Cowlitz County
Corrections Department

Jail Division

1935 1st Avenue Longview, WA 98632

Unexpected Fatality Review Committee Report

2022 Unexpected Fatality Incident

Report to the Legislature
As required by Engrossed Substitute Bill 2119 (2021)

Date of Publication
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Unexpected Fatality Review Committee Report

Defendant Information

- The inmate was a 19-year-old male. He was booked into the Cowlitz County Jail at 1210 hours on July 28, 2022, by Longview Police Department for a Superior Court Warrant for Contempt of Court. The original charge was Rape of a Child 1. The inmate was medically assessed by a Registered Nurse and received a mental health evaluation by a mental health professional during his booking process. The inmate denied all drug use but had a history of mental health issues and self-reported kidney issues.

Incident Overview

- At approximately 1525 hours on July 28, 2022, the inmate was found unresponsive in a cell in the jail's medical unit. The inmate was housed with three other male inmates at the time. An officer was at the cell to check another inmate and noticed the inmate was laying prone and was quiet, when previously he had been snoring. The officer entered the cell to check on him. The officer touched the inmate in order to get a response and noticed the inmate was warm to the touch but did not respond. He further noticed there was a large amount of brown liquid on and around the inmate. The officer called for jail medical personnel to respond. Jail medical personnel and additional custody staff responded immediately and administered lifesaving measures (Narcan, CPR) and at 1526 staff called for a medical response from 911.

  Emergency medical personnel arrived at 1533 and took over lifesaving measures. The emergency medical personnel ceased lifesaving measures and declared the inmate deceased shortly thereafter. All emergency medical personnel left the housing area, and the scene was preserved pending a death investigation.

  The Cowlitz County Sheriffs Office was contacted and arrived on scene at 1610 to conduct a death investigation. The Cowlitz County Coroners Office conducted an autopsy of the inmate on August 2, 2022, at 1018 hours. A urinalysis drug screen was performed during the autopsy and the inmate's urine tested positive for alcohol, Gapapentin, THC, Fentanyl, Ketamine, Amphetamine, Methamphetamine & Morphine. The official autopsy report was delayed pending toxicology report.

  The Cowlitz County Coroner's Office autopsy report listed the manner of death as "accidental". The cause of death was listed as "fentanyl toxicity". Other significant conditions listed "methamphetamine intoxication" and noted "90% stenosis of the left anterior descending coronary artery".

Unexpected Fatality Review (UFR) Committee Meeting Information

Meeting Date: April 21, 2023

Committee Members in Attendance

Cowlitz County Corrections Department
- Director Marin Fox
- Captain Chris Moses

Naphcare
- HSA Dena Brawley

Cowlitz County Risk Management
- Risk Manager Victoria Blosl

Cowlitz County Prosecuting Attorney's Office
- Chief Civil Deputy Doug Jensen

Committee Review & Discussion

Scope of Review:

- Inmates completed booking file
- Inmates current and historical jail medical/mental health records
- Video evidence
- Facility logs and staff scheduled in relation to the defendant and or incident
- All internal staff reports related to the incident
- Body Scan images
- Detectives' investigation report
- Structural issues
- Clinical assessment & response
- Operational response

Committee Findings

Structural

- The incident took place in a cell in the jail's medical/mental health unit (D-unit). The unit had adequate lighting, a functioning emergency call button within the cell, and no known or reported broken or altered fixtures.

- There are several surveillance cameras which capture the booking, processing, and movement throughout the facility and the eventual housing of the inmate in the D-unit. However, there are no surveillance cameras located within the cell the inmate was housed in. As a result, there is not a recording of the inmate's activities within the cell prior to the medical emergency.

- Also of note, there is a body scanner located in the booking area which is used to scan all newly booked inmates. The body scanner was functional and used to scan the inmate in this incident. The scan did not indicate any contraband or other items.

Clinical

- The subject was booked into Cowlitz County Jail on 07/28/2022 at 1210 hours. The medical receiving screening was conducted on 07/28/2022 at 1224 hours. The physical assessment conducted was unremarkable. The subject was alert and oriented, able to respond to medical questions appropriately, vital signs were within limits, and the subject was in no acute distress. The subject denied illicit drug and/or alcohol use. The subject did not report a history of alcohol and/or illicit drug use during previous incarcerations. A urine sample was not requested per negative substance abuse responses during these encounters.

- The subject reported a history of mental health concerns with mental health medication use. The subject reported a history of intent to harm self within the last three months; however, the subject denied current thoughts of self-harm or suicidal ideation. Mental health follow-up was recommended for housing assignment.

- Follow-up was conducted by the mental health therapist at 1335. The subject was responsive to questioning and responses were appropriate. The subject reported a history of mental health concerns. The subject denied suicidal and/or homicidal ideation. The subject was housed in D-unit per mental health recommendation.

- A medical code was called at approximately 1525 hours. Medical staff arrived in a timely manner with the appropriate equipment and medical supplies. While the subject's pulse was palpable, rescue breathes were administered, along with three doses of narcan intermittently. When subject continued to be unresponsive and pulse became undetectable, CPR was initiated, AED was placed, power turned on, and directions followed until AMR arrived on scene and care was handed off.

- There were no identifiable issues with the emergency medical response: response time was appropriate, training was appropriate, facilities and equipment were appropriate, policies and procedures were followed.

Operational

- The jail was fully staffed when the incident occurred. All responding staff acted within policy. Upon jail staff discovering the inmate unresponsive, jail medical personnel responded, and lifesaving measures commenced immediately. Lifesaving measures continued by jail staff and jail medical personnel until they were relieved by emergency medical personnel. Inmate welfare checks were conducted timely and in accordance with policy.

Committee Recommendations

- At the time of this incident the medical assessment conducted at booking did not include a urinalysis (UA) unless the inmate reported drug use. Due to the fact that this inmate denied all drug use, a UA was not conducted. The committee recommended requesting UA's as part of the medical assessment on all bookings regardless of reported drug use. The inmate has the right to decline a UA, but the committee nevertheless recommends implementing this request on a trial basis. This change was implemented after the UFR committee meeting.

- There are few cells in the jail that have cameras installed inside the cell. The cells in the lower tier of the D-unit, and one cell at booking are the only cells that have cameras inside. Due to the fact that the inmates with the most acute medical and mental health needs are housed in the D-unit, the committee supports an existing request to add cameras to all cells in the D-unit. A capitol request has been made to the county for this change.

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 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 unexpected fatality, and an associated corrective action plan for the jail to address root causes and recommendations made by the unexpected fatality 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.