*Yakima County, Washington*

# DEPARTMENT OF CORRECTIONS

Unexpected Fatality Review
Committee Report

2023 Unexpected Fatality Incident 23IA-0036

Report to the Legislature

As required by Engrossed Substitute Bill 5119 (2021)

Date Of Publication: August 3, 2023

Table of Contents

Defendant Information

The deceased inmate, a 31-year-old female, was arrested on Aril 14th, 2023, and booked into the Yakima County Department of Corrections at 2209 hrs. The inmate was being held on one count of Criminal Trespass 2nd Degree.

Incident Overview

On 4/16/2023, the inmate was found non-responsive in her cell. Officers and Medical staff were unable to resuscitate her.

At 2011 hrs Officer Estrada enters her room and finds her on her bunk, not moving. He immediately called for medical backup and felt for a pulse. When he did not feel one, he started giving chest compressions. He was then joined by Sgt. Freeburg, Officer Valdez, and Nurse Abercrombie. Narcan was administered and life saving measures continued being performed by DOC and Medical staff.

Personnel from the City of Yakima Fire Department arrived at 2025 hrs. ALS Ambulance then arrives at 2030 hrs. Fire department and ambulance personnel take over attempts to resuscitate the inmate. Resuscitation is terminated at 2042 hrs, via a remote verbal order from Dr. Edgar of Yakima Valley Memorial Hospital.

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.
- Yakima County Coroner's investigation was initiated.
- The final Coroner's report listed the cause of death as Fentanyl/Methamphetamine Toxicity.

Unexpected Fatality Review Date

The relevant documents were disseminated to the committee members on 7/31/2023.

Meeting Date: 8/2/2023

Location: Yakima County Department of Corrections

111 N. Front St., Yakima, WA 98901

Committee Members

Wellpath- Yakima County Department of Corrections contracted medical provider.

- Christy Waudby – HSA (Health Service Administrator)
- 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

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 final Coroner's report states: Fentanyl/Methamphetamine Toxicity

Committee Recommendations

- There needs to be further investigation as to the origins of the drugs ingested by the inmate.
- When calling for emergency medical services, staff should simply call 911 and not medical services directly.
- Continued training on the ingestion of drugs and security measures concerning contraband. Concerning this, Yakima County is actively pursuing a K9 drug detection dog for the facility. Staff members have now started carrying Narcan on their person.
- There was concern regarding the emergency button in the inmate's room. The Care and Custody Lieutenant should include emergency buttons on his monthly facility inspection.

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.