Yakima County, Washington

SUNNYSIDE CITY JAIL

Unexpected Fatality Review
Committee Report

2024 Unexpected Fatality Incident IA-24-04

Report to the Legislature

As required by Engrossed Substitute Bill 5119 (2021)

Date Of Publication: May 1, 2024

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Defendant Information

The deceased inmate, a 32-year-old male, was arrested on April 2nd, 2024 by Toppenish PD, and booked into the Sunnyside City Jail at 2225 hrs. The inmate was booked for a FTA Warrant 3rd Degree, Warrant # 2A0564191, Case # 22P4861. The inmate was medically cleared before booking.

Incident Overview

On April 04, 2024, at approximately 0810 hours, Correctional Officer (CO) handed out inmate meals to holding A. CO noticed the inmate breathing, by the rise and fall of his chest.

At approximately 0930, CO was conducting a walk-through booking and checking on all holding cells. CO checked on Holding A and noticed the inmate kneeling on the floor with his upper body on the sleeping pad with no movement. The CO touched the inmates' back and arm and noticed he was slightly warm to the touch and his arm felt stiff. The CO turned the inmate a little on his side and noticed vomit on his mouth and nose and his eyes were wide open and not blinking.

Fire district 5 arrived on scene a few minutes later and checked the inmate and advised he was deceased.

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

- Yakima County Sheriff Detectives was immediately called in to evaluate / investigate the scene and subsequent death. No criminal behaviors were identified.
- Sunnyside Police Department Internal Affairs unit conducted an investigation into the incident. No policy violations were identified.
- Yakima County Coroner Examiners investigation was initiated.

Unexpected Fatality Review Date

The relevant documents were disseminated to the committee members on May 30, 2024

Meeting Date: 4/30/2024

Location: Sunnyside Police Department

401 Homer St. Sunnyside, WA 98944

Committee Members

City of Sunnyside Attorney

- Benjamin J Riley

Astria Sunnyside Emergency Department Director

- Joel Cardenas

Sunnyside City Jail Administration

- Robert Layman – Chief
- Johnnie Gusby – Commander
- Andrew Gutierrez – Sergeant

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 (Walk Through)
- 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

At the time of this report, Yakima County Medical Examiner's preliminary pathologic diagnosis:

V. Cause of death: Bacterial pneumonia

V. Mechanism of death: Progressive hypoxia; probable sepsis

VI. Manner of death: Natural

Toxicology is still pending.

Committee Recommendations

- Correctional Officers have already changed the amount of time checks are being done.
- Sunnyside City Jail, has already updated the Sunnyside Jail Intake Form
- Sunnyside Police Department proper documentation on Jail Logs

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.