OFFICE OF THE
CORRECTIONS
OMBUDS

Monthly Outcome Report
February 2024

Unexpected Fatality Reviews: 5

Case Investigations: 150

Assistance Provided: 27
Information Provided: 71
DOC Resolved: 19
Insufficient Evidence to Substantiate: 10
No Violation of Policy: 23
Substantiated: 0

Intake Investigations: 30

Administrative Remedies Not Pursued: 16
Declined: 4
Lacked Jurisdiction: 7
Person Declined OCO Assistance: 1
Person Released from DOC Prior to OCO Action: 2

Resolved Investigations:

185

Assistance or Information Provided in

65%

of Case Investigations

OCO CASEWORK HIGHLIGHTS

February 2024

Assistance Provided

Reported Concern: Person reported that he is on a religious diet, has a food allergy, and received a health status report (HSR) to accommodate his allergy. Person said that staff has been arguing with him and serving him food he cannot have.
OCO Actions: The OCO reviewed this individual's resolution request and found that DOC said that they removed the HSR because it was a preference and not an allergy. The OCO contacted DOC staff and asked if this individual had been tested for this allergy and confirmed he had not.
Negotiated Outcomes: DOC staff scheduled this person to see his provider to discuss his allergies and determine what he can eat without medical issues. The OCO verified that this individual met with his provider, who ordered labs for allergy testing.

Assistance Provided

Reported Concerns: Person reported DOC staff made them strip down in front of each other in a four-person cell with the door open. DOC infracted them but dismissed the infraction because there was no search report. The person reported DOC staff made a huge mess of the cell, broke his TV, and confiscated a lot of property.
OCO Actions: The OCO requested the video evidence from the date provided and found that the DOC staff did perform a strip search in a four-person cell. The OCO was able to visually identify that the door was open during the strip search and individuals could be seen in the cell removing their clothing. The OCO alerted facility leadership and asked how the facility intends to improve how these searches are conducted. The OCO advised the individual to submit a tort claim for lost and broken property.
Negotiated Outcomes: The facility directed the Emergency Response Team to conduct strip searches with only one incarcerated person in the room and the door must remain closed at all times or an alternative area must be used, such as a holding cell or the ADA shower area. Any other people living in the cell will be seated at the tables, a conference room, or other designated area awaiting their search.

Assistance Provided

Reported Concerns: External person reports concerns about their incarcerated loved one being considered for transfer to another facility. The patient confirmed the concern about being considered for SAGE placement due to medical needs, and voiced his concerns that he could receive the medical care he needs at his current facility without the impact on family and community the transfer would cause.

OCO Actions: The OCO elevated this concern through health services, who reported they were not aware of the patient's concerns about the transfer.

Negotiated Outcomes: After further review at OCO's request, DOC headquarters reversed the transfer decision and found that his current medical needs can be met at his current facility.

Assistance Provided

Reported Concerns: Incarcerated individual reported concerns regarding a negative behavior observation entry (BOE) they received after a strip search.

OCO Actions: The OCO reviewed the incident and spoke with DOC staff regarding the concern.

Negotiated Outcomes: After the OCO spoke with DOC about the concern, an internal memo was sent out to all staff updating the protocol for how officers will conduct strip searches. DOC also changed the BOE from negative to neutral.

Assistance Provided

Reported Concerns: A loved one reports that an incarcerated individual is struggling with their mental health and was told they cannot access a mental health provider for several days. This person also reports that the incarcerated individual does not feel safe at this facility.

OCO Actions: The OCO contacted the facility about this person's mental health concerns. The next day, the OCO spoke with this individual in-person.

Negotiated Outcomes: The facility was able to coordinate a provider from a different facility to come speak with this person the day of the initial outreach. This person received a mental health assessment the same day and was moved to segregation per their request. The individual was then transported to a new facility.

Assistance Provided

Reported Concerns: The individual reported that he had been in the IMU for three weeks and he has not been given his address book or any other personal property. He filed a resolution request but had not received a response.

OCO Actions: The OCO was at this facility and did a cell-front interview with this person the day of the initial intake call. The individual reported their property issue, and the OCO spoke to the sergeant on duty. This office requested that the DOC give the individual his property.

Negotiated Outcomes: The next day the sergeant returned the address book to the incarcerated individual.

Unexpected Fatality Reviews

RCW 72.09.770 requires the Department of Corrections to convene an unexpected fatality review (UFR) committee to review any case in which the death of an incarcerated individual was unexpected, or in any case identified by the Office of the Corrections Ombuds (OCO) for review. The purpose of the unexpected fatality review is to develop recommendations for the DOC and the legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for incarcerated individuals in the DOC's custody.

UFR-23-015: The Unexpected Fatality Review Committee reviewed the unexpected death of a 77-year-old person in October 2023. The Unexpected Fatality Review Committee Report dated February 1, 2024, and the Unexpected Fatality Review Correction Action Plan (CAP) dated February 11, 2024, are publicly available documents.

UFR-23-016: The Unexpected Fatality Review Committee reviewed the unexpected death of a 43-year-old person in October 2023. The Unexpected Fatality Review Committee Report dated February 10, 2024 is a publicly available document.

UFR-23-017: The Unexpected Fatality Review Committee reviewed the unexpected death of a 70-year-old person in October 2023. The Unexpected Fatality Review Committee Report dated February 23, 2024 is a publicly available document.

UFR-23-018: The Unexpected Fatality Review Committee reviewed the unexpected death of a 70-year-old person in October 2023. The Unexpected Fatality Review Committee Report dated February 16, 2024, and the Unexpected Fatality Review Correction Action Plan (CAP) dated February 26, 2024, are publicly available documents.

UFR-23-022: The Unexpected Fatality Review Committee reviewed the unexpected death of a 69-year-old person in October 2023. The Unexpected Fatality Review Committee Report dated February 7, 2024, and the Unexpected Fatality Review Correction Action Plan (CAP) dated February 17, 2024, are publicly available documents.

The Office of the Corrections Ombuds has included these UFR reports and UFR CAPs at the end of this Monthly Outcome Report.

MONTHLY OUTCOME REPORT: FEBRUARY 2024

	COMPLAINT SUMMARY	OUTCOME SUMMARY	CASE CLOSURE REASON
		UNEXPECTED FATALITY REVIEWS	
	Coyote Ridge Corrections Center		
1.	Incarcerated individual passed away while in DOC custody.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-23-017 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. Consultative remarks that do not correlate to the cause of death but should be considered for review by the Department of Corrections: 1. DOC should continue implementing the end-of-life care program.	Unexpected Fatality Review
2.	Incarcerated individual passed away while in DOC custody.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-23-016 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The following recommendations accompanied the report: 1. DOC should look for opportunities to educate community providers on the care and support DOC is able to provide for transplant recipients. 2. DOC should implement the use of interdisciplinary or multidisciplinary care conferences as part of their patient centered medical home model of care delivery.	Unexpected Fatality Review
	Monroe Correctional Complex		
3.	Incarcerated individual passed away while in DOC custody.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-23-015 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The following recommendations were made by the UFR Committee: 1. DOC should conduct a root cause analysis with formal recommendations to support incarcerated individuals' care and prevent similar incidents in the future. 2. Tier checks should be completed and	Unexpected Fatality Review

		documented in accordance with post orders and align with the conditions of confinement. 3. Nursing assessments should be completed and documented in accordance with DOC procedures and nursing standards of practice. Additional recommendations not directly related to the individual's death were included: 1. DOC should consider changing the name of 'tier-checks' to 'wellness-checks' to reinforce the purpose of the checks are to ensure appropriate behavior and wellbeing of the incarcerated individual. 2. DOC has initiated a structured training program for transport officers, focusing on the proper securing of wheelchairs during transport. This training will be maintained on a continuous basis.	
	Stafford Creek Corrections Center		
4.	Incarcerated individual passed away while in DOC custody.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-23-022 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The following recommendations accompanied the report: 1. DOC Health Services should determine if the diagnosis of blood in the urine should be added to the DOC Cancer Care tracker. 2. DOC should develop general guidance for when an advanced practitioner should involve the facility medical director and the care management nurse in patient care. Additional recommendations not directly related to the cause of death: 1. DOC should continue to pursue funding for an electronic health record (EHR) to replace paper files and allow interface with community health systems. 2. DOC should pursue implementation of clinical grand rounds and a peer review program in the coming year.	Unexpected Fatality Review
	Washington Corrections Center		
5.	Incarcerated individual passed away while in DOC custody.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-23-018 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The Committee recommended: 1. DOC Health Services should improve communication and care handoffs with their local community hospitals. 2. DOC Health Services should improve communications and care handoffs between transferring facilities and DOC health services.	Unexpected Fatality Review

CASE INVESTIGATIONS			
	Airway Heights Corrections Center		
6.	The individual reports there was a female staff member who was trying to build a rapport with the individual. He reports that he wrote a letter and the staff person took it home and then gave it to his counselor. He was infracted and sent to the hole. He says it was acknowledged that the staff person manipulated him and does not understand how he was found guilty of the infraction. The individual says the infraction hearing should not have been held until the PREA investigation is complete.	Upon receipt of this concern, the OCO contacted facility leadership. The individual's infractions were removed from their record and the PREA investigation is now complete. This office verified that the employee no longer works for the Department of Corrections.	Assistance Provided
7.	Patient reports concerns about a transfer impacting access to surgery, a need for an HSR for front cuffing due to a medical condition, and potentially a medical hold.	The OCO reviewed the concerns and contacted health services. The patient transferred facilities, so OCO discussed his care with both facility health services managers. Since the patient transferred, DOC agreed to schedule him for an appointment to establish care, as well as an appointment with the local orthopedic specialist. The patient was seen by the specialist and surgery was not recommended at this time. The patient's treatment plan was updated and patient was offered joint injections for pain management and follow up assessments. The OCO was not able to identify evidence to substantiate the surgery had been approved or scheduled prior to transfer. The OCO provided the patient with information about next steps in care plan and how to follow up to report ongoing or worsening symptoms. The patient will be scheduled for a follow up to assess efficacy of treatment and is encouraged to kite medical if he needs to be seen sooner. The OCO confirmed DOC provided an HSR for front cuffing prior to OCO outreach.	Assistance Provided
8.	An incarcerated person reported that they have not been issued an appropriate quantity of clothing.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The incarcerated person did file a resolution request response with the DOC resolution program and received a response which indicated that the issue was resolved through the resolution program.	DOC Resolved
9.	Person reported that they appealed an infraction and never received a response.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and found that DOC did respond to the appeal months after the hearing. WAC 137-28-400 states "the time limitations expressed in these regulations are not jurisdictional and failure to	DOC Resolved

		adhere to any particular time limit shall not be grounds for reversal or dismissal of a disciplinary proceeding.”	
10.	Incarcerated individual relayed concerns regarding delayed release planning.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO confirmed that DOC has resolved this concern prior to OCO involvement as the individual now has a PRD (pending release date) and an approved release plan.	DOC Resolved
11.	Person said that DOC took his hobby box when he was moved within the unit, and that his hobby box is very important to him for reducing stress.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and reached out to this individual’s counselor, who confirmed that his hobby box was returned to him, though some of the items were confiscated per policy.	DOC Resolved
12.	Person reported that he and other individuals in his unit are having issues receiving their orders of religious beads.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed this individual’s resolution request and found that he withdrew his resolution request stating that DOC staff fixed the issue.	DOC Resolved
13.	Incarcerated individual expressed concerns about an infraction they received.	DOC resolved this concern prior to OCO involvement. The OCO confirmed that the infraction is no longer visible on the individual’s disciplinary record.	DOC Resolved
14.	External person reports their loved one has not been able to access medication for an acute illness.	DOC staff resolved this concern prior to OCO action. OCO staff contacted health services medical and were informed of the patient’s treatment plan and consult status. OCO staff provided information to the patient regarding his imaging and specialist consults.	DOC Resolved
15.	Incarcerated individual relayed concerns regarding job placement.	The OCO confirmed that DOC resolved this concern prior to OCO involvement as the individual now has a job.	DOC Resolved
16.	Incarcerated individual relayed concerns regarding a loved one not being an approved visitor.	The OCO provided the individual with information that their loved one will need to reach out to DOC headquarters to check on the status of the visitation application.	Information Provided
17.	The individual reports that DOC is taking deductions for legal financial obligations (LFOs) when he should not owe any LFOs.	The OCO provided information. This office spoke with DOC staff at the facility, who verified that once LFOs are paid off, there may be one or two additional deductions depending on how frequently an individual has qualifying deposits to their spendable accounts. DOC staff confirmed that when this occurs, individuals will always receive refunds. The OCO verified that the individual was refunded for the deductions taken once his LFOs were paid.	Information Provided
18.	Incarcerated individual relayed concerns regarding an infraction.	The OCO informed the individual that DOC headquarters has completed their review of all infractions that were eligible to be overturned based on the September 6th presumptive positive	Information Provided

		memo. The infraction that the individual expressed concerns about was a 752 infraction for a positive urinary analysis (UA). The memo only addressed “drug possession infractions issued over the last two years,” not positive UAs.	
19.	Incarcerated individual relayed concerns regarding not being allowed to order looms.	The OCO provided the individual with information regarding the DOC policy revision process and informed the individual that when DOC policy 440.000 is up for review the individual can submit written policy comments to DOC headquarters regarding recommended changes.	Information Provided
20.	Incarcerated individual reports safety concerns at their new facility placement.	The OCO verified the DOC reviewed the individual’s safety concerns and were unable to substantiate them. The OCO provided information regarding what information is required by DOC to substantiate the safety concerns and how to share that information with the correct DOC staff member.	Information Provided
21.	The incarcerated individual reports that he and his wife have been denied Extended Family Visits (EFVs) because they are unable to produce a marriage certificate. The individual reports they were married in another country which is creating a barrier to obtain documents required for the EFV application. The individual requests information about options to prove the marriage to gain the approval of EFVs.	The OCO provided information about the necessary requirements to qualify for EFVs, and where to request these documents. Per DOC 590.100, Extended Family Visiting, individuals must provide original or certified documentation of marriage license/state registered domestic partnership certificate. This office spoke with DOC staff who verified that a marriage certificate is required for approval of EFVs. If the individual does not have the required document(s), he and his loved one will need to go through the marriage application process as outlined in DOC 590.200, Marriages and State Registered Domestic Partnerships, in order to be considered for EFVs. This office shared information regarding options for accessing documents from another country.	Information Provided
22.	Patient reports concerns about access to electrolysis for gender affirming surgery.	The OCO contacted health services and confirmed the patient is scheduled for weekly on-site hair removal by electrolysis for gender-affirming surgery and also confirmed the surgery is scheduled. This office provided information to the patient about next steps in care plan and how to follow up if appointments are impacted again.	Information Provided
23.	Incarcerated individual relayed concerns regarding misleading information being added to a substance abuse history assessment.	The OCO provided information to the individual that they can file a records request with DOC to review the assessment personally. The OCO also informed the individual that they can appeal the outcome of the assessment to the facility superintendent.	Information Provided
24.	Incarcerated individual relayed concerns regarding an alleged infraction hearing that was held in secret without their presence.	The OCO verified that DOC form 05-093 disciplinary hearing notice/appearance waiver was signed by the individual indicating that they waived their appearance at the hearing. This office	Insufficient Evidence to Substantiate

