King County

Department of Adult and Juvenile Detention

Unexpected Fatality Review Committee Report

2025 Unexpected Fatality Incident 25-3036

Report to the Legislature

As required by RCW 70.48.510

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Resident Information

The decedent was a 48-year-old male with history of high blood pressure and opioid use disorder.

On December 26, 2025, the decedent was booked into the King County Correctional Facility (KCCF) on warrant for Harassment DV. The decedent was processed into KCCF per standard practice. A medical pre-screening was conducted. The triage nurse documented that the decedent was not currently on any medications, though he reported a history of treatment for opioid use disorder and recent fentanyl use. A urine toxicology screen ordered at booking was negative for opiates. The decedent received medication to diminish symptoms of withdrawal due to the urine toxicology screen showing positive for MMDA, amphetamines, and cocaine. Although the decedent did not report any current withdrawal symptoms, due to a possible risk for withdrawal symptoms, the decedent was recommended to be housed in lower tier housing. The decedent was also scheduled to meet with a substance use disorder specialist and to be evaluated in the medical clinic. Based on DAJD Classification staff's assessment, the decedent was housed in Receiving housing on S09LC.

Incident Overview

On December 30, 2025, at approximately 0601, officers called for medical assistance aŌer finding the decedent unresponsive in their bed in S09LC. JHS code team arrived and found the patient to be pulseless and asked for the medical response to be raised; JHS immediately began life saving measures including CPR, applying an AED and rescue breathing. One dose of Narcan was administered. Three rounds of CPR were completed, with no AED shock advised. Seattle Fire Department (SFD) Medics were called and responded to the facility. Care was transferred to SFD Medics when they arrived, who continued life saving measures. SFD Medics declared the decedent deceased at about 0633.

At approximately 0731 Seattle Police Department (SPD) responded to review the scene. SPD declined to investigate the event but completed an informational case under SPD case #25-380133. At approximately 0837 the King County Medical Examiner's Office (KCME) responded to KCCF. The KCME processed the scene under KCME case #25-3633.

On January 2, 2026, KCME conducted an autopsy on the decedent. There were no preliminary autopsy results, and samples were sent for toxicology examination. The KCME's final report is still pending at this time. This report will be amended with the KCME's final report upon receipt.

UFR Committee Meeting Information

Meeting date: January 12, 2026, via virtual conference

Committee members in attendance

Department of Seattle-King County Public Health, Jail Health Services (JHS) Division

- Danotra McBride, JHS Division Director
- Dr. Alice Tin, JHS 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, Facility Major

DAJD Investigations Unit

- Jennifer Schneider, IIU Commander
- Cameron Walker, SIU Sergeant

Committee Discussion

The potential factors reviewed include:

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

Jail Health Services did not idenϴfy issues or problems with training, supervision/management, personnel, or culture in JHS specifically related to this incident.

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

There are no structural, clinical, or operaϴonal recommendaϴons related to this event.

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.