



Department of Adult and Juvenile Detention

Unexpected Fatality Review Committee Report

2026 Unexpected Fatality Incident 26-01290 Report to the Legislature

As required by RCW 70.48.510

Date of Publication: September 28, 2026

Contents

Resident Information	3
Incident Overview	3
Committee Meeting Information	4
Committee Members	4
Discussion	5
Findings	5
Recommendations	6
Legislative Directive	6
Disclosure of Information	6

Resident Information

The decedent was a 26-year-old with a medical history of opioid and methamphetamine use disorder.

On June 12, 2026, the decedent was booked into the King County Correctional Facility (KCCF) for Investigation of Violation of a Protection Order (DV), Theft of Motor Vehicle, and Possession of a Stolen Vehicle. The decedent was processed into KCCF per standard practice. A medical prescreening was conducted. The decedent was seen by Jail Health Services (JHS) staff and had a urine toxicology screen that was positive for methamphetamines and fentanyl. Based on a clinical review the decedent was recommended to be housed in lower tier housing for anticipated opioid withdrawal. The decedent was prescribed medications that would treat symptoms of withdrawal, and arranged to be seen by a Medication Assisted Therapy (MAT) provider.

On June 12, 2026, the decedent was assigned to group housing on S09LA. The decedent remained in S09LA housing until the medical event.

Incident Overview

On June 26, 2026, at about 2200 the decedent was seen on facility video walking in the dayroom and talking with another residents. At about 2206 the decedent is observed on video crouching over a stool in the dayroom; the decedent appears to ingest by inhalation an unknown substance from the stool seat. The decedent continues to walk around the dayroom and speak with numerous other residents.

At about 2219 the decedent sits on the stool adjacent to his bunk and slumps over the desk attached to the bunks. The decedent is observed sitting up and slumping over several times until the decedent slumps over at about 2224 and does not move further.

At approximately 2252, DAJD officers enter S09LA to conduct a security check and headcount. The officers observed the decedent slumped over the desk and attempted to rouse the decedent. The decedent was unresponsive to the officer shaking and speaking to the decedent. DAJD officers called for assistance via the radio and moved the decedent to the floor in a prone position. DAJD officers started life saving measures. A DAJD officer began chest compressions, and another retrieved the automatic external defibrillator (AED) device. Jail Health Staff (JHS) arrived at 2254 and continued life saving measures including attaching the AED, and administering a total of 3 doses of naloxone, an opioid reversal medication. The AED was attached and a single shock was delivered at 2300.

At approximately 2306 Seattle Fire Department (SFD) arrived on scene. At about 2310 Seattle Medics arrived at KCCF. SFD and Seattle Medics continued life saving

measures. At approximately 2329 on June 26, 2026, Seattle Medics pronounced time of death for the decedent.

On June 27, 2026, at approximately 0143 King County Medical Examiner's (KCME) staff arrived at KCCF. KCME staff processed the scene and left the facility at about 0226 with the decedent.

On June 26, 2026, Seattle Police Department (SPD) was contacted. SPD provided a case number (SPD Case #2026-185413) but declined to attend the scene.

On June 29, 2026, when additional video was reviewed concerning the events surround the decedent's death DAJD contacted SPD to ensure the full information was relayed. SPD stated they would not investigate further.

On June 29, 2026, the KCME conducted an autopsy on the decedent (KCME Case #26-1709).

On July 24, 2026, KCME provided a final autopsy report with toxicology. The listed cause of death was: Acute fentanyl intoxication. The manner of death was classified as "accident".

UFR Committee Meeting Information

Meeting dates: July 30, 2026, via virtual conference.

Committee members in attendance

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

- Danotra McBride, Jail Health Division Director
- Dr. Alice Tin, Medical Director

DAJD Administration

- Allen Nance, Director
- Steve Larsen, Deputy Director

DAJD Investigations Unit

- Jennifer Schneider, IIU Commander
- Mark Hanning, 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

Continue reviewing technology that could facilitate real time monitoring of resident vital signs and/or health status

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.