

Unexpected Fatality Review

Introduction – Purpose – Legal Requirements

Pursuant to state law, the Chief of Police of the City of Puyallup is required to conduct “an unexpected fatality review in any case in which the death of an individual confined in the [City’s] jail is unexpected.” *RCW 70.48.510(1)(a)*. The primary purpose of the review is to develop recommendations to the City of Puyallup and the state legislature “regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for individuals in custody.” *RCW 70.48.510(1)(c)*.

In order to conduct the required review, the Chief of Police must select members to comprise the “unexpected fatality review team” (“UFR Team”). The team must include “individuals with appropriate expertise,” and may not include anyone who has had “previous involvement in the case.” *RCW 70.48.510(1)(b)*.

Once the UFR Team completes its review, the Chief of Police must issue a report on the results of that review. *RCW 70.48.510(1)(d)*. The report must include (1) “an analysis of the root cause or causes of the unexpected fatality,” and (2) “an associated corrective plan for the jail to address any root causes and recommendations” made by the UFR Team. *RCW 70.48.510(5)(c)*.

Current Incident – UFR Team – Investigation

On June 24, 2025, Puyallup Jail inmate **35 Death w Dignity** was found deceased in his cell. Because **35 Death w** death was “unexpected” as defined in *RCW 70.48.510(5)(c)*, I (Police Chief Scott Engle) requested the following individuals to comprise the UFR Team for this incident, and to perform the required review:

- Michael Armstrong, Commander, Kent City Jail
- Shawn Stredwick, Corrections Lieutenant, Kirkland Police Department

Captain Wayne Blackard, who oversees the Puyallup Police Department Corrections Division, including the jail, provided the UFR Team a binder containing a variety of records relevant to the incident, including:

- A timeline of events taken from jail logs, CCTV surveillance, and other internal records;
- Arrest report for **35 Death w Dignity**
- Puyallup PD case #2517502361 (death investigation);

- Crime Response Unit (CRU) case #2517600051;¹
- Computer Aided Dispatch (CAD) printout of 911 call;
- Statements from Jail Staff;
- Puyallup Jail Report;
- Pierce County Medical Examiner's Postmortem Examination Report;
- Puyallup Corrections Division Policies; and
- Conquer Clinic's Policies

The UFR Team completed their work in December of 2025, and has since provided me the results of their review. The following constitutes the report regarding that review, as required by RCW 70.48.510(d).

Facts of Incident

June 23, 2025

At approximately 1645 hours, on June 23, 2025, Puyallup Police Officer Alfaro arrested [REDACTED] for Theft in the Third Degree, and for a Puyallup warrant for Possession of a Controlled Substance. A search incident to arrest located four (4) blue M-30 Fentanyl pills in his front right pocket. [REDACTED] was booked into the Puyallup Jail for his charges at approximately 1735.

During the booking process, [REDACTED] answered "yes" when asked if had had a history of illegal drug use, and stated he used approximately .5 grams of Fentanyl a day. He also answered "yes" when asked if he expected to go through withdrawals while in custody. Because there were narcotics found on [REDACTED] at the time of his arrest, he met the criteria to be strip searched prior to being housed in the general population. The strip search was conducted by Officer Anglin at 1740 hours. No further contraband was located. [REDACTED] was then housed in Cell 5, and took the top right bunk.

According to Corrections Officers and the other occupants of Cell 5, [REDACTED] was going through withdrawals that evening, moaning and moving in his sleep. He refused dinner, and continued to try and sleep.

June 24, 2025

At approximately 0106 hours, [REDACTED] came out of his cell to participate in a telehealth medical evaluation by Jacob Grillo, MBA, PA-C, CCHP. Mr. Grillo owns and operates Conquer Clinics, which is the medical provider for the Puyallup Jail. Mr. Grillo documented that [REDACTED] presented with mild opioid withdrawal symptoms, but denied any current medical or mental health concerns. Mr. Grillo wrote that [REDACTED] "was calm, oriented, and cooperative throughout the

¹ The CRU is a multijurisdictional team comprised of officers from various cities in the area, for the purpose of conducting third-party investigations into major incidents involving member cities. Following [REDACTED] death, Puyallup requested CRU to perform an independent investigation into the circumstances, which they did.

encounter.” Based on the clinical assessment of [REDACTED] Mr. Grillo began preparing the appropriate buprenorphine prescription following standard MOUD protocols. [REDACTED] returned to his cell after the medical assessment.

During the course of the day, [REDACTED] appeared to have difficulty sleeping or resting. At approximately 1850 hours Officer Cramer offered [REDACTED] the opportunity to participate in a Clinical Opiate Withdrawal Scale (COWS) assessment, and to have his vitals taken. [REDACTED] verbally declined to participate, and remained in his bunk.

At approximately 1923 hours there was a fight in the female section of the jail, tying up Sergeant Murray and Officer Cramer, for approximately an hour. At approximately 2115 hours, Officer Taylor brought in a female suspect for booking.

At approximately 2156 hours, Sergeant Murray heard yelling from Cells 3/4/5, advising that [REDACTED] was unresponsive. Sergeant Murray and Officer Cramer immediately responded to Cell 5. Sergeant Murray found [REDACTED] unresponsive, administered a dose of Narcan, called for Central Pierce Fire, and began CPR. Officer Taylor assisted Sergeant Murray in moving [REDACTED] from the bunk to the floor. [REDACTED] received two more doses of Narcan and continued CPR prior to the arrival of Central Pierce Fire. Upon arrival, Central Pierce Fire personnel took over lifesaving efforts, but eventually determined [REDACTED] was deceased.