		also confirmed that it had the same signature the individual utilized to sign previous infraction paperwork, thus there is insufficient evidence to substantiate that the individual did not have notice of the hearing.	
25.	The individual reports that he was put on dry cell watch because a confidential informant let an officer know that he had drugs on him. He reports that he was left living in his own feces and they would not give him a change of clothes or any hygiene.	The OCO reviewed the concern and the level three resolution investigation, and verified the DOC did substantiate that his clothing was not changed daily as it should have been. However, the DOC did not substantiate that he was left in his own feces. Several staff members were interviewed and they all denied he was left in his feces. Without any kind of video evidence or additional eye witness statements to substantiate this claim, this office has insufficient evidence to substantiate the claim. Additionally, in the resolution response, DOC staff stated the dry cell watch checklist had been updated to ensure staff are offering clothing exchange daily.	Insufficient Evidence to Substantiate
26.	Person reports that serial testing was not being done on his living unit where active COVID infections existed.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff contacted DOC staff at the facility and were informed that the unit the person was assigned to did not have active infections. DOC staff confirmed a different unit in the facility was quarantined and serial testing had been completed per the current DOC protocol.	Insufficient Evidence to Substantiate
27.	Incarcerated individual relayed concerns regarding an infraction they received.	The OCO reviewed the infraction materials for a 607 failure to provide urinary analysis (UA) and found that because the individual did not have a valid HSR for an extra hour at the time of the infraction, the infraction elements were substantiated.	No Violation of Policy
28.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found the individual’s behaviors met the infraction elements required by the “some evidence” standard utilized by DOC, thus there was no violation of DOC policy 460.000.	No Violation of Policy
	Cedar Creek Corrections Center		
29.	Loved one relayed concerns regarding a visitation denial.	The OCO verified that DOC resolved this concern prior to OCO involvement as the individual has several visitors now approved.	DOC Resolved
30.	Incarcerated individual relayed concerns regarding having to take the Thinking for a Change program (T4C) at a reentry center.	The OCO provided information about working with their counselor to access T4C prior to their release.	Information Provided
31.	Loved one relayed concerns regarding a visitation denial.	The OCO reviewed the visitation denial and found no violation of DOC policy 450.300 in the denial decision. The OCO also informed the individual of when the visitor can reapply.	No Violation of Policy

32.	Incarcerated individual relayed concerns regarding infractions for failure to provide a urinary analysis (UA) but stated this was due to health reasons.	The OCO was unable to identify a violation of DOC policy. The OCO reviewed the infraction narratives and medical records related to this concern and confirmed that the individual did not have a valid health status report (HSR) at the time of the infractions. For this reason, the issuance of the infractions was allowable under DOC policy 460.000.	No Violation of Policy
	Clallam Bay Corrections Center		
33.	Person reported that he is on a religious diet, has a food allergy, and received a health status report (HSR) to accommodate his allergy. Person said that staff has been arguing with him and serving him food he cannot have.	The OCO provided assistance. The OCO reviewed this individual's resolutions request and found that DOC said that they removed the HSR because it was a preference and not an allergy. The OCO reached out to DOC staff and asked if this individual had been tested for this allergy, and confirmed he had not. DOC staff scheduled him to see his provider to discuss his allergies and figure out what he can eat without medical issues. The OCO verified that this individual met with his provider, who ordered labs for allergy testing.	Assistance Provided
34.	A loved one reports that the individual was approved for a program which is only available at a particular facility. He was approved several months ago and does not understand why his transfer has been delayed this long.	The DOC resolved this concern prior to OCO taking action on this complaint. The OCO reviewed this person's current facility placement and determined he has been transferred to the facility he requested.	DOC Resolved
35.	External person reports their loved one is having trouble accessing the medication assisted treatment program, despite having a qualifying diagnosis.	The OCO provided information to the patient regarding the medication assisted treatment (MAT) program. Currently the protocol is that people with a release date that is greater than six months from admission will be tapered off the medication. Patients with an eligible diagnosis can start the induction process at 90 days from release. The medication portion would be started 6-8 weeks prior to release and will depend on the person's individual treatment plan. The OCO will review the protocol for potential recommendations when it is being revised.	Information Provided
36.	An incarcerated person reported that their headphones were sent by DOC to be replaced under warranty and they would like help getting them back.	The OCO provided information regarding the status of the headphones and the person's options to find out how to pursue compensation if the headphones were destroyed by DOC.	Information Provided
37.	Incarcerated individual expressed concerns about their trans housing protocol.	The OCO provided information to the individual regarding the trans housing protocol in accordance with DOC policy 490.700 and advised the individual that if they are still having problems after their upcoming custody facility review to contact the OCO.	Information Provided

38.	Incarcerated individual relayed concerns regarding allegations that a job termination was racially motivated.	The OCO was unable to find evidence to substantiate the individual's claim. The OCO spoke with DOC and confirmed the individual was terminated from their job because they obtained contraband during their job. The OCO was unable to substantiate the allegation that it was racially motivated.	Insufficient Evidence to Substantiate
39.	Person reported that a book was rejected by the mailroom, and that books related to justice often get rejected. Person wanted to be compensated for the book that he had to send out after getting rejected.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the mail rejection and found that it was rejected due to an unknown substance or contraband being found on the book. DOC Mail for Individuals in Prison 450.100 III. C. states that "mail will be rejected based on legitimate penological interests" and per 450.100, DOC is not required to compensate an individual for rejected books.	No Violation of Policy
40.	Incarcerated individual relayed concerns regarding an infraction they received.	The OCO was unable to identify a violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
	Coyote Ridge Corrections Center		
41.	Person reported DOC staff made them strip down in front of each other in a four person cell with the door open. They infracted them but they dismissed the infraction because there was no search report. They made a huge mess of the cell, and broke his TV and confiscated a lot of their property. Person plans to file tort claim for TV and other property.	The OCO requested the video evidence from the date provided and found that the DOC staff did perform a strip search in a four person cell. The OCO was able to visually identify that the door was open during the strip search and individuals could be seen in the cell removing their clothing. The OCO alerted facility leadership and asked how the facility intends to improve how these searches are conducted. The facility directed the Emergency Response Team to conduct strip searches with only one incarcerated person in the room and the door must remain closed at all times or an alternative area must be used, such as a holding cell or the ADA shower area. Any other people living in the cell will be seated at the tables, a conference room, or other designated area awaiting their search. The OCO advised the individual to submit a tort claim for lost and broken property.	Assistance Provided
42.	Individual reported DOC is not allowing individuals to use the Securus app during count times unlike the higher custody level, MI3.	The OCO contacted the facility leadership regarding this concern. The facility is working with Securus to fix the issue.	Assistance Provided
43.	Incarcerated individual relayed concerns regarding frustrations with a delayed transfer.	The OCO confirmed that the individual has since transferred facilities, thus this concern was resolved prior to OCO involvement.	DOC Resolved
44.	Person reported receiving an infraction for a positive urinalysis (UA) test. Person said that per a recent DOC memo, the infraction should be dismissed because it was not sent to the lab for a test.	The OCO provided information. The DOC memo from September 6, 2023, addressed "drug possession infractions issued over the last two years" not positive UAs, and DOC has completed their review of all infractions eligible under that	Information Provided

		memo. Because this person was infracted for a positive UA, not drug possession, the infraction was not eligible for review under the memo.	
45.	Person reported that DOC deducted legal financial obligations (LFO) from money that was sent to him, and that this violates his judgement and sentencing which set up a payment schedule.	The OCO provided information. The OCO reviewed DOC records and confirmed the payment schedule in his judgment and sentencing and that a deduction was made from his account. The OCO reviewed RCW.94a.760 regarding legal financial obligations and how they apply to indigent individuals. The OCO reviewed his resolutions request and spoke with DOC staff, who said that deductions were made because this individual got a job and was no longer considered indigent by DOC. If this individual feels that these LFOs are being deducted incorrectly, he can reach out to the courts.	Information Provided
46.	Incarcerated individual relayed concerns regarding frustrations with classification.	The OCO confirmed that the individual's custody promotion is currently under review but recommended that after the individual is classified, they work with their counselor to transfer to GRE or a reentry center.	Information Provided
47.	The individual reports that he wants to transfer to out of state and is trying to start the process for a transfer but keeps getting new counselors and the process keeps getting interrupted. He reports he qualifies under all the requirements to transfer per DOC 330.600. He has been trying to transfer for three years but it has never gotten to headquarters. He has a letter of support but has a new counselor and a new level. He says they want a letter of support but he has the other qualifications and should not need a new letter.	The OCO reviewed this concern and DOC policy 330.600. This individual will need to discuss the transfer with his new classifications counselor. The counselor will then forward the request to headquarters. DOC does not make the decision for the other state. The receiving state will make the ultimate decision on the approval. While the OCO understands that staffing changes have made this process difficult, the counselor will still be the staff that needs to start the process. The OCO did reach out to the facility to ensure this individual has the opportunity to apply.	Information Provided
48.	Person reported that his family ordered hobby craft supplies through approved vendors, but he was not allowed to have the items because the purchase did not come from his spendable account. Person said that he read through the policy and thought he went through the proper process.	The OCO provided information. The OCO reviewed the response to his resolutions request, which cited DOC 450.120, II, which states, "3. prepaid vendor packages will include merchandise ordered by the offender, prepaid from his/her facility trust account and approved by the superintendent/designee." The OCO shared steps he can take for him to receive hobby craft supplies.	Information Provided
49.	Incarcerated individual relayed concerns regarding the new DOC drug testing policy that was supposed to result in some of the individual's infractions being overturned but the individual has not received a determination notification.	The OCO informed the individual that DOC headquarters has completed their review of all infractions that were eligible to be overturned based on the September 6th presumptive positive memo. The infraction that the individual expressed concerns about was a 752 infraction for a positive urinary analysis (UA). The memo only	Information Provided

		addressed "drug possession infractions issued over the last two years" not positive UAs.	
50.	Person reported that tier representatives received mixed messages from the OCO regarding the use of Securus tablets in the dayroom. Person said that individuals got letters from the OCO stating this office provided assistance, but that DOC has not changed the process yet, and that the OCO did not review all of the concerns that individuals reported.	The OCO provided information. Multiple OCO staff have spoken with the facility leadership and found that there is an issue with the tablets being able to function in the dayroom due to an issue with Securus programming. The OCO confirmed that the facility is working with Securus and has spoken with individuals in the facility to update them on the issue.	Information Provided
51.	An incarcerated person reported that they have been requesting to be sent to work release but DOC will not allow them to go prior to 6 months from their earned release date.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC as timelines are not outlined in DOC policy.	No Violation of Policy
52.	Incarcerated individual expressed concerns about an infraction they received.	The OCO was unable to identify a violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
53.	The individual reports that there is a keep separate between him and another incarcerated person who is his fiancé and would like it to be removed.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The DOC creates keep separates for documented safety and security concerns as deemed appropriate by staff. DOC's decision to uphold the keep separate order falls within DOC 320.180 Separation and Facility Prohibition.	No Violation of Policy
54.	Incarcerated individual relayed concerns regarding an infraction they received.	The OCO reviewed the infraction materials and was unable to identify a violation of DOC policy 460.000. Because the cameras do not have audio recordings, this office is unable to substantiate whether the officer's recollection or the incarcerated individual's recollection is correct. The "some evidence" standard allows just a staff member's statement to substantiate an infraction.	No Violation of Policy
	Mission Creek Corrections Center for Women		
55.	Incarcerated individual reports concerns regarding the community parenting alternative (CPA) application process.	The OCO provided information regarding the CPA application process. The OCO spoke with DOC staff regarding the CPA application process and are continuing conversations regarding access to partial confinement programs. The OCO shared information with the individual about their application and ensured they will be placed into the program soon.	Information Provided
56.	An incarcerated person reports dissatisfaction with the facility they are living at and wishes to be transferred to another facility.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. There was no violation of DOC 300.380 described in the complaint or in the document review conducted.	No Violation of Policy
	Monroe Correctional Complex		

57.	External person reports concerns about their loved one's access to medical care.	The OCO provided assistance by meeting with the patient in person during a facility visit. The patient provided updates and clarified their concern and requested resolution. The patient was transferred and the OCO contacted health services to request the patient be scheduled to establish care at the new facility and to discuss outcome of recent labs and next steps in care plan. DOC agreed to schedule the patient.	Assistance Provided
58.	External person reports concerns about their incarcerated loved one being considered for transfer to another facility. The patient confirmed the concern about being considered for SAGE placement due to medical needs, and voiced his concerns that he could receive the medical care he needs at his current facility without the impact on family and community the transfer would cause.	The OCO provided assistance by elevating this concern through health services, who reported they were not aware of the patient's concerns about the transfer. After further review at OCO's request, DOC headquarters reversed the transfer decision and found that his current medical needs can be met at his current facility.	Assistance Provided
59.	Incarcerated individual reported concerns regarding a negative behavior observation entry (BOE) they received after a strip search.	The OCO provided assistance. The OCO reviewed the incident and spoke with DOC staff regarding the concern. After the OCO spoke with DOC about the concern, an internal memo was sent out to all staff updating the protocol for how officers will conduct strip searches. DOC also changed the BOE from negative to neutral.	Assistance Provided
60.	Patient expressed concerns about another incident where his conditions of confinement were not followed and he was provided plastic, which he used to self harm. He requested the OCO review the incident and contact DOC to make sure his conditions of confinement are followed since he transferred units.	The OCO provided assistance by elevating this concern and requesting resolution. This office discussed the incident with DOC staff who followed up with involved staff. The OCO substantiated that staff accidentally provided plastic as part of a meal tray, and DOC staff reiterated the patient's conditions of confinement for unit staff. DOC staff also discussed the issue with the kitchen to make sure the food trays do not include plastic for this patient moving forward.	Assistance Provided
61.	Person reports he has a rash that is covering his body and has received some treatment for it, but the treatment was not effective. The person is requesting to have his rash treated again.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff reviewed the patient's consults and found he was already referred to a specialist for further evaluation. OCO staff contacted health services to confirm the patient had received the specialist's recommended treatment and had follow up scheduled with the specialist.	DOC Resolved
62.	Incarcerated individual expressed concerns about an infraction they received.	DOC resolved this concern prior to OCO involvement. This infraction is no longer visible on the individual's infraction record as it was dismissed on appeal by DOC.	DOC Resolved

