



*Yakima County, Washington*  
**DEPARTMENT OF CORRECTIONS**

Unexpected Fatality Review  
Committee Report

2023 Unexpected Fatality Incident 23IA-0052

Report to the Legislature

As required by Engrossed Substitute Bill 5119 (2021)

Date Of Publication: May 30<sup>th</sup>, 2024

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### Defendant Information

The deceased inmate, a 39-year-old male, was arrested on December 21<sup>st</sup>, 2023, and booked into the Yakima County Department of Corrections at 1803 hrs. The inmate was being held on Criminal Trespass 1<sup>st</sup> Degree, Resisting Arrest, and Shoplifting.

### Incident Overview

On December 23<sup>rd</sup>, 2023, Yakima County Department of Corrections staff found the inmate unresponsive in his bunk. Attempts to revive him were not successful. Lifesaving efforts were then started. The Yakima Fire Department and ALS ambulance arrived. The inmate was declared dead at the scene.

The following actions were immediately taken or were taken in the days following the incident.

- Yakima Valley Special Investigations unit was immediately called in to evaluate / investigate the scene and subsequent death. No criminal behaviors were identified.
- Yakima County Department of Corrections Internal Affairs unit conducted an investigation into the incident. No policy violations were identified.
- The Yakima County Coroner's Office conducted an autopsy.

### Unexpected Fatality Review Date

The relevant documents were disseminated to the committee members on 5/28/2024.

Meeting Date: 5/30/2024

Location: Yakima County Department of Corrections

111 N. Front St., Yakima, WA 98901

### Committee Members

Wellpath- Yakima County Department of Corrections contracted medical provider.

- Tela Sigsworth – HSA (Health Service Administrator)
- Heather Morse – Charge Nurse

Comprehensive Health Care – Yakima County Department of Corrections mental health provider.

- Whitney Gregory – Mental Health Supervisor

Yakima County Department of Corrections Administration

- Jeremy Welch – Director
- Bill Splawn – Chief
- Ernest Coxen – Care and Custody Lieutenant

### Committee Review and Discussion

Scope of review:

- Defendant’s complete booking file
- Defendant’s current and historical jail medical records
- Photos/video evidence if any
- Floor Plan
- Facility logs (electronic or written) related to the incident.
- Coroner’s report and autopsy results

### Committee Findings

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

### Cause of Death

The Yakima County Coroner’s Office determined the manner of death to be accidental.

### Committee Recommendations

Although the committee did not have any recommendations in this incident, Yakima County has made improvements to inmate and staff safety.

- Yakima County has been approved for vital sign readers, which will be placed on the wrists of inmates. This will allow for a faster response to any potential medical issues.
- Yakima County has deployed a drug detection K9 unit. The K9 and its handler will be responsible for drug interdiction inside of jail.
- A new body scanner has been purchased and it will be deployed in late summer 2024.

#### 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 membership and purpose of the team is specified.

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.

