Cowlitz County
Corrections Department

Jail Division

1935 1st Avenue Longview, WA 98632

Unexpected Fatality Review Committee Report

2023 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 50-year-old male. He was booked into the Cowlitz County Jail at 1910 hours on November 2, 2021, by the Cowlitz County Sheriff's Office for one count of Felony Harassment, one count of Intimidating a Witness and a DOC Hold. On December 1, 2021, charges were added for three counts of Rape 1, three counts of Kidnapping 1, two counts of Child Molestation 2, one count of Child Molestation 1, and one count of Commercial Sex Abuse of a Minor.

On July 24, 2022, the inmate was found not competent and was ordered to Western State Hospital for restoration. On April 28, 2023, the inmate was transported to WSH for restoration and returned to the Cowlitz County Jail on July 24, 2023, having been found competent, schizophrenia in remission and with no medication ordered.

The inmate had a long history of unusual, unpredictable behavior as well as violent incidents in custody. Due to this he was designated as a "two officer caution" inmate, which means a minimum of two officers were required to be present for interactions and restraints must be used for all facility movement. This inmate had spent approximately five years incarcerated in the Cowlitz County Jail since 2011.

Incident Overview

At approximately 0900 hours on November 1, 2023, jail administration went to the inmate's cell with the intent to move the inmate to the mental health unit due to the unclean condition of the cell and the mental deterioration of the inmate. The inmate was found naked in a kneeling position on the floor with his hands and head on the lower bunk. Due to the inmate's status as two officer caution, additional officers were called to respond. The inmate was found to be non-responsive and appeared to have large chunks of an orange in his mouth. Medical staff were called to the cell to perform life saving measures and at 0902 hours, 911 was called for medical response.

Emergency medical personnel arrived at 0910 hours and took over lifesaving measures. The emergency medical personnel ceased lifesaving measures and declared the inmate deceased at 0939 hours. 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 approximately 0950 hours to conduct a death investigation. The Cowlitz County Coroners Office conducted an autopsy of the inmate on November 1, 2023, at 1327 hours.

The Cowlitz County Coroner's Office autopsy report listed the manner of death as natural and cause of death as complications of schizophrenia. The autopsy report further listed the complications of schizophrenia as mouth filled with orange, extensive froth throughout airways, drug urine screen negative & history of schizophrenia.

Unexpected Fatality Review (UFR) Committee Meeting Information

Meeting Date: March 8, 2024

Committee Members in Attendance

Cowlitz County Corrections Department Director Marin Fox

Naphcare Health Service Administrator Sandra Farley

Lewis County Sheriff's Captain Chris Tawes

Dr. Radha Sadacharan

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 administrative segregation unit, F-unit. The unit/cell 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 dayroom area of F-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.

Clinical
Inmate was a 50-year-old male with severe mental illness and antisocial personality disorder, incarcerated at Cowlitz County from November 3, 2021 to November 1, 2023. He had been sent to Gage Center for Forensic Excellence (formerly known as Western State Hospital) for restoration April 28, 2023 and returned July 24, 2023; at that point not managed on any medications for his severe mental illness. It appeared he was stable from a behavioral health perspective until September 28, 2023, at

which point, until November 1, 2023 multiple staff members documented a significant change from the inmate's mental health baseline. This was not uncommon for the inmate, but appropriate linkage to mental health was not provided despite the evidence of decompensation.

The autopsy noted to be completed Wednesday November 1, 2023 at 1427 hours. The panel found this turnaround is quite remarkable, and it would be helpful to know if the patient's medical records had been reviewed.

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

Ensure that any significant change from mental health baseline is referred in an urgent fashion, by any personnel (both security and medical) to a mental health provider and confirm that policies for when to alert medical/mental health are in place.

Review the autopsy results and ensure that the final cause of death reported is consistent with the clinical history of the patient.

There are few cells in the jail that have cameras installed inside the cell. The cells in the lower tier of the mental health unit, and one cell at booking are the only cells that have cameras inside. Due to the fact that some inmates with acute medical, mental health & behavioral needs are housed in the F-unit, the committee supports a request to add cameras to all cells in the F-unit.

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.