63.	Incarcerated individual relayed concerns regarding placement in IMU due to COVID.	The OCO confirmed that DOC resolved this concern prior to OCO involvement. The individual was released from IMU and returned to their living unit.	DOC Resolved
64.	Person reports he is not receiving dental treatment that was approved. The person also voiced concerns about not receiving durable medical equipment after the one he was issued was broken.	The OCO provided information to the person regarding the status of his outside medical appointments. OCO staff also contacted DOC staff and was informed the requested durable medical equipment had been provided to the patient.	Information Provided
65.	The individual reports that he went on a medical trip to see a specialist and the officer pulled him out of his appointment before it was over. This person reports the doctor did not have time to do an examination or any physical testing.	The OCO confirmed this individual has been rescheduled for another appointment. This office also reviewed the resolution request regarding the staff's conduct and verified that DOC did look further into this issue.	Information Provided
66.	An incarcerated person reached out to the OCO concerned about the outcome of their facility plan.	The OCO provided information regarding their release date and their right to appeal their custody facility plan (CFP).	Information Provided
67.	An incarcerated person reached out to the OCO concerned about release planning.	The OCO provided information regarding their release date.	Information Provided
68.	A loved one reported a staff conduct concern on behalf of an incarcerated individual.	The OCO provided information. The OCO reviewed this individual's resolution request regarding the staff conduct concern and found that it was substantiated at level one. The OCO encouraged this individual to appeal his concern to level two and contact the OCO once he receives a response, if he wants the OCO to review the concern.	Information Provided
69.	An incarcerated person reported to the OCO that they were concerned about an upcoming transfer that was decided by DOC at their last custody facility plan. Person states they have a general safety concern and they state they did not participate fully in program screening resulting in DOC deeming them not appropriate for the program in question.	The OCO provided information regarding what DOC considers at the custody facility plan (CFP). The OCO also verified appropriate screening was done during the process. The OCO also encouraged the incarcerated person to reach out to the appropriate DOC staff should they believe there is a specific safety concern.	Information Provided
70.	Patient reports a concern about being hospitalized related to a medication.	The OCO was unable to identify evidence to substantiate the medication was the cause of the hospitalization. This office contacted health services and requested a records review for the 2023 incident. Medication was assessed for cause and later determined to be safe. The medication was prescribed again and the patient is currently on this medication without complication. The patient requested the OCO ensure any future HSRs for wheelchair use are not removed by DOC, and this office provided information about how to follow up if this occurs.	Information Provided

71.	Person reported that he had a hearing with the Indeterminate Sentence Review Board (ISRB) and had an attorney present. Person said he wanted to appeal the decision and has a disability which makes it difficult to write the appeal by himself, but is not allowed to have any help from DOC staff or other incarcerated individuals in writing the appeal.	The OCO provided information. The OCO reviewed DOC and ISRB records and reached out to DOC staff, who said that a DOC contract attorney should be able to help him, but was not sure if ISRB decisions could be appealed. The OCO reviewed DOC Indeterminate Sentence Review Board 320.100 and RCW 9.95 Indeterminate Sentences, and could not find any evidence that ISRB decisions have an appeal process.	Information Provided
72.	Incarcerated individual relayed concerns regarding frustrations with the custody facility plan.	The OCO confirmed that DOC is currently working to resolve the individual's concern as their current custody facility plan (CFP) is being worked on. The OCO informed the individual that if they are unhappy with the outcome of the CFP, they can appeal the classification decision in the event that headquarters does not approve the good conduct time (GCT) restoration pathway.	Information Provided
73.	Incarcerated individual relayed concerns regarding appealing a care review committee (CRC) decision and not getting a copy of the outcome.	The OCO confirmed with DOC that the individual's CRC appeal is still pending as additional information is needed and informed the individual that a copy of the response will be provided to them.	Information Provided
74.	Incarcerated individual relayed concerns regarding a desire to be screened for a different job.	The OCO reviewed the individual's record and did not see any notation that the individual spoke to their counselor about this desire. The OCO informed the individual that they will need to work with their counselor and attend their next custody facility plan (CFP) to participate and share their request for being screened for different jobs.	Information Provided
75.	Incarcerated individual relayed concerns regarding having issues with a cellmate.	The OCO informed the individual that they will need to speak to their counselor about this concern and request a courtesy move.	Information Provided
76.	Patient reports not receiving a hair removal device (IPL) and is now being told the only option is a waitlist or to purchase the machine via commissary.	The OCO contacted health services and headquarters gender affirming care specialist to gather more information about patient's access to IPL devices and this patient's pathway in particular. The IPLs that were originally passed out to patient were part of a pilot project that is now complete. The OCO confirmed the patient is on a waitlist for the device, which would depend on a patient releasing, transferring from the facility, and that the device they turn in is still in working condition. Since there are limitations to the pilot program, the OCO provided the patient with information about the current pathway for accessing an IPL device through commissary. An HSR for durable medical equipment is not required for this item and it can be purchased the same as electric razors.	Information Provided

77.	Patient reports after a previous OCO case was closed with DOC agreement to re-review the patient through the care review committee (CRC) for disposable cleaning wipes, DOC did not review his case through the CRC. Patient also disagrees with his current pain management access and requested pain management through an addiction specialist.	The OCO contacted health services and confirmed the CRC did re-review the HSR item, which was determined by clinicians as not medically indicated. The OCO confirmed the patient appealed the CRC decision, which was upheld. DOC 600.000 states, "Clinical decisions are the sole province of the responsible health care practitioner and are not countermanded by non-clinicians." This office confirmed the patient was scheduled for pain management and declined the recommended treatment, requesting to be seen by an addiction specialist instead. The OCO confirmed the patient was scheduled for follow up with his primary care provider to discuss additional pain management options and next steps. The OCO provided this information to the patient as well as the pathway for follow up regarding pain management options and MAT program protocol in DOC custody.	Information Provided
78.	Incarcerated individual reports concerns regarding their placement in segregation. The individual reports they require medical care and need to be transferred to a facility that can meet his medical care requirements. The individual also requested information regarding accessing documentation related to his medical care.	The OCO verified the individual was transferred to a facility that meets his care needs. This office also provided the individual with information about how to access information related to his medical care and shared other self advocacy tools to ensure his medical needs are met. The OCO encouraged the individual to utilize the DOC resolutions process and the OCO hotline if he has further concerns related to his medical care.	Information Provided
79.	Person reports DOC is not following the dietary recommendations for people needing a low potassium diet. The person states that there are often incorrect items in his meals and he has to wait for staff to exchange the items.	The OCO provided information to the person regarding changes that were made to food service at his facility. OCO staff contacted the correctional industries (CI) food manager about the diet substitution mistakes. The food preparation at Monroe has moved to Twin Rivers Unit. Thus, any issues with what foods are substituted will be remedied when staff pick up the trays after the meal is finished. This process does take more time than the previous process but will not be impacted by low staffing. The OCO is engaged in ongoing discussions with DOC regarding the menus and dietary guidelines. DOC staff also informed this office of the current collaboration with DOC health services to remedy special diet conflicts.	Information Provided
80.	Incarcerated individual relayed concerns regarding a potential transfer, wanting out from under Indeterminate Sentence Review Board (ISRB) supervision and help with a name change.	The OCO informed the individual that DOC policy 300.380 addresses transfers as they occur per policy. The OCO informed the individual that they will need to work with an attorney for any concerns about the ISRB and underlying conviction. Third, the OCO informed the individual that to complete a legal name change they will need to kite the law library as they will need to go	Information Provided

		through the courts to get a name change and then have that documentation reported to DOC. DOC policy 400.280 advises on the legal name change process and states the individual must go through the court process for this to occur. Once the individual files for a name change, they must give the Department of Corrections written notice of the hearing time and date along with copies of their petition five days before the hearing on the name change in accordance with RCW 4.24.130(2).	
81.	Person states their HIPAA rights were violated by custody staff being present during a discussion about treatment.	OCO staff provided the person with information regarding what would constitute a HIPAA violation and how to submit a complaint to the Department of Health and Human Services.	Information Provided
82.	Loved one relayed concerns regarding DOC ignoring safety concerns regarding placement with a certain cellmate.	The OCO reviewed the individual's resolution history, infraction record and related incident reports and found there is insufficient evidence to substantiate that these safety concerns were expressed prior to the altercation and that DOC ignored any safety concerns.	Insufficient Evidence to Substantiate
83.	Incarcerated individual relayed concerns regarding an infraction they received in which they state they requested the urinary analysis (UA) be sent to the lab but the officer refused.	The OCO contacted the infracting officer who stated that the individual did not request the sample be sent to the lab. For this reason, the OCO was unable to substantiate the individual's concern.	Insufficient Evidence to Substantiate
84.	A person no longer incarcerated with DOC reports he is experiencing retaliation which has resulted in being transferred to an outside facility.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO investigated the transfer and was not able to prove that the transfer was related to DOC staff actions linked close in time to an incarcerated individual's protected action and found no evidence of a clear relationship between the transfer and DOC staff action. Rather, the transfer was a result of court action.	Insufficient Evidence to Substantiate
85.	Person reports concerns about a negative behavior observation entry (BOE).	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the two BOEs and confirmed the individual was provided access to appeal the BOEs, which is noted on the entries. DOC 300.010 Behavior Observations states, "Individuals may challenge the content in a BOE by submitting a written request identifying the information the individual believes inaccurate/incomplete... The CPM/CCS will make the final determination concerning content in a BOE and whether it will be updated, deleted, or remain the same."	No Violation of Policy
86.	The individual reported that he was given an infraction which would disqualify him for Extended Family Visits (EFVs) per policy, but it was reduced to a lesser infraction which would not	The OCO was unable to substantiate a violation of policy by the DOC. This office spoke with DOC headquarters staff who verified that while the disqualifying infraction was reduced, the individual subsequently received and was found guilty of	No Violation of Policy

	disqualify him for EFVs. The individual said that he meets the requirements for participation in EFVs.	several additional serious infractions. Per DOC 590.100, Extended Family Visiting, a multidisciplinary Facility Risk Management Team (FRMT) review must occur after an individual receives any guilty finding for a serious infraction to determine continued eligibility. The OCO verified that the FRMT review recommended the suspension of EFVs for one year from the date of the individual's most recent serious infraction, which was approved by the Superintendent/designee. The individual and his loved one may reapply for EFVs after one year from the date of the infraction(s).	
	Olympic Corrections Center		
87.	A loved one reports that an incarcerated individual is struggling with their mental health, and was told they cannot access a mental health provider for several days. This person also reports that the incarcerated individual does not feel safe at this facility.	The OCO provided assistance. This office contacted the facility about this person's mental health concerns, and the facility was able to coordinate a provider from a different facility to come speak with this person. This person received a mental health assessment the same day and was moved to segregation per their request. The next day, the OCO spoke with this individual in-person, and the individual was transported to a new facility.	Assistance Provided
88.	An incarcerated individual reports that the facility is not allowing him access to a mental healthcare provider. The individual reports that his mental health has been declining and he has been requesting to speak with someone, but the facility says no staff member will be available for several days. Due to the severity of this person's mental health concerns, they are concerned for their well-being.	The OCO provided assistance. This office contacted the facility about this person's mental health concerns, and the facility was able to coordinate a provider from a different facility to come speak with this person. This person received a mental health assessment the same day and was moved to segregation per their request. The next day, the OCO spoke with this individual in-person, and the individual was transported to a new facility.	Assistance Provided
89.	Incarcerated individual relayed concerns regarding being forced to take chemical dependency class.	The OCO reviewed the individual's records and see that they have not yet been assessed, and they first will need to have an assessment and then work with their counselor regarding options after the assessment is completed.	Information Provided
90.	Incarcerated individual relayed concerns regarding asbestos being in the area that incarcerated workers have to handle.	The OCO elevated the concern to the facility management team who verified that DOC has a specialist who comes out to notify them of where asbestos is located to ensure that proper PPE is worn when those areas are worked on. It was also confirmed that only DOC staff work on those areas, not incarcerated individuals.	Information Provided
91.	The incarcerated individual reports concerns about Securus and says the DOC taps into his tablet and controls the volume or ends his game. He reports	The OCO provided information about the Securus trouble tickets this person has submitted. The OCO contacted DOC staff and asked about the kites this person submitted related to Securus.	Information Provided

	that he has submitted multiple trouble tickets about this issue, but Securus does not respond, and the DOC has not scheduled an appointment for him with a Securus technician.	DOC staff reported that this person has sent kites about issues with his mail, but they have not received any requests to schedule an appointment with the Securus technician. This office also checked in with the Securus liaison and they confirmed they have not received any kites from this person requesting an appointment. The OCO encouraged the individual to kite the mailroom staff and request an appointment to speak with a technician from Securus.	
92.	Incarcerated individual relayed concerns regarding having to turn grievances into the dining area where officers often question what one is grieving.	The OCO spoke with facility leadership about this concern, but DOC is unwilling to add resolution boxes to the living units. The OCO relayed this information to the individual.	Information Provided
93.	Incarcerated individual relayed concerns regarding being forced to do a chemical dependency treatment program that was not court ordered.	The OCO informed the individual that DOC can make a clinical recommendation for treatment based on an individual's drug use history, it does not have to be listed in the judgment and sentence.	No Violation of Policy
	Other - Out of State		
94.	A loved one reports that an incarcerated individual needs a copy of his DOC sentence calculations sent out-of-state to another prison.	The OCO provided information about how to make a DOC public records request.	Information Provided
	Stafford Creek Corrections Center		
95.	Patient reports concerns about access to treatment and a delayed biopsy related to cancer.	The OCO contacted health services and confirmed a referral for a fusion biopsy was recommended, scheduled, and occurred. The OCO confirmed the patient's care is being tracked via DOC cancer tracker and provided assistance by requesting the patient be scheduled with his primary care provider to discuss the biopsy results and next steps. This office provided information to the patient about the next steps in his cancer care and how to follow up with the OCO if additional concerns arise around cancer treatment.	Assistance Provided
96.	Patient reports concerns about his medical records being destroyed and no record of him reporting shoulder issues.	The OCO provided assistance by contacting health services about the patient's records and medical concern. DOC agreed to schedule a Multi-Disciplinary Team (MDT) meeting, and this office confirmed the meeting occurred and a plan of care was developed. At that time, an ultrasound was authorized and scheduled, however, the patient transferred facilities. The OCO contacted health services at the new facility to confirm the ultrasound was still scheduled. DOC agreed to and confirmed he was scheduled for an upcoming ultrasound.	Assistance Provided

