Yakima County, Washington

DEPARTMENT OF CORRECTIONS

Unexpected Fatality Review
Committee Report

2024 Unexpected Fatality Incident 24IA-0006

Report to the Legislature

As required by Engrossed Substitute Bill 5119 (2021)

Date Of Publication: July 16, 2024

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Defendant Information

The deceased inmate, a 27-year-old male, was arrested on March 8, 2024, and booked into the Yakima County Department of Corrections at 1140 hrs. The inmate was being held on a warrant for Theft 3rd Degree.

Incident Overview

When the deceased was booked into the jail he told officers he was a daily fentanyl user. After being housed he was offered acetaminophen on a regular basis. He continued to refuse. He was also offered electrolyte replacement drinks. On March 11, 2024 he appeared to stumble on his way to court. He was offered court a different day or a wheelchair. He refused both. He stumbled and fell down, after grabbing a linen rack. He was then evaluated by Medical staff and taken back to his housing unit. Later in the day he fell in his housing unit and was seen by a nurse.

On March 12, 2024, at 0042 hrs, an officer talked to him while he is on his bed. At 0139 hrs another officer finds him on the floor near his bed. The deceased was unresponsive were life saving measures are started. CPR and Narcan were utilized. YCDOC staff were then joined by Wellpath Medical staff, who take over first aid. At 0147 hrs CPR is stopped by the Wellpath RN. AMR Ambulance and the Yakima Fire Department both arrive at 0152 hrs. At 0153 hrs fire personnel determine the male had expired.

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

- The Yakima Police Department 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.
- Yakima County Coroner's Office investigation was initiated.

Unexpected Fatality Review Date

The relevant documents were disseminated to the committee members on 7/11/2024.

Meeting Date: 7/15/2024

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)
- Tanya Lawson – HSA
- 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
- Travis Irion – Admin Lieutenant
- 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

Natural – Acure Cardiac Dysrhythmia

Committee Recommendations

- Staff should be trained to remove inmates whenever possible from the unit to contact Medical.
- Wellpath already addressed with their staff that CPR will not cease, until relieved by EMS.
- Yakima County is purchasing warning devices that would alert staff to medical emergencies involving inmates.

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.