



Cowlitz County Corrections Department

Jail Division

1935 1st Avenue Longview, WA 98632



Unexpected Fatality Review Committee Report

2025 Unexpected Fatality Incident

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

**Date of Publication
February 2, 2026**

Table of Contents

Defendant information	2
Incident Overview	2
Committee Meeting Information	3
Committee Members	3
Scope of Review	3
Findings	3, 4
Recommendations	4
Legislative Directive	5
Disclosure of Information	5

Unexpected Fatality Review Committee Report

Defendant Information

The inmate was a 55-year-old male. He was booked into the Cowlitz County Jail at 2200 on June 22, 2025, by Kelso Police Department for Driving Under the Influence and Driving with a License Suspended 2nd degree.

The inmate had been incarcerated in the Cowlitz County Jail two previous times, once in 2024 and once prior in 2025.

Incident Overview

When the inmate was booked, he was initially housed in a holding cell at booking due to his intoxication level. On June 23, 2025, at 1452 the inmate was rehoused to D11 in the medical housing unit with a 30-minute check due to detoxification from alcohol.

At approximately 0430 an officer entered the cell to check on the inmate and found him unresponsive. The officer contacted medical staff to check on him. Medical staff advised the control room officer to call 911 at approximately 0440. Multiple custody staff arrived to assist. Custody staff moved the inmate to the floor to begin life saving measures.

Emergency medical personnel arrived and took over life saving measures. The emergency medical personnel ceased life saving measures and declared the inmate was deceased at approximately 0530. Emergency medical personnel left the housing area, and the scene was preserved pending a death investigation.

The Cowlitz County Sheriffs Office and the Coroner's Office were contacted to conduct a death investigation. The Cowlitz County Coroner's Office conducted an autopsy of the inmate on June 24, 2025, at approximately 1000 hours.

The Cowlitz County Coroner's Office autopsy report listed the manner of death as natural and the cause of death as cardiac arrhythmia secondary to hypertensive cardiovascular disease (heart attack) with chronic obstructive pulmonary disease and chronic alcoholic liver disease as contributing factors.

Unexpected Fatality Review (UFR) Committee Meeting Information

Committee Members

Cowlitz County Corrections Department Director Marin Fox

Mediko Health Service Administrator Maria Roe

Clark County Jail Commander Ken Clark

Cowlitz County Corrections Captain Blain Lux

Committee Review & Discussion

Scope of Review:

- Inmate's completed booking file
- Inmate's 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
- Detectives' investigation report
- Coroner's autopsy 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 housing area, D-unit. The unit/cell had adequate lighting, a functioning emergency call button within the cell, and no known or reported broken or altered fixtures.

Clinical

The committee noted that the initial medical staff to respond did not have a medical code bag and had to return to the medical office to retrieve it. The medical office is located one door away from D-11, so the impact of this was minimal. There were no additional, 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 committee noted that the officer that found the inmate unresponsive did not announce a "code blue" (facilities term for medical emergency) over the radio. Custody staff and medical staff were very near and responded promptly to the area so the impact of this was minimal. There were no additional identifiable operational issues. 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

Custody staff to ensure that medical emergencies are clearly stated on the radio as “code blue” to indicate the nature of the incident to all responding, Medical staff to ensure they bring medical code bags with them to all medical emergencies.

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.