97.	Patient reports concerns about mental health staff at the facility and wants them to respect his refusal form.	The OCO provided assistance by contacting health services and confirming there is an active mental health refusal form and kites reiterating the patient's refusal. The OCO provided the patient with this confirmation and information about mental health staff's requirement to follow up with the patient if a DOC 13-240 form is submitted for off baseline behaviors he will be seen by mental health. The OCO provided the individual with information about pathways to Residential Treatment Unit (RTU) placement or transfer to another facility if unwilling to work with facility mental health staff but still interested in working with mental health.	Assistance Provided
98.	Patient reports concerns about the way nursing staff open his jumpsuit during insulin line and requested accommodation that considered PTSD triggers.	The OCO provided assistance by contacting health services and asking for resolution. DOC health services agreed to provide an HSR to wear shirt and shorts under the jumpsuit. The patient can attend insulin line with jumpsuit open. The requested resolution of being able to wear only shirt and shorts at insulin line out of cell cannot be met as it is against IMU protocol. The OCO provided the patient with information on how to follow up through mental health and self-advocacy information. The OCO confirmed blood sugar checks and insulin injections are still being offered to the patient.	Assistance Provided
99.	External person reports concerns about their loved one's access to cancer care and requested he be released from prison and receive medical care.	The OCO set up a phone call with the patient to discuss current medical concern and Extraordinary Medical Placement (EMP) process details. The OCO confirmed an EMP was submitted for this patient and is currently in the review process. This office also confirmed the patient is on the cancer tracker, scheduled for follow ups as well as PRCS-PET scan, results will determine next steps in treatment plan. The OCO provided this information directly to the patient along with details on how to follow up with medical and the OCO if new issues arise.	Assistance Provided
100.	Patient reports concerns about a milk allergy that has not been accommodated with a medical diet health status report (HSR).	The OCO provided assistance by contacting health services and requesting the individual receive allergy testing to determine eligibility for medical diet HSR. DOC approved a consult for allergy testing and the OCO confirmed the patient is scheduled with a local provider that provides the specific allergy testing.	Assistance Provided
101.	External person reports their loved one received an inappropriate substitution for his medically ordered diet.	DOC staff resolved this concern prior to OCO involvement. OCO staff reviewed the situation and noted that the kitchen confirmed the substitution made was temporary and due to the original menu item running out and is not a regular practice.	DOC Resolved

102.	Person states he has been waiting for his medical provider to see him about his injured finger. He is requesting to receive treatment and information about his treatment plan.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff contacted health services management and were informed of the care plan made with the patient. OCO staff confirmed the patient was referred to a specialist for further evaluation.	DOC Resolved
103.	Incarcerated individual relayed concerns regarding frustrations with release planning.	The OCO confirmed DOC resolved this concern prior to OCO involvement and the reason for the delay has been resolved.	DOC Resolved
104.	The incarcerated individual reports that he is part of AMEND and wanted to share some ideas/recommendations for the DOC. He thinks that incarcerated people should be able to write BOEs on staff (positive, negative, neutral). The individual also thinks that it would be a good idea to rotate staff around the facility frequently so people do not become too comfortable.	The OCO provided information regarding DOC's formalization of AMEND through the WA Way, creation of resource teams and assignment of permanent DOC positions to push toward AMEND related goals.	Information Provided
105.	Patient expressed concerns about not receiving radiation after a 2023 cancer related surgery.	The OCO contacted health services to request review of the patient's post-op recommendations. Radiation was not medically indicated at this time as levels did not meet the level recommended by oncology for radiation treatment. OCO provided information to the patient about when radiation would be indicated and how to follow up with their medical team and the patient care navigator if he has further questions.	Information Provided
106.	Person said that he was told he is mild/high risk to reoffend and needs to take specific programming that was not court ordered. Person said he wanted to know what he did to get assessed at that risk level.	The OCO provided information. The OCO spoke with this individual and reviewed his WA-ONE assessment and found indicators from the events surrounding his conviction that led to his risk level. Regarding DOC requiring him to take programming because of his risk level, DOC 390.600 Imposed Conditions states, "I. The Department may impose conditions or request conditions on eligible causes that relates to the crime of conviction [and] the risk to re-offend."	Information Provided
107.	Person reported that incarcerated individuals have been harassing him and his family, and that the harassment is racially motivated. Person said he wanted to be transferred to a different facility.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed multiple DOC records and resolutions requests showing that he has alerted DOC staff of these concerns multiple times and requested a move out of the unit. The OCO spoke with DOC staff, who shared that they have been keeping a close eye on this individual and have not been able to substantiate that he is being harassed by other incarcerated individuals. DOC staff said that they can recommend that this individual be transferred, but health services will make the final determination. The OCO is working on this	Insufficient Evidence to Substantiate

		individual's concern related to transferring facilities in a separate case. The OCO also reached out to the resolutions specialist, who was not able to substantiate an instance of this individual being harassed and targeted.	
108.	Person reported that he was fired from a correctional industries position due to a health status report (HSR) he had to accommodate a health condition. Person said that his counselor closed all of his job referrals other than one job he would not get hired for.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed DOC records and found that a Facility Risk Management Team (FRMT) met regarding this individual's HSR, and that the individual stated he was trying to get a different job, and the FRMT recommended he be terminated because this position could not accommodate his HSR. The OCO found that this individual's HSR has since expired and that he has an open referral to another position and encouraged him to talk to his counselor about other employment opportunities. The OCO could not find a violation of DOC 700.000 Work Programs in Prisons or 710.040 Correctional Industries Work Programs.	No Violation of Policy
109.	Incarcerated individual relayed concerns regarding deductions that DOC took from a stimulus check.	The OCO was unable to locate a violation of DOC policy. DOC is statutorily required to take the deductions from stimulus checks received from the IRS. Those deductions are made in accordance with state law and 28 U.S.C. § 1918 which DOC must comply with.	No Violation of Policy
110.	Incarcerated individual expressed concerns about an infraction they received as they feel the sanctions are excessive.	The OCO was unable to locate a violation of DOC policy. The OCO reviewed the infraction materials and verified that all of the sanctions are within DOC policy 460.050.	No Violation of Policy
	Washington Corrections Center		
111.	External individual reports concerns regarding an infraction issued to their incarcerated loved one.	The OCO provided assistance. The OCO spoke with the individual about their infraction appeal and determined it was not under review by DOC. The OCO communicated with DOC staff regarding the appeal, and DOC agreed to review it. The infraction appeal is currently under review by the department.	Assistance Provided
112.	Individual has an issue with mailroom staff sharing the content of his mail inappropriately with people outside the prison.	The OCO asked the facility to investigate this concern. The investigations department at the facility interviewed individuals and followed up with the names of staff they were given by the population.	Assistance Provided
113.	Incarcerated individual followed up with the OCO. Previously, the OCO was told DOC would allow the individual to resubmit an infraction appeal even though it was now outside of the	The OCO contacted the individual's new facility and requested assistance be provided to the individual to ensure the resubmitted appeal get sent to the proper facility. DOC confirmed that the resubmitted appeal has been sent.	Assistance Provided

	timeframes. At this time, the individual is now having difficulties getting the resubmitted appeal to the proper facility.		
114.	Incarcerated individual reports they are living in a higher custody level unit than their custody points reflect. The individual reports they are eligible to go to camp and wish to transfer.	DOC resolved this concern prior to OCO action. The OCO spoke with the individual's classification counselor who shared the individual agreed to move to the facility to obtain a specific job available. Prior to OCO outreach, the individual expressed in his Custody Facility Plan meeting that he would like to transfer to a camp setting and DOC approved and completed the transfer.	DOC Resolved
115.	External person reports concerns about their incarcerated loved one's access to a specialist for ongoing choking, difficulty eating, and swallowing.	The OCO confirmed DOC scheduled the patient for an offsite swallow study and PCP follow up. The patient is also scheduled for an offsite consult with a gastroenterologist. The OCO provide information about OCO's review and the person's options for next steps if not resolved via appointments. This office also shared information about how to contact OCO directly since complaint was from a loved one and there is no related DOC resolution request on file for 2023. The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Information Provided
116.	Incarcerated individual relayed concerns regarding expressing safety placement concerns but staff is not willing to discuss them further.	The OCO reviewed the individual's file and confirmed that they were demoted custody levels per DOC policy 300.380 and verified that their safety concerns were reviewed and determined to not be verified. The OCO informed the individual that if they are experiencing safety concerns they will need to provide their counselor or I&I with a written statement naming the individuals who are posing a safety risk to them.	Information Provided
117.	Person reported that he was given the wrong medication at pill line because his name was spelled wrong, and he had an adverse reaction.	The OCO provided information about the resolution request this person filed, and how to file a tort claim with the Department of Enterprise Services.	Information Provided
118.	An individual reports he has made several attempts to contact Securus and they have not responded. He is requesting that Securus replace the content he had on his JPay player or refund his money.	The OCO provided information regarding how to contact Securus. Incarcerated individuals can kite the facility Securus liaison and request to get on a callout to speak with a Securus Representative. Family members can call (972) 734-1111 or (800) 844-6591 to report any issues or problems they are experiencing. The OCO does not have jurisdiction over Securus but is in discussion with DOC regarding their contract with Securus and is bringing issues and concerns from incarcerated individuals to DOC's attention.	Information Provided

119.	Incarcerated individual relayed concerns regarding classification placement.	The OCO informed the individual that they will need to report any safety concerns to the unit staff.	Information Provided
120.	Anonymous information request reported to the OCO. Information was provided at initial contact.	The OCO provided information regarding infractions and timeframes at the initial contact on the phone.	Information Provided
121.	Patient reports concerns about not being able to access the specific mental health medication he was prescribed prior to being in DOC custody.	The OCO reviewed the patient's concerns and found that the patient transferred facilities. OCO confirmed the patient was scheduled with mental health at his new facility to establish care, discussed the outcome of the related DOC Resolution Request (grievance). The patient did not request this medication at this most recent appointment. The OCO provided information to the patient regarding pathway for mental health medication if he changes his mind.	Information Provided
122.	External person reports their loved one has an infection following a dental procedure and was denied emergency evaluation and antibiotics. The patient's condition worsened and he now has to see a specialist.	OCO provided information to the patient. OCO staff reviewed the patient's records and contacted the Chief of Dentistry to request a review of the patient's care. OCO staff provided the patient with information regarding the denial of evaluation and tort claim information. Individuals who have been harmed or who have suffered a loss as a result of negligent actions by a state employee or agency can submit a tort claim to the Office of Risk Management (ORM). ORM is required by law (RCW Chapter 4.92) to receive these claims.	Information Provided
123.	A loved one reported concern with an incarcerated individual's custody level and placement in solitary confinement, even after an infraction was reduced. The individual also wrote to the OCO stating that he wanted to be placed in medium custody.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed multiple Custody Facility Plans and found that this individual requested an override to medium custody, and that it was denied because of the nature of the infraction behavior and a previous override to medium. This office found in his most recent Custody Facility Plan that he was demoted to maximum custody and placed in solitary confinement because he refused housing in general population options. The OCO reached out to DOC Headquarters Classification regarding his maximum custody placement and other potential options, and they explained that there were no options for him other than general population close custody, which he refused. The OCO could not find a violation of DOC 300.380 Classification and Custody Facility Plan Review.	No Violation of Policy
124.	Incarcerated individual expressed concerns about an infraction they received.	The OCO was unable to find a violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
125.	Incarcerated individual relayed concerns regarding the termination of visitation privileges.	The OCO was unable to locate a violation of DOC policy. The OCO confirmed the visitation was terminated because the visitor brought in	No Violation of Policy

		contraband in violation of DOC policy 450.300(VIII)(B) "persons identified as being involved in attempting/conspiring to introduce or aiding and abetting another to introduce contraband, in any way, will have their visit privileges suspended or terminated."	
126.	Person reported concerns regarding his safety during a long transport due to a medical condition. The person is also concerned the facility that he is being sent to cannot meet his medical needs and is too far from a hospital to feel safe.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed the person's custody facility plan and transfer order and noted that the transfer was reviewed by the facility medical director and the person's institution assignment was made with his medical needs in mind.	No Violation of Policy
	Washington Corrections Center for Women		
127.	Patient expressed concerns about being abruptly transferred to MSU without a pathway plan that considers her mental health needs.	The OCO provided assistance by contacting health services about this concern. This office confirmed after outreach, a DOC Multi-Disciplinary Team (MDT) met and developed a placement plan that includes transition and an Individualized Behavior Management Plan (IBMP).	Assistance Provided
128.	An incarcerated individual reports a concern regarding another individual who is not allowed to use their tablet. The person states that the individual is being punished harshly, has issues with staff, is isolated from others, cannot call the Ombuds, and is not allowed to appeal their infractions.	The OCO provided assistance to this individual. This office did a welfare check and had a cell-front conversation with the person. The OCO verified that the individual was housed next to another incarcerated individual in the administrative segregation unit and spoke with the individual about their current concerns. The OCO encouraged this person to communicate with the Ombuds via mail until their phone privileges are restored. This office also suggested this person document all staff misconduct concerns by opening a resolution request each time an incident occurs so the DOC can address misconduct issues. The DOC also agreed to let this person file an appeal for their infraction outside the standard timeframe.	Assistance Provided
129.	A loved one reports that the incarcerated individual is being punished harshly, has issues with staff, is isolated from others, cannot call the Ombuds, and is not allowed to appeal their infractions.	The OCO provided assistance to this individual. This office did a welfare check and had a cell-front conversation with the person. The OCO verified that the individual was housed next to another incarcerated individual in the administrative segregation unit and spoke with the individual about their current concerns. The OCO encouraged this person to communicate with the Ombuds via mail until their phone privileges are restored. This office also suggested this person document all staff misconduct concerns by opening a resolution request each time an incident occurs so the DOC can address misconduct issues. The DOC also agreed to let this	Assistance Provided

		person file an appeal for their infraction outside the standard timeframe.	
130.	External person reports concerns about their incarcerated loved one's access to ADA information, mental health support, and staff conduct issues.	The OCO provided information directly to the patient regarding ADA requests, policies, and how to contact mental health. The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Information Provided
131.	Patient reports concerns about access to surgery, medication, and appointments. Patient requested access to medications previously prescribed for pain management, seizures, and psoriasis.	The OCO contacted health services and confirmed the patient's active prescriptions for pain management, seizures, and psoriasis. This office confirmed surgery and follow up appointments occurred. OCO cannot override prescription orders; according to DOC 600.000 Health Services Management, "Clinical decisions are the sole province of the responsible health care practitioner and are not countermanded by non-clinicians." The OCO provided information about the confirmed prescriptions and how to follow up with providers if medication is not effective.	Information Provided
132.	The individual reports a PREA investigation regarding her cellmate was opened. The individual reports that the cellmate did not report anything and it came about through rumors. The PREA was substantiated even though there was no evidence. They were both infracted, the individual for rape and the cellmate for lying. The cellmates infraction ended up being dropped. She says the PREA is now unsubstantiated but she would like it to be unfounded since there was no evidence.	The OCO reviewed the final PREA investigation and determined that the unsubstantiated finding was accurate based on DOC 490.860. The definition of unsubstantiated in DOC policy states , "Evidence was insufficient to make a final determination that the allegation was true or false."	Information Provided
133.	Individual reports that the DOC is sending her to a male facility as punishment. She is a trans women and a men's facility is not safe for her.	The OCO met in person with this individual regarding their concern. This office has been in contact with the DOC and facility regarding this individuals placement and currently this individual has not been transferred and the custody facility plan does not show a transfer to a male facility.	Information Provided
134.	Patient reports concerns about access to medical care and requested a full body scan, MRI, and outside care for lipoma and spleen issues.	The OCO contacted health services to review the patient's access to medical care. This office confirmed the patient has received care and a treatment plan for the reported diagnoses and symptoms. Additional testing, specialist follow up, and surgery were not medically recommended. DOC 600.000 Health Services Management states, "Clinical decisions are the sole province of the responsible health care practitioner and are not countermanded by non-clinicians." The OCO cannot recommend medical services that are not	Information Provided

