Yakima County, Washington

SUNNYSIDE CITY JAIL

Unexpected Fatality Review
Committee Report

2024 Unexpected Fatality Incident IA-24-05

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 51-year-old male, was arrested on April 5, 2024 by Toppenish PD, and booked into the Sunnyside City Jail at 0842 hrs. The inmate was booked for an FTA Warrant 3rd Degree, Warrant # 3A0730171, Case # 24P1762. The only medical issue on file was an Albuterol Inhaler which inmate kept on person. No other medical issues.

Incident Overview

On April 5, 2024 at approximately 0842 hours, inmate was booked into Sunnyside Jail. Inmate was housed in POD 200.

On April 06, 2024, at approximately 1707 hours, inmate was sitting by the door with his stuff rolled up, wanting to be moved into SEG-1 due to past issues. The CO moved inmate to SEG- 1 from POD 200.

At approximately 2103 hours, the CO contacted the inmate in SEG-1, and inmate wanted to be moved back into POD 200. The CO moved the inmate into POD 200.

At approximately 2325 hours, the inmate was moved back into SEG. The CO moved the inmate into SEG-1 due to the fact he did not want to be in population.

At approximately 2327 hours, inmate requested to go to the hospital due to medication he took several days ago. CO informed the inmate they could move him into a holding cell to keep an eye on him. The inmate was moved to hold D for monitoring every 30 minutes.

On April 07, 2024 at approximately 0436 hours, inmate was moved to SEG-1 from holding D due to opening up holding cell D in booking.

On April 08, 2024 at approximately 1700 hours, during medication pass out, inmate was complaining to dispatch that his stomach hurt and that he wanted medical treatment immediately. CO contacted the inmate who was alert, sitting up right and was talking clearly. The inmate advised the CO that his stomach hurt but would not elaborate. The inmate advised he might be coming down from something he took. The CO advised the inmate that he would not be taking the inmate to the hospital for a stomach ache but would check up on him often to monitor his progress.

At approximately 2000 hours, CO was conducting a walk through and contacted inmate in SEG and they spoke for several minutes. The inmate advised the CO that his stomach was hurting. The CO asked the inmate if he wanted to come out to the booking area with him so he could be observed, just in case it started getting worse. Inmate refused. The CO advised the inmate once medication was done being passed out and if

he is feeling worse, the CO would take him to get checked out. The inmate replied, "OK." The CO continued his walk through.

At approximately 2200 hours, once 41 medications were prepped, the CO started passing out medication. The CO started at POD 600. The CO walked by SEG and noticed the inmate laying on his bunk leaning against the wall. The CO asked the inmate if he was okey. The inmate did not move and didn't appear to be blinking. The CO advised dispatch to notify District 5 and CO began rendering aid.

At approximately 2210 hours, District 5 arrived on scene and took over lifesaving efforts. At approximately 2243 hours, the inmate was pronounced Code 5 by Dr. Roler.

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 April 30, 2024

Meeting Date: 04/30/2024

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 the official cause of death is still pending from the Yakima County Medical Examiner's Officer

Committee Recommendations **

- Correctional Officers have already changed the amount of time checks are being done.
- Sunnyside City Jail, has already made sure all AED(s) are up-to-date and working.
- Sunnyside Police Department undated Mail system to electronic, Visital "Chirper"

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.