Yakima County, Washington

DEPARTMENT OF CORRECTIONS

Unexpected Fatality Review
Committee Report

2023 Unexpected Fatality Incident 23IA-0050

Report to the Legislature

As required by Engrossed Substitute Bill 5119 (2021)

Date Of Publication: March 27, 2024

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Defendant Information

The deceased inmate, a 41-year-old male, was arrested on November 18th, 2023, and booked into the Yakima County Department of Corrections at 2059 hrs. The inmate was being held on one count of 4th Degree Domestic Violence Assault.

Incident Overview

On 11/18/2023, other inmates in the unit notice the deceased was acting strangely and notified officers.

Cpl. Cooley asked him to step out of the unit, because he was upsetting the other inmates. He refused and became agitated. Cpl. Cooley attempted to deescalate him, but the inmate only became more upset. He was asked to put his hands behind his back for handcuffs, but again he refused. He took a bladed stance, and pepper spray was then deployed. Other officers arrived and the inmate began to fight. Due to his combative nature the spit hood was placed on his head.

He had to be carried out of the unit. Once in the hallway he continued to fight and kick. Shortly after this point he stopped fighting and breathing. He was placed on the floor, and staff began life-saving measures.

Personnel from the City of Yakima Fire Department arrived at 2006 hrs. They are joined by ALS Ambulance. Fire department and ambulance personnel took over attempts to resuscitate the inmate. He is placed on a gurney and transported to the sallyport, where an ambulance is waiting. Resuscitation is terminated at 2101 hrs in the jail sallyport.

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 Natural Causes

Unexpected Fatality Review Date

The relevant documents were disseminated to the committee members on 3/20/2024.

Meeting Date: 3/27/2024

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)
- Heather Morse – Charge Nurse

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

- Kevin Avilez – Mental Health

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: Cardiac Dysrhythmia, Atherosclerotic Cardiovascular Disease. With Diabetes and hypertension as contributing factors. The manner of death is Natural.

Committee Recommendations

- Staff were already reminded of the placement of the WRAP restraint systems. A new reminder needs to go out.
- Additional training should take place on how to carry a person.
- Cameras need to be added to the living units to avoid blind spots. Even though this would not have prevented anything in this case, the review process would have been easier.

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.