		medically indicated. The OCO provided information about the patient's pathway for follow up, reporting new and ongoing symptoms.	
135.	The individual reports they are unable to obtain an HSR for a lower bunk despite their inability to climb the ladder to the upper bunk.	The OCO provided information about this person's HSR denial. This office also provided information about how to appeal a care review committee (CRC) decision, keeping their provider up to date on their symptoms, and gave an update regarding their physical therapy appointments.	Information Provided
136.	An individual reports they have been in the therapeutic community (TC) program for seven months and has been told that she has to start over from level zero because of an infraction.	The OCO was unable to identify evidence to substantiate there was a violation of policy. DOC 580.000 B. says that individuals who refuse admission, do not complete the treatment program due to their refusal to continue treatment, or are out of compliance with program requirements will be subject to disciplinary action. The OCO verified that this person was transferred to another facility due to an investigation and resulting infraction for threatening a staff member. This incident put her out of compliance with the TC program and is why she had to restart the program.	No Violation of Policy
	Washington State Penitentiary		
137.	External person reports concerns about their loved one's access to medical care.	The OCO provided assistance by meeting with the patient in person during a facility visit. The patient provided updates and clarified their concern and requested resolution. The patient was transferred and the OCO contacted health services to request the patient be scheduled to establish care at the new facility and to discuss outcome of recent labs and next steps in care plan. DOC agreed to schedule the patient.	Assistance Provided
138.	Patient reported a mental health self-harm emergency and said the emergency call button wasn't working, he was stuck in the yard and staff were not helping escort him to a holding cell as he had requested.	The OCO contacted health services and requested immediate mental health emergency follow up. DOC agreed to send the mental health emergency responder to meet with the patient.	Assistance Provided
139.	Person reported that he was denied a classification appeal form and envelope and was not provided with a copy of his Custody Facility Plan.	The OCO provided assistance. The OCO reviewed DOC records and found that this individual was moved to a different unit. The OCO reached out to the classification counselor, who provided this individual with the appeal form and envelope, and copies of his last two Custody Facility Plans.	Assistance Provided
140.	The individual reports that he has been in the IMU for three weeks and he has not been given his address book or any other personal property. He has filed a resolution request but has not received a response.	The OCO provided assistance. The OCO was at this facility and interviewed this person. The individual reported their property issue, and the OCO spoke to the sergeant on duty about this concern. The next day, DOC staff returned the address book to the incarcerated individual.	Assistance Provided

141.	Person reported that his cell was searched, and he was infracted, but the corrections officers did not leave a search report.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and could not find any infractions on record.	DOC Resolved
142.	Incarcerated individual reported concerns regarding access to interpretation services.	The OCO provided the individual with information about language access services. The OCO found that currently the individual has adequate access to translation services. This office shared that DOC headquarters has been working to ensure all individuals needing translation services have access to them as needed and they are not questioned about the request for services. The OCO shared with the individual that interpretation needs can be changed as needed and recommended he work with his classification counselor if changes to his current translation needs are required. The OCO reviewed the individual's file and confirmed that the current noted need for services matches the needs he shared with the OCO.	Information Provided
143.	This person is reporting that the Resolutions Department is not sending back resolution requests as unaccepted. The DOC is asking them to rewrite the resolutions when they are clear and don't need to be rewritten. This is happening throughout the unit and multiple people are experiencing this issue. This person feels like they cannot use the resolution process to fix anything.	The OCO reviewed this concern and contacted the facility. The facility leadership shared with the OCO, that they are currently working on adding more support to the Resolutions Department by adding new staff. This office will continue to monitor the concerns at this facility regarding the Resolutions Program.	Information Provided
144.	Incarcerated individual expressed concerns about an individual passing away in his unit and requested OCO review of the incident.	The OCO provided information about the Unexpected Fatality Review (UFR) Committee process and confirmed the reported incident is scheduled for review. RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO will conduct a review of records associated with this individual's death. This case will be reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding committee findings and corrective action plans will be delivered to the Governor and state legislators. It will also be publicly available on the DOC website and at the end of the OCO Monthly Outcome Report once the report is published.	Information Provided
145.	An incarcerated individual reports concerns regarding a public records	The OCO provided information to this person about the appeal process for public record	Information Provided

	request related to their hospital stay last year and the DOC has told them that no records were found. The person is concerned that DOC is not following policy by properly documenting the shift log.	requests and encouraged this person to contact DOC records again with an appeal. This office spoke with DOC staff who confirmed a logbook is kept during an individual's hospital stay to document who is on shift, and restraint checks.	
146.	Incarcerated individual reports he wants to start the interstate prison compact process in order to transfer to his home state. The person said that he was working with his classification counselor at his previous facility, but since he transferred it seems that he needs to start the process again and DOC staff have not been helpful in this process.	The OCO provided information. This office spoke with DOC staff at the individual's current facility who reported that they have spoken with the individual about the interstate compact and provided information regarding the process. DOC staff verified that the individual will be eligible to apply at his upcoming Facility Risk Management Team (FRMT) review.	Information Provided
147.	Incarcerated individual relayed concerns regarding the new DOC drug testing policy that was supposed to result in some of the individual's infractions being overturned but the individual has not received a determination notification.	The OCO informed the individual that DOC headquarters has completed their review of all infractions that were eligible to be overturned based on the September 6th presumptive positive memo. The infraction that the individual expressed concerns about was a 752 infraction for a positive urinary analysis (UA). The memo only addressed "drug possession infractions issued over the last two years," not positive UAs.	Information Provided
148.	Incarcerated individual expressed concerns about placement in segregation.	The OCO reviewed the individual's custody facility plan and spoke with DOC staff regarding the individual's future plan. He is currently placed in segregation because of his behavior, infraction history, and corresponding custody level. The OCO provided the individual with information regarding the assigned expectations needed in order to work with staff in the future for appropriate placement in a general population setting.	Information Provided
149.	Person reports he has been waiting for surgery and has faced delays in the procedure being scheduled. The patient asked for his concern to remain confidential.	The OCO provided information to the patient. OCO staff placed the patient's consult on the appointment tracker and confirmed the consult was approved and that the surgery had been scheduled. OCO also verified that the patient was pending a Care Review Committee review of his pain management access. OCO staff will continue to monitor the appointment until the procedure has been completed.	Information Provided
150.	Incarcerated individual relayed concerns regarding transfer to a reentry center.	The OCO confirmed that per the individual's most recent custody facility plan (CFP) this person will transfer to a reentry center when they are eligible. This office provided the individual with this information.	Information Provided
151.	Person reported that he has a hernia and DOC has not provided any treatment.	The OCO provided information. The OCO reviewed DOC records and could not find that this individual filed a resolution request regarding a hernia. The OCO found that this individual is scheduled for sick	Information Provided

		call, and if his concerns are not addressed there, the OCO encouraged him to kite Health Services and set up an appointment with his provider. If these steps do not address his concerns, he needs to file a resolution request and appeal it to Level 1 before reaching out to the OCO.	
152.	An incarcerated person expressed concerns regarding their Custody Facility Plan (CFP). The individual also reports they were unable to access a classification appeal in a timely manner, therefore could not meet the appeal timeframes.	The OCO provided the individual with information about how to remain active in their classification planning. This office spoke with DOC staff who explained the department is currently building a new CFP on the individual's behalf that includes their input. The OCO shared this information with the individual and shared how to stay involved with this process.	Information Provided
153.	Incarcerated individual expressed concerns about being infracted for a mental health concern.	The OCO was unable to substantiate this complaint due to insufficient evidence. The OCO conducted a review of the documentation and mental health records, and then interviewed the individual. This office was unable to identify sufficient evidence to substantiate that the individual had been infracted for behaviors associated with a mental health disorder.	Insufficient Evidence to Substantiate
154.	Person reports that he was not given an appropriate cast after being injured. The person request to have the cast replaced with a different material.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff contacted Health Services management and were informed of the type of splint the person was given prior to surgery. OCO staff provided information to the patient about the difference in the use of a splint versus a cast. OCO staff also verified the patient had received surgery and had follow-up scheduled with the surgeon.	Insufficient Evidence to Substantiate
155.	Incarcerated individual expressed concerns about an infraction they received.	The OCO was unable to locate a violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy

	INTAKE INVESTIGATIONS		
	Airway Heights Corrections Center		
156.	An incarcerated person asks that rules for what a librarian can print be changed.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
157.	Incarcerated individual relayed concerns regarding two general infractions they received.	The OCO declined to investigate this concern per WAC 138-10-040(3)(c) due to the nature and quality of the evidence as the hearings for general infractions are not audio recorded.	Declined

158.	Incarcerated individual relayed concerns regarding a request for OCO to provide a document that specifically substantiates their claim that cell confinement as a sanction is a violation of law.	The OCO declined to investigate this concern per WAC 138-10-040(3)(e) as the requested resolution is not within the ombuds' statutory power and authority.	Declined
	Clallam Bay Corrections Center		
159.	Loved one relayed concerns regarding staff conduct.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
160.	An incarcerated person reported that they were worried about being charged multiple times for their property needing to be shipped after being moved by DOC several times in succession.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
	Coyote Ridge Corrections Center		
161.	Loved one relayed concerns regarding staff conduct.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
162.	Incarcerated individual expressed concerns about various nonemergent medical requests.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
163.	Incarcerated individual relayed concerns regarding staff conduct.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
164.	Incarcerated individual relayed concerns regarding a job termination.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
165.	Incarcerated individual relayed concerns regarding not receiving a food package.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued

166.	Incarcerated individual relayed concerns regarding sentencing under the Persistent Offender Accountability Act.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint as the OCO cannot assist an individual with their sentence, other than to ensure accuracy of their time.	Lacked Jurisdiction
	Mission Creek Corrections Center for Women		
167.	Incarcerated individual relayed concerns regarding staff conduct.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
	Monroe Correctional Complex		
168.	An incarcerated person reports legal documents are being returned to the courts and were not accepted by DOC. They are asking the OCO to provide explanations for DOC actions.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
169.	Incarcerated individual relayed concerns regarding staff conduct.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
170.	Incarcerated individual relayed concerns about an infraction.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
171.	Incarcerated individual relayed concerns about staff misconduct.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
172.	Incarcerated person reported concerns regarding OCO staff safety.	As described in WAC 138-10-040(3), the OCO declined to investigate the complaint beyond the intake investigation phase because the nature and quality of evidence was insufficient.	Declined
173.	Incarcerated individual relayed concerns regarding being wrongfully incarcerated.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
	Other - Jail/County/City		
174.	Person incarcerated in a jail facility sent mail to the OCO requesting the OCO forward the mail to another person located in a jail facility.	The OCO informed the individual that per WAC 138-10-040(3)(e) the requested resolution is not within the ombuds' statutory power and authority and thus this concern would not be further investigated.	Declined

175.	Loved one relayed concerns regarding conditions of confinement in Spokane County Jail.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint. The OCO provided the individual with resources they can reach out to in order to assist in this concern.	Lacked Jurisdiction
176.	Incarcerated individual relayed concerns regarding the impact a void statute has on their sentence.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint. The OCO provided the individual with a list of resources the individual can contact to gain the assistance they are seeking.	Lacked Jurisdiction
177.	Incarcerated individual expressed concerns about medical care they received while in county jail.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint. The OCO provided the individual with information of helpful resources who may be able to assist in achieving their desired resolution.	Lacked Jurisdiction
178.	Incarcerated individual expressed concerns about the SCORE jail.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint. The OCO provided the individual with resources who they may be able to contact to get the assistance they are requesting.	Lacked Jurisdiction
	Stafford Creek Corrections Center		
179.	An incarcerated person reported that they have a concern related to the mail room and banking.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
180.	Individual reports staff conduct concern. He reports the officers are not kind to new officers.	The OCO asked the individual if he could elaborate on DOC staff member names. This office needs that information to better review the concern. This person said he would reply but has now been released from custody.	Person Released from DOC Prior to OCO Action
	Washington Corrections Center		
181.	Incarcerated individual relayed concerns regarding the denial of a tort claim.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint. The OCO informed the individual that tort claims are handled by the Department of Enterprise Services which the OCO lacks jurisdiction over and is unable to assist in the event the tort claim is denied.	Lacked Jurisdiction
182.	A loved one reported safety concerns with an incarcerated individual getting transferred to specific facilities.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance

	Washington State Penitentiary		
183.	An incarcerated person reported that they disagree with the prescribed medical treatment they are receiving. States they were injured prior to incarceration with DOC and need different treatment than what DOC is offering. The incarcerated person reached out to the OCO prior to filing any appeals on any Resolution Program solutions they have requested. Additionally, the incarcerated person acknowledges in their report that DOC is providing healthcare, but the incarcerated person disagrees with the medical decisions made by the medical providers they are working with.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
184.	Incarcerated individual relayed concerns regarding legal access.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. The OCO also confirmed with the individual's counselor that they have not expressed these concerns regarding legal access to DOC staff.	Administrative Remedies Not Pursued
185.	Incarcerated individual relayed concerns regarding sentencing calculation.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-015

Report to the Legislature

As required by RCW 72.09.770

February 1, 2024

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
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Unexpected Fatality Review Committee Report

UFR-23-015 Report to the Legislature–600-SR001

Legislative Directive and Governance

RCW 72.09.770 requires the Department of Corrections (DOC) to convene an Unexpected Fatality Review (UFR) Committee to review any case in which the death of an incarcerated individual was unexpected, or in any case identified by the Office of the Corrections Ombuds (OCO) for review.

The purpose of the unexpected fatality review is to develop recommendations for DOC and the legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for incarcerated individuals in DOC's custody.

This report describes the results of one such review and presents recommendations. Within ten days of the publication of this report, DOC must publish an associated corrective action plan. DOC will then have 120 days to implement that plan.

Disclosure of Protected Health Information

RCW 72.09.770 requires DOC to disclose protected health information - including mental health and sexually transmitted disease records - to UFR committee members. Under federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying information to state, federal, or local agencies in the course of conducting audits or evaluations mandated by statute or regulation.

