



Yakima County, Washington
DEPARTMENT OF CORRECTIONS

Unexpected Fatality Review
Committee Report

2026 Unexpected Fatality Incident 25IA-0025

Report to the Legislature

As required by Engrossed Substitute Bill 5119 (2021)

Date Of Publication: February 26, 2026

Table of Contents

Defendant Information	3
Incident Overview	3
Committee Meeting Information	3
Committee Members	4
Discussion	4
Findings	4
Recommendations	5
Legislative Directive	5
Disclosure Information	5

Defendant Information

The deceased inmate, a 44-year-old female, was arrested on December 15th, 2025, and booked into the Yakima County Department of Corrections at 1504 hrs. The inmate was being held on Assault 4th Degree and Violation Harassment NCO.

Incident Overview

On December 16th, 2025 the inmate was found unresponsive on the floor of her cell. She was administered Narcan and CPR was started. The Yakima Fire Department and ALS ambulance arrived. The inmate was later pronounced dead at 2123 hours on December 16th, 2025.

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.
- Benton County Medical Examiner investigation was initiated.

Unexpected Fatality Review Date

The relevant documents were disseminated to the committee members on 02/17/2026.

Meeting Date: 02/20/2026

Location: Yakima County Department of Corrections

111 N. Front St., Yakima, WA 98901

Committee Members

Wellpath- Yakima County Department of Corrections contracted medical provider.

- Rhonda Cook – HSA (Health Service Administrator)
- Heather Morse – Charge Nurse

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

- Marc Marble – 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
- Robert McGuire – Internal Affairs 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
- 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 cause of death was deemed due to Acute Fentanyl and Methamphetamine Intoxication by the Benton County Medical Examiner’s Office.

Committee Recommendations

- Medical has already trained their nurses that when an inmate's vital signs have shown a major change, but still does not reach the level of going to the hospital that the Provider is contacted
- Mental Health, Medical and YCDOC has committed to better documentation of what the inmate is doing, their living conditions and signs of life.
- Yakima County is looking into purchasing a contactless vital sign sensor to monitor an inmate's vitals if they are not wanting to wear an Overwatch Wrist Sensor.
- YCDOC also needs to better encourage the inmates to wear an Overwatch Wrist Sensor and let staff know that Medical or Corrections staff can request an inmate wear a wrist sensor.

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.

