history
 - b. Interactions with Jail Health Services (JHS)
 - c. Relevant root cause analysis and/or corrective action
 - d. After action response

- C. Operational
 - a. Supervision (e.g., security checks, kite requests)
 - b. Classification and housing
 - c. Staffing levels
 - d. Known self-harm statements
 - e. Review of inmate communications (phone calls/video visits)
 - f. Life saving measures taken
 - g. Training recommendations

COMMITTEE FINDINGS

The committee found the overall response and handling of this unfortunate incident resulting in the loss of life was both appropriate and professional. All the tools and resources available were utilized in the efforts to preserve the life of this individual.

STRUCTURAL FINDINGS

The incident took place in 5 West B Unit, located on the 5th floor of the Pierce County Jail. The cell had adequate lighting. The cell window was not obstructed, allowing clear view for welfare checks.

COMMITTEE FINDINGS – CLINICAL

At the time of the incident, this individual was under the care of Jail Health Services for detox protocols and had not been contacted by Mental Health prior to this incident. Postmortem Examination Report identifies Hanging as cause of death. Postmortem Toxicology Report indicates presumptive positive for Fentanyl, Morphine, Methamphetamine and Naloxone.

COMMITTEE FINDINGS – OPERATIONS

The area of this incident was fully staffed. After discovery, responding Corrections Deputies immediately began CPR and continued its application until relieved first by Naphcare Medical Staff, then by Tacoma Fire Department medics. As far as the actions in response to the Medical Emergency, the JHS team did not identify issues or failure to follow policies/procedures, training, supervision or management, personnel, culture or other variables.

COMMITTEE RECOMMENDATIONS

The following requests/recommendations were made in effort to strengthen measures to maintain a safe, secure, and constitutional facility. Although we have a contract for 24/7 on-sight Jail Health Services, our custody staff have been provided CPR Training and issued Narcan. As the opiate crisis is felt across the nation, our medical team is seeing a pattern of patients coming to the facility with history of Fentanyl addiction. Fentanyl withdrawals are seemingly worse than withdrawals from Heroin. We continue to prioritize recognition and treatment for those exhibiting withdrawal symptoms while under our care. Welfare and security checks remain a crucial part of our standard operating procedures.