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on January 11, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Arieg Awad, Deputy Chief Medical Officer
- Dr. Zain Ghazal, Administrator
- Patty Paterson, Director of Nursing
- Mark Eliason, Deputy Assistant Secretary
- Rae Simpson, Director – Quality Systems
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager
- Paul Clark, Health Services Manager 3

DOC Office of the Secretary

- Megan Pirie, Director – Person Centered Services

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- Lorne Spooner, Correctional Operations Program Manager

DOC Women's Prison Division

- Deborah Jo Wofford, Deputy Assistant Secretary

DOC Risk Mitigation

- Mick Pettersen, Director

DOC Reentry Division (Reentry Centers)

- Danielle Armbruster, Assistant Secretary
- Scott Russell, Deputy Assistant Secretary
- Susan Leavell, Senior Administrator – Reentry
- Michelle Eller-Doughty, Corrections Specialist 4

DOC Community Corrections Division

- Kelly Miller, Administrator – Graduated Reentry
- Dell-Autumn Witten, Administrator

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director, Office of the Corrections Ombuds
- Elisabeth Kingsbury, Senior Corrections Ombuds - Policy
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

Health Care Authority (HCA)

- Dr. Judy Zerzan, Medical Director

This report includes a summary of the unexpected fatality, committee discussion, findings, and recommendations.

Fatality Summary

Year of Birth: 1946 (77-years-old)

Date of Incarceration: April 2023

Date of Death: October 2023

At the time of his death, this incarcerated individual was housed in a prison facility. The cause of death was end-stage renal disease. The manner of death was natural.

Below is a brief timeline of events leading up to the incarcerated individual's death:

Days prior to death	Event
120 days - 7 days	• The incarcerated individual had specialty medical appointments in the community several times a month and then returned to the prison facility the same day.
2 days	• He was transferred to a new prison facility so he could access the hemodialysis unit. • During transport, his wheelchair tipped backwards in the transport van. He complained of back and neck pain. • Transport staff brought him to the nearest hospital emergency room where he was evaluated and discharged with no urgent medical concerns noted related to his wheelchair tipping over.
Day of death	**Event**
Day 0	• The incarcerated individual found deceased in his cell.

UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee (MRC). The UFR Committee members considered the information from the review in formulating recommendations for corrective action.

A. The DOC MRC reviewed the medical record, the care delivered and provided the following findings and recommendations.

1. The committee found:

a. The incarcerated individual had end stage renal disease being treated with peritoneal dialysis.

b. A community nephrologist recommended that he transition from peritoneal dialysis to hemodialysis within seven days of his visit because he was not thriving on the peritoneal dialysis and was not adhering to the treatment regime.

c. There were no community hemodialysis beds available near the facility where the incarcerated individual was housed necessitating a facility transfer.

d. There was a care hand-off between the medical providers at the sending and receiving facilities and from the community nephrologist to the nephrologist that manages the DOC hemodialysis unit.

   i. Discussion included timing of treatment, and

   ii. The need for peritoneal treatment prior to transfer to accommodate the transfer and timelines exceeding the original seven-day recommendation.

e. The incarcerated individual transferred to the inpatient unit that supports the DOC hemodialysis unit.

   i. He was assessed multiple times by medical staff and found to be stable and at his baseline.

f. The care transition was not coordinated seamlessly between the clinical disciplines.

2. The Mortality Review Committee recommended.

   a. A root cause analysis with formal recommendations be completed to support incarcerated individuals' medical care and prevent similar incidents in the future.

B. Independent of the mortality review, DOC conducted a critical incident review (CIR) to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operational procedures. The Unexpected Fatality Committee members reviewed the findings and recommendations of the CIR and have considered this information in formulating the recommendations for corrective action.

1. The CIR found that custody staff documented tier checks and nursing staff documented assessments that were not supported by video evidence. DOC leadership will remediate per Article 8 of the Teamsters 117 Collective Bargaining Agreement.

2. Additional findings and recommendations did not directly correlate to the cause of death and have been remediated per DOC policy 400.110 Reporting and Reviewing Critical Incidents.

C. The Department of Health (DOH) representative agreed with the recommendations and asked how DOC handles coordination of care and the care handoff when there are transitions.

Note: DOC Health Services holds a weekly Medical Transfer Conference which is a case coordination and care conference. In this case, there were several care providers involved including community consultants which made the hand-off more complex. The Mortality Review Committee members were unable to identify specific corrective actions that would prevent a similar situation in the future. A root cause analysis (RCA) was requested to get a deeper look and to determine if there are improvements DOC can make as a care delivery system.

D. The Health Care Authority (HCA) representative offered that it appears the incarcerated individual was not interested in transitioning to hemodialysis prior to his incarceration and chose to continue peritoneal dialysis. Based on his history, his death would have probably still occurred even if he was residing in the community. The HCA representative asked if DOC has enough capacity for an urgent hemodialysis start.

   Note: DOC has the option to send incarcerated individuals to the community hospital for urgent hemodialysis and DOC does this when needed.

E. The OCO representative said they appreciated the ongoing discussion and raised concerns around the documentation of tier checks that could not be validated through video review. The OCO representative recommends DOC change the terminology used from "tier-check" to "wellness-check" to reinforce the purpose of these checks is to ensure appropriate behavior and wellbeing of incarcerated individuals.

   The OCO asked why DOC Health Services has chosen to conduct a failure modes and effects analysis (FMEA) instead of the recommended RCA and whether a final report or a corrective action plan will be shared. Additionally, the OCO representative asked why this incarcerated individual was denied for extraordinary medial placement (EMP) by the Community Custody Board (CCB) and whether CCB includes clinical representation.

   Note: DOC has chosen to conduct a FMEA which expands the scope of a RCA to a comprehensive, system-wide examination that will help identify areas for systemic improvement. The findings from the analysis will be shared with the members of the UFR Committee.

   At the time of the application, the incarcerated individual did not meet the criteria to participate in EMP. The criterion for participation is determined by the court and the CCB, whose chair and members are appointed by the governor in accordance with RCW 9.95.003.

Committee Findings

The manner of the incarcerated individual's death was natural. The cause of death was end-stage renal disease.

Committee Recommendations

1. DOC should conduct a root cause analysis with formal recommendations to support incarcerated individuals' care and prevent similar incidents in the future.
2. Tier checks should be completed and documented in accordance with post orders and align with the conditions of confinement.
3. Nursing assessments should be completed and documented in accordance with DOC procedures and nursing standards of practice.

Consultative remarks that do not correlate to the cause of death but should be considered for review by the Department of Corrections

1. DOC should consider changing the name of “tier-checks” to “wellness-checks” to reinforce the purpose of the checks are to ensure appropriate behavior and wellbeing of the incarcerated individual.
2. DOC has initiated a structured training program for transport officers, focusing on the proper securing of wheelchairs during transport. This training will be maintained on a continuous basis.

Unexpected Fatality Review DOC Corrective Action Plan

Unexpected Fatality UFR-23-015

Report to the Legislature

As required by RCW 72.09.770

February 11, 2024

DOC Corrective Action, Publication Number 600-PL001

Cheryl Strange, Secretary
cheryl.strange@doc.wa.gov

Unexpected Fatality Review DOC Corrective Action Plan

DOC Corrective Action Publication Number 600-PL001

Legislative Directive

Engrossed Substitute Senate Bill 5119 (2021)

Unexpected Fatality Review Governance

RCW 72.09.770 requires the Department of Corrections (DOC) to convene an Unexpected Fatality Review (UFR) committee and meeting in any case "in which the death of an incarcerated individual is unexpected, or any case identified by the Office of the Corrections Ombuds." The department is also required to issue a report on the results of the review within 120 days of the fatality and, within 10 days of completion of the review, develop an associated corrective action plan to implement any recommendations made by the review team. The statute took effect July 25, 2021.

The "primary purpose of the unexpected fatality review shall be the development of recommendations to the department and legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for prisoners in the custody of the department."

"'Unexpected fatality review' means 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 jurisdiction of the department, 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 department to address identified root causes and recommendations made by the unexpected fatality review team under this section."

Unexpected Fatality Review Committee Report

The department issued the UFR committee report 23-015 on February 01, 2024 (DOC publication 600-SR001). This document includes the required corrective action plan. The department is required to implement the corrective actions within 120 days from the corrective action plan publication.

Corrective Action Plan

CAP ID Number:	UFR-23-015-1
Finding:	A community nephrologist recommended changing from peritoneal dialysis to hemodialysis within seven days. Transitioning a patient from peritoneal dialysis to hemodialysis in DOC is rare and DOC currently lacks a process by which staff members manage the overall transfer and treatment timeline for patients. The lack of identified process and owner caused a delay beyond the seven-day recommendation.
Root Cause:	DOC's current process for managing nephrology care transitions including transfers of patients from the DOC facility that facilitates peritoneal dialysis to the DOC facility that facilitates hemodialysis was insufficient to provide the necessary care coordination for this case.
Recommendations:	DOC should conduct a root cause analysis with formal process improvement recommendations to support the care of incarcerated individuals who require urgent dialysis and prevent similar incidents in the future.
Corrective Action:	Urgent dialysis services and transition from peritoneal dialysis will be included in a Failure Mode Effects Analysis (FMEA) conducted by DOC HS targeted to improve care timelines.
Expected Outcome:	Increased safety and care outcomes for the incarcerated individuals who require urgent dialysis service and those who transition from peritoneal to hemodialysis.

CAP ID Number:	UFR-23-015-2a
Finding:	The tier check standards were not consistently followed by custody staff when conducting and documenting tier checks.
Root Cause:	Staff did not follow the standards for the tier check.
Recommendations:	Tier checks should be completed and documented in accordance with post orders and align with the conditions of confinement.
Corrective Action:	DOC leadership should pursue progressive discipline per Article 8 of the Teamsters Collective Bargaining Agreement when there is evidence that appropriately trained custody staff are not following post orders and DOC policy.
Expected Outcome:	Increased safety and care outcomes for the incarcerated individuals.

CAP ID Number:	UFR-23-015-2b
Finding:	Nursing staff documented an assessment that was not supported by video

	evidence.
Root Cause:	Nursing staff did not follow DOC procedures and nursing standards of practice.
Recommendations:	Nursing assessments should be completed and documented in accordance with DOC procedures and nursing standards of practice.
Corrective Action:	DOC leadership should pursue progressive discipline per Article 8 of the Teamsters Collective Bargaining Agreement when there is evidence that appropriately trained custody staff are not following post orders and DOC policy.
Expected Outcome:	Increased safety and care outcomes for the incarcerated individuals.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-016

Report to the Legislature

As required by RCW 72.09.770

February 10, 2024

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
cheryl.strange@doc.wa.gov

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Unexpected Fatality Review Committee Report

UFR-23-016 Report to the Legislature–600-SR001

Legislative Directive and Governance

RCW 72.09.770 requires the Department of Corrections (DOC) to convene an unexpected fatality review (UFR) committee to review any case in which the death of an incarcerated individual was unexpected, or in any case identified by the Office of the Corrections Ombuds (OCO) for review.

The purpose of the unexpected fatality review is to develop recommendations for DOC and the legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for incarcerated individuals in DOC's custody.

This report describes the results of one such review and presents recommendations. Within ten days of the publication of this report, DOC must publish an associated corrective action plan. DOC will then have 120 days to implement that plan.

Disclosure of Protected Health Information

RCW 72.09.770 requires DOC to disclose protected health information - including mental health and sexually transmitted disease records - to UFR committee members. Under federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying information to state, federal, or local agencies in the course of conducting audits or evaluations mandated by statute or regulation.

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on January 11, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Arieg Awad, Deputy Chief Medical Officer
- Dr. Zain Ghazal, Administrator
- Patty Paterson, Director of Nursing
- Mark Eliason, Deputy Assistant Secretary
- Rae Simpson, Director – Quality Systems
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Office of the Secretary

- Megan Pirie, Director – Person Centered Services

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- Lorne Spooner, Correctional Operations Program Manager

DOC Women's Prison Division

- Deborah Jo Wofford, Deputy Assistant Secretary
- Paul Clark, Health Services Manager 3

DOC Risk Mitigation

- Mick Pettersen, Director

DOC Reentry Division (Reentry Centers)

- Danielle Armbruster, Assistant Secretary
- Scott Russell, Deputy Assistant Secretary
- Susan Leavell, Senior Administrator – Reentry
- Michelle Eller-Doughty, Corrections Specialist 4

DOC Community Corrections Division

- Kelly Miller, Administrator – Graduated Reentry
- Dell-Autumn Witten, Administrator

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director, Office of the Corrections Ombuds
- Elisabeth Kingsbury, Senior Corrections Ombuds - Policy
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

Health Care Authority (HCA)

- Dr. Judy Zerzan, Medical Director

This report includes a summary of the unexpected fatality, committee discussion, findings, and recommendations.

Fatality Summary

Year of Birth: 1980 (43-years-old)

Date of Incarceration: December 2018

Date of Death: October 2023

At the time of his death, this incarcerated individual was housed in a prison facility. The cause of death was acute cardiorespiratory arrest, acute hypoxic respiratory failure, and severe rapidly progressive interstitial lung disease. The manner of death was natural.

Below is a brief timeline of events leading up to the incarcerated individual's death:

Months/Weeks prior to death	Event
13 months - 9 months	• Initial treatment for shortness of breath. • Imaging and testing completed. • Referred to specialist. • Imaging and testing showed severe restrictive lung disease.
8 months	• Seen by community pulmonologist and formally diagnosed with interstitial lung disease and provided treatment.
7 months - 3 months	• Seen multiple times by primary care provider and pulmonologist for ongoing treatment and monitoring of his condition. • Lung disease progressed despite treatment.
2 months - 1 month	• Seen in follow-up with pulmonologist and admitted to community hospital for 15 days. • Discharged to DOC facility inpatient unit for continued treatment.
Final two weeks	• Increased shortness of breath. • He declined transport to emergency room. • Transferred back to home facility for end-of-life care. • During transport, his oxygen level decompensated, and he was transported back to community hospital and admitted. • He failed to improve with treatment.
Day of death	• Death pronounced in community hospital.

UFR Committee Discussion

Upon request of the Office of the Corrections Ombuds, the UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee. The UFR Committee members considered the information from the review in formulating recommendations for corrective action.

A. The DOC Mortality Review Committee (MRC) reviewed the medical record, the care delivered and provided the following findings and recommendations.