The Pierce County Medical Examiner, Ami Jackson, DO determined [REDACTED] that the cause of death was acute methamphetamine and fentanyl toxicity.

Root Cause – Policy/Practice Recommendations

Based on my review and analysis of the records provided, including jail records, CRU investigative records, the Medical Examiner’s Postmortem examination report, and the review performed by the UFR Team, it is clear that the root cause of [REDACTED] death appears to be his use of methamphetamine and fentanyl immediately prior to being booked at the jail. Notwithstanding that determination, our goal as the City of Puyallup, and in fact our statutory mandate under RCW 70.48.510(1)(b), is to consider any way in which changes to our practices and policies might help to prevent such fatalities and strengthen safety and health protections for individuals in custody.

For that purpose, and in that spirit, the UFR Team identified various policies and practices that may be relevant to the facts and circumstances of [REDACTED] death and recommended that the City consider the extent to which changes to those policies and practices may serve the goals of the health and safety of inmates at our jail. These policies and practices, and my determination as the Chief of Police regarding further consideration of those issues, are as follows:

Inmate Safety Checks

The UFR Team identified potential confusion among jail staff on the specific policy for inmate welfare checks; in particular, the extent to which an officer is required to make direct visual or verbal contact with each inmate during these regular checks. Jail administration is addressing both the policy and training for safety checks, requiring that officers physically enter the day room areas so that each inmate can be directly observed and contacted.

This will enable officers to more directly observe the specific conditions of each individual inmate, and more fully assess whether an inmate may need additional resources or assistance, regardless of whether he/she has previously requested assistance or even declined prior offers of assistance.

Inmate Counts

Inmate counts provide another opportunity for corrections staff to check the welfare of inmates. Jail administration will be updating policy and practice to require so that inmate counts at the beginning of each shift include verbal contact with each individual inmate. This policy will provide an additional opportunity for staff to make more independent determinations of the condition of each inmate, particularly in situations where an inmate may decline offers of medical consultation and/or treatment.

Mandatory COWS

Relatedly, the UFR Team discussed the fact that inmates routinely refuse to participate in COWS/RODS and vital checks. Based on the experience of the team, it was recommended that policy and practice be updated to require medical staff to directly contact any inmate who refuses to participate in COWS/RODS and/or vital checks on two separate occasions.

Medical Sensor Program

The Puyallup Corrections Division uses Overwatch medical sensors to monitor the health of inmates with severe medical concerns, and those suffering from withdrawal. The inmate wears a device on his/her wrist, much like a smartwatch, that monitors biometric information and transmits it to officers' and healthcare provider's computers. The system is designed to alert officers if the inmate is experiencing a medical crisis, allowing quicker detection and response times.

At the time of 35 Death w death, we had recently begun implementing the program, full implementation had not yet occurred. This program is now fully functioning and utilized daily.

Close Observation Cells and Alternatives

The UFR Team addressed the potential for establishing close observation cells for inmates needing more direct attention, particularly when the holding cells (traditionally used for close observation) are full. While establishing separate observation cells is largely prohibited by our current space, Jail administration will implement procedures to address this concern through

increased in-person safety checks, which will be logged in the inmate's electronic file, for inmates who may need close observation.

Conclusion

35 Death w Dignity fatality was unexpected, unfortunate, and the result of his own decisions and actions. However, we remain committed to our responsibility for the health and safety of our inmates. And, as outlined above, the City of Puyallup is committed to a full examination of the extent to which changes to jail policies and/or practices could held to prevent such fatalities in the future, or generally strengthen the safety and health protections for individuals in custody.

Redaction Log

Total Number of Redactions in Document: 2

Redaction Reasons by Page

Page	Reason	Description	Occurrences
1	35 Death w Dignity	Death with Dignity Records - RCW 42.56.360(1)(h); RCW 70.245.150: Health care - Information collected by the department of health under Chapter 70.245 RCW are not public records and may not be made available to the public, except as provided in RCW 70.245.150 (3).	3
2	35 Death w Dignity	Death with Dignity Records - RCW 42.56.360(1)(h); RCW 70.245.150: Health care - Information collected by the department of health under Chapter 70.245 RCW are not public records and may not be made available to the public, except as provided in RCW 70.245.150 (3).	
3	35 Death w Dignity	Death with Dignity Records - RCW 42.56.360(1)(h); RCW 70.245.150: Health care - Information collected by the department of health under Chapter 70.245 RCW are not public records and may not be made available to the public, except as provided in RCW 70.245.150 (3).	14
4	35 Death w Dignity	Death with Dignity Records - RCW 42.56.360(1)(h); RCW 70.245.150: Health care - Information collected by the department of health under Chapter 70.245 RCW are not public records and may not be made available to the public, except as provided in RCW 70.245.150 (3).	1
5	35 Death w Dignity	Death with Dignity Records - RCW 42.56.360(1)(h); RCW 70.245.150: Health care - Information collected by the department of health under Chapter 70.245 RCW are not public records and may not be made available to the public, except as provided in RCW 70.245.150 (3).	1

Redaction Log

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2	35 Death w Dignity	Death with Dignity Records - RCW 42.56.360(1)(h); RCW 70.245.150: Health care - Information collected by the department of health under Chapter 70.245 RCW are not public records and may not be made available to the public, except as provided in RCW 70.245.150 (3).	1