King County

Department of Adult and Juvenile Detention

Unexpected Fatality Review Committee Report

2025 Unexpected Fatality Incident 25-02349

Report to the Legislature

As required by RCW 70.48.510

Date of Publication: January 13, 2026

Contents

Resident Information

The decedent was a 32-year-old with medical history, including mental health problems and possible asthma, without follow up or use of prescription medications in the community.

On July 3, 2025, the decedent was booked into the King County Correctional Facility (KCCF) for Telephone Harassment, Bomb Threats and Escape 2. The decedent was processed into KCCF per standard practice. A medical prescreening was conducted. The decedent was seen by Jail Health Staff (JHS).

The decedent was verbally uncooperative at booking and made threats to harm staff. Based on DAJD Classification staff's assessment, the decedent was initially housed on E11UB04, in restrictive housing, due to the aforementioned threats.

On August 4, 2025, the decedent was transported to Western State Hospital (WSH) for psychiatric treatment. The decedent returned to KCCF from WSH on September 15, 2025, and was housed on N11LC01, restrictive housing. The decedent was ordered treatment with daily medications started at WSH to treat psychosis and insomnia.

On September 18, 2025, the decedent was assigned to Droplet Precaution Isolation housing on E07UA05 after being seen by JHS for "cold and flu symptoms"; the reported upper respiratory symptoms were assessed as possibly due to viral syndrome including infections with SARS CoV 2 (COVID) and influenza (flu). The decedent was treated for respiratory symptoms and tested for Covid and Flu. The test results were received on September 23, 2025, after the medical event. All viral testing was negative.

Incident Overview

On September 23, 2025, between 1056 and 1156 the decedent was seen walking in the dayroom and talking with another resident at that resident's cell door. The decedent return to his cell at about 1201. The decedent was seen standing at his cell door at approximately 1210.

At approximately 1233, a DAJD officer entered E07UA to conduct a security check. The officer observed through the cell door window that the decedent was is apparent medical distress. The decedent was lying face up on the bunk, with their legs hanging over the side of the bunk. The officer tried to call out to the decedent, but the decedent did not respond. The officer notified the deck officer who called for medical assistance at approximately 1236. As the officers waited for JHS to arrive, they entered the cell and started Cardiopulmonary Resuscitation (CPR) and administered one dose of "Narcan". JHS arrived at approximately 1239. Once JHS arrived, they requested the medical response level to be raised; Central Control called for Seattle Fire Department (SFD) Medical units to respond to the facility. JHS continued

resuscitative measures, including CPR chest compressions, administering oxygen via a mask and supervised two additional doses of "Narcan". SFD Medical units arrived at approximately 1244. At about 1303, the decedent was confirmed to have a pulse, and a SFD medical unit transported the decedent from the KCCF housing area to Harborview Medical Center (HMC).

On September 23, 2025, at about 1657, HMC staff moved the decedent to HMC ICU and HMC medical staff placed a Do Not Resuscitate (DNR) order. HMC staff declared the decedents time of death was 1924 on September 23, 2025.

On September 24, 2025, the King County Medical Examiner (KCME) conducted an autopsy on the decedent (KCME Case # 25-02761). The final autopsy results are listed as pending as of December 22, 2025, due to pending toxicology results.

On October 10, 2025, Seattle Police Department (SPD) reviewed the provided documents and video. In the video from the housing area, the decedent and another resident have an interaction at the other resident's cell door. SPD determined that they would investigate this incident to see if the other resident had provided substances that may have caused the decedent's medical event. The SPD case# is 25-278829. As of January 13, 2026, that investigation is pending completion.

UFR Committee Meeting Information

Meeting dates: September 25, 2025, via virtual conference.

Committee members in attendance

Department of Seattle-King County Public Health, Jail Health Services Division
- Danotra McBride, Jail Health Staff Division Director
- Dr. Ben Sanders, Medical Director
- Dr. Heather Flynn, Senior Jail Health Physician
- Chris Haguewood, Regional Health Administrator

DAJD Administration
- Allen Nance, Director
- Steve Larsen, Deputy Director

DAJD Facility Command Staff
- Lisaye Manning, Facility Commander
- Michael Taylor, Operations Major

DAJD Investigations Unit
- Jennifer Schneider, IIU Commander
- Ernesto Vazquez, SIU Sergeant

Committee Discussion

The potential standard factors for review include the following:

A. Structural
    a. Risk factors present in design or environment.
    b. Broken or altered fixtures or furnishings.
    c. Safety/Security measures circumvented or compromised.
    d. Lighting.
    e. Layout of incident location.
    f. Camera locations.

B. Clinical
    a. Relevant decedent health issues/history.
    b. Interactions with Jail Health Services (JHS).
    c. Relevant root cause analysis and/or corrective action.

C. Operational
    a. Supervision (e.g., security checks, kite requests).
    b. Classification and housing.
    c. Staffing levels.
    d. Video review if applicable.
    e. Presence of contraband.
    f. Training recommendations.
    g. Inmate phone call and video visit review.
    h. Known self-harm statements.
    i. Life saving measures taken.
    j. Use of Force review.

Committee Findings

Structural

There were no internal DAJD structural components deemed to be factors in the death.

Clinical

There were no clinical factors identified that would have impacted the medical response to this event.

Operational

The area of the medical event prior to the incident was fully staffed. Reviewed video and JMS records show that security checks leading up to this event were conducted within policy.

Committee Recommendations

Pending the results of SPD's October 10, and the KCME's September 24, 2025, investigation, there are no identified recommendations based on the reviewed Structural, Clinical or Operational factors.

Legislative Directive
Per RCW 70.48.510

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 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.

(2)(4) No provision of this section 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.