1. The committee found:

   a. The incarcerated individual had a history of heavy smoking (tobacco and methamphetamine). He reported illicit substance use prior to age 14.
   b. He had no documented chronic medical issues and did not seek care prior to his final illness.
   c. He requested to be seen for shortness of breath and was subsequently diagnosed with severe interstitial lung disease.
   d. There was significant weight loss in the year prior to his death and there was no nutritional consult or definitive plan of care to address his weight loss.
   e. He requested to be transferred from the inpatient unit (IPU) to his home facility for end-of-life care where he had the support of friends. Prior to transfer, his condition deteriorated, and he declined an emergency room evaluation.
   f. His condition further deteriorated during transport to his home facility. Upon arrival, medical staff attempted treatment to improve his breathing. His condition did not significantly improve so he was transported via ambulance to the community hospital for stabilization.
   g. His condition continued to deteriorate, and he elected to switch to comfort care and died three days later.
   h. The cause of death was acute on chronic respiratory failure with severe interstitial lung disease.
   i. During one of his hospitalizations, the community hospitalist noted that he needed to be evaluated for a lung transplant after he releases from incarceration in 2025.

2. The Mortality Review Committee recommended:

   a. Conducting a fact finding on why the incarcerated individual was transferred to his home facility when he was clinically fragile.

      Note: DOC Clinical leadership looked into this case further and found the incarcerated individual wanted to return to the facility where his friends resided, and he had support. He was aware he was terminal and wanted to return to his home facility to die.

   b. Acknowledging an opportunity to educate community providers on DOC Health Services treatment levels vs community and that being incarcerated does not eliminate the possibility of being considered for an organ transplant.

B. The Department of Health (DOH) representative appreciates the thoughtful approach and acknowledgement of where the breakdowns occurred. DOH has several programs and wonders how they can support the DOC with their nutrition planning.

Note: DOC has one statewide nutritionist that completes nutritional consults. DOC would welcome a partnership with DOH to support nutrition planning.

C. The Health Care Authority (HCA) representative stated they were not surprised by the weight loss as it is part of this disease. The HCA representative asks if incarcerated individuals are considered for transplant.

Note: DOC will support an individual through the transplant process. There seems to be a misperception by community providers that DOC will not support the individual through the process. Community providers seem to believe that the transplant process will be too complex and difficult to manage during incarceration, placing the incarcerated individual at risk for organ failure. DOC sees that community providers often elect to wait until release for individual to be considered for transplant.

D. The Office of the Corrections Ombuds (OCO) asked if custody staff were advised this was a transport to support his end-of-life care wishes and recommends including custody partners in the handoff discussions, especially the unit supervisor. The OCO representative stated in their experience even when transplants are being considered and DOC does all the required steps, the transplants do not happen for incarcerated individuals. The OCO supports incarcerated individuals having the same access to care as individuals who reside in the community.

Note: DOC is exploring the use of interdisciplinary or multidisciplinary care conferences that will include appropriate custody partners. DOC will continue to support incarcerated individuals needing an organ transplant.

Committee Findings

The manner of the incarcerated individual's death was natural. The cause of death was acute cardiorespiratory arrest, acute hypoxic respiratory failure, and severe rapidly progressive interstitial lung disease.

Committee Recommendations

The UFR Committee did not offer recommendations to prevent a similar fatality in the future.

Consultative remarks that do not correlate to the cause of death but should be considered for review by the Department of Corrections

1. DOC should look for opportunities to educate community providers on the care and support DOC is able to provide for transplant recipients.
2. DOC should implement the use of interdisciplinary or multidisciplinary care conferences as part of their patient centered medical home model of care delivery.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-017

Report to the Legislature

As required by RCW 72.09.770

February 23, 2024

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
cheryl.strange@doc.wa.gov

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Unexpected Fatality Review Committee Report

UFR-23-017 Report to the Legislature–600-SR001

Legislative Directive and Governance

RCW 72.09.770 requires the Department of Corrections (DOC) to convene an unexpected fatality review (UFR) committee to review any case in which the death of an incarcerated individual was unexpected, or in any case identified by the Office of the Corrections Ombuds (OCO) for review.

The purpose of the unexpected fatality review is to develop recommendations for DOC and the legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for incarcerated individuals in DOC's custody.

This report describes the results of one such review and presents recommendations. Within ten days of the publication of this report, DOC must publish an associated corrective action plan. DOC will then have 120 days to implement that plan.

Disclosure of Protected Health Information

RCW 72.09.770 requires DOC to disclose protected health information - including mental health and sexually transmitted disease records - to UFR committee members. Under federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying information to state, federal, or local agencies in the course of conducting audits or evaluations mandated by statute or regulation.

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on January 25, 2024:

DOC Health Services

- Dr. Frank Longano, Chief Medical Information Officer representing the Chief Medical Officer
- Melissa Freeman, Registered Nurse 3
- Dawn Williams, Program Administrator – Substance Abuse Recovery unit
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Office of the Secretary

- Megan Pirie, Director – Person Centered Services

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Eric Jackson, Deputy Assistant Secretary
- Lorne Spooner, Correctional Operations Program Manager
- Rochelle Stephens, Project Manager

DOC Women's Prison Division

- Melissa Andrewjeski, Assistant Secretary
- Deborah Jo Wofford, Deputy Assistant Secretary

DOC Risk Mitigation

- Mick Pettersen, Director

DOC Reentry Division (Reentry Centers)

- Danielle Armbruster, Assistant Secretary
- Scott Russell, Deputy Assistant Secretary
- Susan Leavell, Senior Administrator – Reentry

DOC Community Corrections Division

- Kelly Miller, Administrator – Graduated Reentry
- Dell-Autumn Witten, Administrator

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director, Office of the Corrections Ombuds
- Elisabeth Kingsbury, Senior Corrections Ombuds - Policy
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services
- Ellie Navidson, Nursing Consultant Institutional, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Christopher Chen, Associate Medical Director

This report includes a summary of the unexpected fatality, committee discussion, findings, and recommendations.

Fatality Summary

Year of Birth: 1953 (70-years-old)

Date of Incarceration: November 2004

Date of Death: October 2023

At the time of his death, this incarcerated individual was housed in a prison facility. The cause of death was metastatic renal cell carcinoma. The manner of death was natural.

Below is a brief timeline of events leading up to the incarcerated individual's death:

Day of death	Event
1805 hours	• Cellmate reported concerns for the incarcerated individual.
1806 hours	• Priority radio call was initiated for shortness of breath.
1809 hours	• Staff retrieved AED and Narcan before entering the cell. • Incarcerated individual was found unresponsive on his bed. • Custody transferred him to the ground in preparation for aid.
1810 hours	• Facility medical staff arrived on scene and began rendering aid including Narcan administration and CPR.
1832 hours	• Community emergency medical services arrived and assumed responsibility for care.
1847 hours	• Incarcerated individual was declared deceased by EMS personnel.

UFR Committee Discussion

Upon request of the Office of the Corrections Ombuds (OCO), the Unexpected Fatality Review (UFR) Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee and the DOC Critical Incident Review. The UFR Committee members considered the information from both reviews in formulating recommendations for corrective action.

A. The DOC Mortality Review Committee (MRC) reviewed the medical record, the care delivered and provided the following findings and recommendations.

   1. The committee found:

      a. He did not have an advanced directive or physician orders for life sustaining treatment form on file to document his goals of care wishes.

      b. Lack of an electronic health record creates barriers for care coordination.

c. Care coordination could be improved with primary care staff calling the specialists to discuss treatment.

2. The committee recommended:

   a. DOC Health Services end-of-life care committee create a documentation tool or decision-making matrix for goals of care discussions.

   b. DOC Health Services will work on communication strategies with community care partners as part of their strategic goals for 2024.

   c. Explore opportunities for DOC Health Services to participate in the Washington State Health Information Exchange initiative.

B. Independent of the mortality review, DOC conducted a critical incident review (CIR) to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operational procedures.

1. The CIR found:

   a. The medical response was within policy and procedural framework for a medical emergency response.

   b. The custody response was within policy and procedural guidelines.

   c. The manual suction device in the red bag was not effective. Alternative methods were appropriately employed.

2. The CIR did not recommend corrective actions.

C. The Department of Health (DOH) representative asked if there is a standard procedure for testing medical equipment including tracking and trending equipment failures. They wanted to know if a community 911 response can be initiated prior to medical staff arrival at the emergency. They also requested information regarding the DOC standard for Physician Orders for Life-Sustaining Treatment (POLST) discussions.

Note: DOC Health Services tests medical equipment routinely. The Clinical Services Board evaluates the effectiveness and appropriateness of medical equipment used. Clinical leadership is currently conducting a review of medical emergency response equipment and procedures. Concerns that are noted more than one time are tracked and evaluated for needs to change. When the need is obvious, custody staff call 911 prior to medical staff arrival. DOC is in process of launching an end-of-life care committee, as part of their work, this committee will propose establishment of DOC standards for POLST discussions.

D. The Health Care Authority (HCA) representative asked what supports are available to individuals with a terminal diagnosis like cancer.

Note: End-of-life care patients are generally managed by a physician in the facility inpatient unit (IPU). Some facilities already have contracts with community hospice providers. The new end of life care committee is in process of establishing a palliative care program to further support the wishes and care for incarcerated individuals with a terminal diagnosis.

E. The Office of the Corrections Ombuds representative (OCO) appreciated the conversation and asked if he was being considered for the DOC's Sage unit which is equipped to provide care services for an aging and ill population. The OCO representative asked to hear more about the development of the end-of-life care plan.

   Note: His primary care providers had discussions with the individual about transferring to Sage. However, he felt his current living unit was home, and he did not want to move. The facility Care Management Nurse visited with him in his cell and confirmed that he had everything in place to manage his current needs.

   The DOC end-of-life committee is in its early stages and is currently focused on standardizing the palliative and hospice level of care being provided.

Committee Findings

The manner of the incarcerated individual's death was natural. The cause of death was metastatic renal cell carcinoma.

Committee Recommendations

The UFR committee did not identify any recommendations for corrective action.

Consultative remarks that do not correlate to the cause of death but should be considered for review by the Department of Corrections

1. DOC should continue implementing the end-of-life care program.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-018

Report to the Legislature

As required by RCW 72.09.770

February 16, 2024

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
cheryl.strange@doc.wa.gov

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Unexpected Fatality Review Committee Report

UFR-23-018 Report to the Legislature–600-SR001

Legislative Directive and Governance

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The purpose of the unexpected fatality review is to develop recommendations for DOC and the legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for incarcerated individuals in DOC's custody.

This report describes the results of one such review and presents recommendations. Within ten days of the publication of this report, DOC must publish an associated corrective action plan. DOC will then have 120 days to implement that plan.

Disclosure of Protected Health Information

RCW 72.09.770 requires DOC to disclose protected health information - including mental health and sexually transmitted disease records - to UFR committee members. Under federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying information to state, federal, or local agencies in the course of conducting audits or evaluations mandated by statute or regulation.

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on December 14, 2023:

<u>DOC Health Services</u>

- Dr. MaryAnn Curl, Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

<u>DOC Office of the Secretary</u>

- Megan Pirie, Director – Person Centered Services

<u>DOC Prisons Division</u>

- Jeffrey Uttecht, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- Lorne Spooner, Correctional Operations Program Manager

<u>DOC Reentry Division (Reentry Centers)</u>

- Susan Leavell, Senior Administrator – Reentry

<u>Office of the Corrections Ombuds (OCO)</u>

- Dr. Caitlin Robertson, Director, Office of the Corrections Ombuds
- Elisabeth Kingsbury, Senior Corrections Ombuds - Policy
- EV Webb, Assistant Corrections Ombuds – Investigations

<u>Department of Health (DOH)</u>

- Brittany Tybo, Deputy Director, Office of Nutrition Services

<u>Health Care Authority (HCA)</u>

- Dr. Heather Schultz, Associate Medical Director

This report includes a summary of the unexpected fatality, committee discussion, findings, and recommendations.

Fatality Summary

Year of Birth: 1953 (70-years-old)

Date of Incarceration: October 2023

Date of Death: October 2023

This incarcerated individual was transferred to DOC custody from a county jail significantly ill. He died two weeks later while being cared for in a community hospital. The cause of his death was congestive heart failure, arteriosclerotic cardiovascular disease, and chronic lung disease with pneumonia. The manner of death was natural.

Below is a brief timeline of events leading up to the incarcerated individual's death:

Days prior to death	Event
14 days	• Readmitted to prison • Transported to local community hospital for medical needs
8 days	• Returned from the community hospital
7 days	• Transported to larger community hospital for advanced care
Day of death	• The incarcerated individual died at the community hospital.

UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee (MRC). The UFR Committee members considered the information from the review in formulating recommendations for corrective action.

A. The MRC reviewed the medical record, the care delivered and provided the following findings and recommendations.

1. The committee found:

    a. The incarcerated individual was significantly ill when he arrived at the reception center from the county jail.

    b. DOC was not forewarned about his condition prior to his transfer.

    c. He spent less than a total of 24 hours at the DOC facility.

    d. He was discharged from the local community hospital back to the prison without warning after DOC health services staff advised they were unable provide the level of care necessary.

    e. His hospital treatment was complicated by his age and his existing chronic conditions.

f. His condition continued to deteriorate, and his family chose to switch his treatment to comfort care.
g. DOC health care staff responded appropriately when confronted with a seriously ill incarcerated individual upon arrival.
h. DOC does not have a system to communicate regularly with all of the county jails and other detention centers that regularly send people to the reception centers.

2. The Mortality Review Committee recommended exploring opportunities to discuss medical hand-off of significantly ill individuals with county jails beginning with the county responsible for this incarcerated individual.

B. The Department of Health (DOH) representative agreed that an improvement in communications when an individual is being transferred to a DOC facility is needed. If DOC knew in advance this individual was significantly ill, there could have been a different and quicker response and treatment. The DOH representative acknowledged that the UFR Committee's scope is limited to care provided by DOC and asked what options DOC has for addressing outside medical providers when their care has not met clinical standards.

Note: When an issue occurs, DOC leadership meets with the transferring entity to discuss the specific case to offer an opportunity for improvement and the resetting of expectations. This is an ongoing need and when DOC notices a pattern, we are able to file a report with the appropriate licensing board.

C. The Health Care Authority (HCA) representative stated they disagreed with the decision of the local hospital to discharge the incarcerated individual when DOC clearly advised that there were not appropriate resources to care for him in their infirmary. The HCA representative concurs that continuing education and improving communication with community caregivers is an important focus for DOC.

D. The Office of the Corrections Ombuds (OCO) representative agreed with DOC's concerns regarding not receiving notification from the county jail prior to the individual's transfer. OCO recommends DOC explore a formal process for transferring seriously ill individuals into DOC from county jails.

Note: The DOC Chief Medical Officer (CMO) met with the county jail involved in this individual's care to discuss the case and identify opportunities for improvement. DOC is working to improve care handoffs and communication with community partners.

The OCO representative also expressed concerns about the individual being inappropriately discharged back to DOC and asked if there has been a conversation with the community hospital.

Note: The DOC CMO discussed this situation with the community hospital leadership. Most DOC facilities meet routinely with their community hospitals, and DOC intends to formalize this process for all facilities. This DOC facility will continue to reach out to their local hospital to educate and reinforce realistic expectations regarding the level of care DOC can provide.

