

King County Department of Adult and
Juvenile Detention

Unexpected Fatality Review Committee Report

2025 Unexpected Fatality Incident 25-02817
Report to the Legislature

As required by RCW 70.48.510

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Contents

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

Resident Information

The decedent was a 70-year-old male with history of hypertension, coronary artery disease and right above the knee amputation.

On November 24, 2025, the decedent was booked into the King County Correctional Facility (KCCF) on Investigation Fugitive (ID). A medical prescreening was conducted. The decedent was seen by Jail Health Staff (JHS) and orders were placed for blood pressure, cholesterol-lowering medications and aspirin, which can be used to prevent heart attacks in individuals with increased risk of heart attack. Orders for the patient to be seen for a follow-up visit in the jail clinic were also placed at that time. Based on DAJD Classification staff's assessment, the decedent was initially housed in Receiving housing on S09LA until the decedent was moved to medical group housing on S07LA on November 26, 2025. This move was in response to decedent's request for shower accommodations due to his amputation, and JHS staff would be able to assist the decedent with this activity of daily living in medical group housing.

Incident Overview

On November 28, 2025, at approximately 0025 the decedent reported chest pain while housed in S07LA. JHS were called and responded to the S07 core area to assess the decedent. At the time, the medical record shows that the decedent's vital signs were within normal limits, and the decedent was cleared to remain in group medical housing. The medical event was cleared at approximately 0030. The decedent was placed on a list to be seen in Clinic for follow-up when Clinic opened later that morning.

At approximately 0300 the decedent experienced a bout of extreme diarrhea. The decedent was moved to E07LC10 which is a single cell housing area on the medical floor. At approximately 0610 the E07 officer was completing a security check and observed the decedent inside E07LC10. The decedent was not responding so the Officer called for assistance from a second Officer. The two Officers entered the cell and found the decedent unresponsive. The S07 Officer called for medical assistance from JHS. JHS responded at about 0623 and began life saving measures. JHS asked for 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 chest compressions and rescue breathing with a bag-valve mask until SFD Medical units arrived. A SFD Medical unit arrived at about 0633, a second SFD Medic unit arrived at about 0639. SFD units continued live saving measures until 0652 when the decedent was declared deceased. Seattle Police Department (SPD) and the King County Medical Examiner's Office (KCME) were notified and responded.

On December 1, 2025, DAJD staff confirmed with the SPD that they would not further investigate this in-custody death due to their determination that this was a medical event. SPD stated their case # 25-349250 would be closed administratively with no further investigation.

On December 1, 2025, KCME conducted an autopsy on the decedent (KCME Case # 25-03323). The final KCME report concluded that the cause of death is due to an upper gastrointestinal hemorrhage due to peptic ulcer disease and deemed the death as natural causes.

UFR Committee Meeting Information

Meeting dates: December 18, 2025, via virtual conference

Committee members in attendance

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

- Danotra McBride, JHS Division Director
- Chris Haguewood, JHS Deputy Division Director
- Dr. Alice Tin, JHS Medical Director

DAJD Administration

- Allen Nance, Director
- Steve Larsen, Deputy Director

DAJD Facility Command Staff

- Lisaye Manning, Facility Commander

DAJD Investigations Unit

- Jennifer Schneider, IIU Commander

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

JHS is exploring protocols that would prompt a nurse to consult with a provider, as well as the process for DAJD staff to notify JHS of when a resident is moved, particularly if it is related to a clinical symptom such as severe diarrhea. JHS did not identify issues or problems with 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

DAJD and JHS will work to implement the JHS clinical observations as appropriate.

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.