Yakima County, Washington

DEPARTMENT OF CORRECTIONS

Unexpected Fatality Review
Committee Report

2021 Unexpected Fatality Incident 21IA-0036

Report to the Legislature

As required by Engrossed Substitute Bill 5119 (2021)

Date of Publication: March 9, 2023

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Defendant Information

The deceased inmate, a 23-year-old male, was arrested on August 14th, 2021, and booked into the Yakima County Department of Corrections at 0048 hrs. The inmate was being held on two counts of Assault 3rd Degree.

Incident Overview

On 10/19/2021, the inmate was found non-responsive in his cell in Booking from an apparent suicide. Officers and Medical staff responded but were unable to resuscitate the inmate.

At 1038 hrs Officer J. Rodriguez conducts a seg check. He notices the inmate is on his back with his arm hanging off the side of his bunk. He did not see the inmate's chest rise. He entered the room and attempted to wake the inmate. He saw a towel around the inmate's neck and called for ALS Ambulance. Officer J. Rodriguez is joined by Officer Fifer. They remove the towel and start CPR.

Wellpath Nurse, Heather Morse arrives at 1040 hrs. More Medical staff arrive at 1041 hrs. The oxygen tank and AED arrive at 1041 hrs. ALS Ambulance and the Yakima Fire Department arrive at 1048 hrs. Ambulance and fire personnel then take over. Resuscitation is terminated at 1119 hrs, via a remote verbal order from Dr. Schmelzer 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 report indicated the cause of death to be suicide.

Unexpected Fatality Review Date

The relevant documents were disseminated to the committee members on 2/23/2023.

Meeting Date: 2/23/2023

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
- Ernest Coxen – Care and Custody Lieutenant
- 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: "Self-inflicted ligature around the neck."

Committee Recommendations

- There was confusion by some staff as to the location of the red bag. This had been rectified prior to the meeting, and staff were given appropriate training.
- Mental Health mentioned the need to screen high risk inmates more often, even though this inmate was not listed as a suicide risk. Since the incident, they have changed protocol.
- It was mentioned that too many staff were standing around, and they did not have any duties in the response. It was recommended that supervisors do a better job at policing this.

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.