Committee Findings

The manner of the incarcerated individual's death was natural. The cause of death was congestive heart failure, arteriosclerotic cardiovascular disease, and chronic lung disease with pneumonia.

Committee Recommendations

1. DOC Health Services should improve communication and care handoffs with their local community hospitals.
2. DOC Health Services should improve communications and care handoffs between transferring facilities and DOC health services.

Unexpected Fatality Review DOC Corrective Action Plan

Unexpected Fatality UFR-23-018

Report to the Legislature

As required by RCW 72.09.770

February 26, 2024

DOC Corrective Action, Publication Number 600-PL001

Cheryl Strange, Secretary
cheryl.strange@doc.wa.gov

Unexpected Fatality Review DOC Corrective Action Plan

DOC Corrective Action Publication Number 600-PL001

Legislative Directive

Engrossed Substitute Senate Bill 5119 (2021)

Unexpected Fatality Review Governance

RCW 72.09.770 requires the Department of Corrections (DOC) to convene an Unexpected Fatality Review (UFR) committee and meeting in any case "in which the death of an incarcerated individual is unexpected, or any case identified by the Office of the Corrections Ombuds." The department is also required to issue a report on the results of the review within 120 days of the fatality and, within 10 days of completion of the review, develop an associated corrective action plan to implement any recommendations made by the review team. The statute took effect July 25, 2021.

The "primary purpose of the unexpected fatality review shall be the development of recommendations to the department and legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for prisoners in the custody of the department."

"'Unexpected fatality review' means 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 jurisdiction of the department, 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 department to address identified root causes and recommendations made by the unexpected fatality review team under this section."

Unexpected Fatality Review Committee Report

The department issued the UFR committee report 23-018 on February 16, 2024 (DOC publication 600-SR001). This document includes the required corrective action plan. The department is required to implement the corrective actions within 120 days from the corrective action plan publication.

Corrective Action Plan

CAP ID Number:	UFR-23-018-1
Finding:	The local community hospital discharged the incarcerated individual back to DOC after DOC's clinical staff advised they were unable to provide the necessary level of care.
Root Cause:	Premature discharge from the local community hospital to the DOC infirmary resulted in the incarcerated individual being placed at risk and required a hospital readmission.
Recommendations:	DOC Health Services should develop a strategy to help community hospitals understand the level of care that a DOC infirmary is able to provide.
Corrective Action:	DOC Health Services will develop an outreach proposal to partner with their local community hospitals to support care coordination and education.
Expected Outcome:	Increased safety and care outcomes for the incarcerated individuals.

CAP ID Number:	UFR-23-018-2
Finding:	The county jail transferred a seriously ill incarcerated individual to DOC without appropriate care coordination.
Root Cause:	Inadequate communication from county jail.
Recommendations:	DOC Health Services should improve communication and care handoffs between jail facilities and DOC health services.
Corrective Action:	DOC Health Services will develop an outreach proposal to increase communication and support care handoffs with jails.
Expected Outcome:	Improved care outcomes for individuals being transferred from jail to a DOC facility.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-022

Report to the Legislature

As required by RCW 72.09.770

February 7, 2024

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
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Unexpected Fatality Review Committee Report

UFR-23-022 Report to the Legislature–600-SR001

Legislative Directive and Governance

RCW 72.09.770 requires the Department of Corrections (DOC) to convene an unexpected fatality review (UFR) committee to review any case in which the death of an incarcerated individual was unexpected, or in any case identified by the Office of the Corrections Ombuds (OCO) for review.

The purpose of the unexpected fatality review is to develop recommendations for DOC and the legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for incarcerated individuals in DOC's custody.

This report describes the results of one such review and presents recommendations. Within ten days of the publication of this report, DOC must publish an associated corrective action plan. DOC will then have 120 days to implement that plan.

Disclosure of Protected Health Information

RCW 72.09.770 requires DOC to disclose protected health information - including mental health and sexually transmitted disease records - to UFR committee members. Under federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying information to state, federal, or local agencies in the course of conducting audits or evaluations mandated by statute or regulation.

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on December 28, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Zainab Ghazal, Administrator
- Patty Paterson, Director of Nursing
- Rae Simpson, Director – Quality Systems
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Office of the Secretary

- Megan Pirie, Director – Person Centered Services

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Eric Jackson, Deputy Assistant Secretary
- Lorne Spooner, Director, Correctional Services

DOC Women's Prison Division

- Deborah Jo Wofford, Deputy Assistant Secretary
- Paul Clark, Health Services Manager 3

DOC Reentry Division (Reentry Centers)

- Danielle Armbruster, Assistant Secretary
- Scott Russell, Deputy Assistant Secretary

DOC Community Corrections Division

- Mac Pevey, Assistant Secretary
- Dell-Autumn Witten, Administrator

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director, Office of the Corrections Ombuds
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

Health Care Authority (HCA)

- Dr. Heather Schultz, Associate Medical Director

This report includes a summary of the unexpected fatality, committee discussion, findings, and recommendations.

Fatality Summary

Year of Birth: 1954 (69-years-old)

Date of Incarceration: October 1997

Date of Death: October 2023

At the time of his death, this incarcerated individual was housed in a prison facility. The cause of death was metastatic bladder cancer. The manner of death was natural.

Below is a brief timeline of events leading up to the incarcerated individual's death:

Months prior to death	Event
March 2021 - August 2022	• The incarcerated individual complained of urinary symptoms including intermittent blood in his urine. • Treatment provided by primary care practitioner for his symptoms.
September 2022 - October 2022	• Seen for initial consult with urologist who requested advanced diagnostic testing.
January 2023	• Neurology found bladder mass and recommended surgery to remove tumor.
February 2023	• He started complaining of back pain.
March 2023	• He underwent surgery. • Was diagnosed with bladder cancer. • Was advised the tumor was not completely removed. • Urologist recommended additional biopsies in 6 weeks.
April 2023 - July 2023	• Symptomatic treatment for back pain continued including medication and X-ray ordered.
Mid-June 2023	• Second biopsy was conducted through urology. • Results showed the spread of cancer.
Mid-July 2023	• Followed up with Urologist and advised cancer had spread. • Bladder removal was recommended.

Days prior to death	Event
55 days	• Xray completed and showed possible cancer spread to spine. • He was seen in follow-up for backpain. • Diagnosed with spinal cord impingement. • Sent to ER and admitted for treatment including surgery to stabilize spine.
28 days	• Sent to Local ER for worsening condition. • Found to be septic. • Transferred to larger hospital for higher level of care.
Day 27 – Day 1	• Hospital provided treatment. • Condition continued to deteriorate. • Healthcare DPOA consulted by hospital staff. • DPOA elected to transition him to comfort care.
Day of death	• Incarcerated individual died at the community hospital.

UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee. The UFR Committee members considered the information from the review in formulating recommendations for corrective action.

A. The DOC Mortality Review Committee (MRC) reviewed the medical record, the care delivered and provided the following findings and recommendations.

1. The committee found:

    a. In addition to the community specialty consultants, the incarcerated individual was under the care of multiple DOC staff and contracted primary care providers in the last 12 -18 months of his life.

    b. DOC staff and contracted primary care providers focused on the diagnoses of benign prostate enlargement and chronic back pain leading to delayed workup for the continued presence of blood in his urine and the ultimate diagnosis of bladder cancer.

    c. The DOC staff and the contracted primary care providers failed to document, in the paper health record, the bladder cancer diagnosis and the severity of the cancer, which delayed the diagnosis of metastatic spread.

    d. Lack of access to X-ray imaging on site caused care delay.

    e. The lack of an electronic health record delays receiving results, makes it difficult to locate consult reports in the chart, and to comprehensively review and trend results to see the holistic picture.

2. The Mortality Review Committee recommended:

    a. A referral to the Unexpected Fatality Committee.

b. A retrospective clinical care review by the Facility Medical Director (FMD).
c. A discussion with statewide FMDs regarding when an advanced practitioner should involve the FMD and the care management nurse in patient care.

B. The Department of Health (DOH) representative expressed appreciation of DOC's deep analysis of the gaps that occurred in this case and asked if there are problems system-wide with the continuity of care and what recommendations could the committee propose to help improve continuity.

   Note: The lack of continuity of care is endemic in the US and not just DOC. In terms of collaboration, DOC must urgently obtain an electronic health record and eliminate the reliance on paper medical files. DOC is a member of the Enterprise Planning Committee formed in spring of 2023. This committee is tasked with creating a common technology solution for electronic health records across the Health and Human Service Coalition agencies.

   In addition, DOC, as a system, has not been funded to have physicians as primary care providers. The advanced practitioners who act as the front-line primary care providers do not have the same level of training in differential diagnostic decision making.

   The DOH representative stated support of DOC EHR implementation and will offer support during the legislative session on bills that will assist DOC with obtaining an electronic health record (EHR).

C. The Health Care Authority (HCA) representative asked what formal process DOC has to provide feedback to a practitioner who didn't understand the need for additional diagnostic workup, and also asked if there is a system in place for practitioners to ask for help when they are unsure about the next treatment steps.

   Note: Each facility has an assigned FMD whose main job is to provide clinical oversight and feedback on an ongoing basis. Most FMDs have daily patient rounding with the advanced practitioners. In addition to the FMD, practitioners also have virtual resources available. DOC Health Services is working on implementing grand rounds and a peer review program. The majority of this individual's diagnostic course occurred during the COVID-19 pandemic. The facility was experiencing extreme staffing shortages for both advanced practitioners and physicians. The vacancies were being filled with contract staff that changed every three months. The Chief Medial Offer and the Deputy Chief Medical Officer were providing support remotely in addition to an FMD from another facility coming onsite every other week. The facility currently has a permanent FMD and Physician 3 as well as several advanced practitioners.

D. The Office of the Corrections Ombuds (OCO) representative asked if there are options to get individuals x-rays when the local x-ray machine is down, and asked if DOC could confirm the x-ray machine at this facility has been repaired.

   Note: DOC always has an option to send incarcerated individuals offsite to a community facility for imaging when necessary. DOC has confirmed the x-ray machine has been repaired.

The OCO representative asked if this individual was included on the DOC Cancer Care Tracker.

Note: DOC does not currently flag blood in the urine (hematuria) for inclusion on the Cancer Care Tracker. The members of the DOC Clinical Services Board will be discussing whether it should be included going forward.

The OCO representative asked about the patient's extraordinary medical placement (EMP) request.

Note: The extraordinary medical placement referral was requested eight days before his death. All documents were received, and the packet was sent for review the day before his death. He died before the request could be reviewed and approved.

The OCO representative asked if there were opportunities to catch the spinal infection sooner.

Note: There were opportunities for nursing to advocate for this incarcerated individual to make his end-of-life more comfortable. DOC Health Services has added nursing leadership as members of the mortality review committee going forward to augment the care reviews with a nursing perspective.

Committee Findings

The manner of the incarcerated individual's death was natural. The cause of death was metastatic bladder cancer.

Committee Recommendations

1. DOC Health Services should determine if the diagnosis of blood in the urine should be added to the DOC Cancer Care tracker.
2. DOC should develop general guidance for when an advanced practitioner should involve the facility medical director and the care management nurse in patient care.

Consultative remarks that do not correlate to the cause of death but should be considered for review by the Department of Corrections

1. DOC should continue to pursue funding for an electronic health record (EHR) to replace paper files and allow interface with community health systems.
2. DOC should pursue implementation of clinical grand rounds and a peer review program in the coming year.

Unexpected Fatality Review DOC Corrective Action Plan

Unexpected Fatality UFR-23-022

Report to the Legislature

As required by RCW 72.09.770

February 17, 2024

DOC Corrective Action, Publication Number 600-PL001

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Unexpected Fatality Review DOC Corrective Action Plan

DOC Corrective Action Publication Number 600-PL001

Legislative Directive

Engrossed Substitute Senate Bill 5119 (2021)

Unexpected Fatality Review Governance

RCW 72.09.770 requires the Department of Corrections (DOC) to convene an Unexpected Fatality Review (UFR) committee and meeting in any case "in which the death of an incarcerated individual is unexpected, or any case identified by the Office of the Corrections Ombuds." The department is also required to issue a report on the results of the review within 120 days of the fatality and, within 10 days of completion of the review, develop an associated corrective action plan to implement any recommendations made by the review team. The statute took effect July 25, 2021.

The "primary purpose of the unexpected fatality review shall be the development of recommendations to the department and legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for prisoners in the custody of the department."

"'Unexpected fatality review' means 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 jurisdiction of the department, 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 department to address identified root causes and recommendations made by the unexpected fatality review team under this section."

Unexpected Fatality Review Committee Report

The department issued the UFR committee report 23-022 on February 07, 2024 (DOC publication 600-SR001). This document includes the required corrective action plan. The department is required to implement the corrective actions within 120 days from the corrective action plan publication.

Corrective Action Plan

CAP ID Number:	UFR-23-022-1
Finding:	A diagnosis of blood in the urine is not automatically included in the DOC Cancer Care tracker and may have been meaningful to diagnose cancer at an early stage for this patient.
Root Cause:	Cancer Care Tracker does not include some diagnostic criteria that might enable DOC HS to identify cancer in early stages.
Recommendations:	DOC Health Services should review the DOC Cancer Care Tracker to decide if a diagnosis of blood in the urine should be included.
Corrective Action:	DOC Health Services Clinical Services Board will determine the criteria for including the diagnosis of blood in the urine to the DOC Cancer Care tracker.
Expected Outcome:	Additional clinical guidance for DOC Health Services staff to support the care of incarcerated individuals.

CAP ID Number:	UFR-23-022-2
Finding:	The Facility Medical Director and the Nurse Care Manager were not actively involved in this incarcerated individual's care.
Root Cause:	There is no written guidance for escalation of cases to the Facility Medical Director or referring to the Nurse Care Manager.
Recommendations:	DOC should develop general guidance for when an advanced practitioner should involve the Facility Medical Director and the Nurse Care Manager in patient care.
Corrective Action:	DOC Health Services Clinical Services Board will develop general guidance for referring cases to the Facility Medical Director (FMD) and Nurse Care Managers.
Expected Outcome:	Improve appropriate escalation of care to reduce barriers to access and delays in response.

The Office of the Corrections Ombuds (OCO) investigates complaints regarding any Department of Corrections' (DOC) actions or inactions that adversely affect the health, safety, welfare, and rights of incarcerated individuals. RCW 43.06C.040. RCW 43.06C.040(2)(k) directs the ombuds to render a public decision on the merits of each complaint at the conclusion an investigation. All cases opened by the OCO are considered investigations for the purposes of the statute. As of March 15, 2022, the OCO opens an investigation for every complaint received by this office. The following pages serve as the public decisions required by RCW 43.06C.040(2)(k).

Case Closure Reason	Meaning
Unexpected Fatality Review	The incarcerated person died unexpectedly, and the death was reviewed by the unexpected fatality review team, as required by RCW 72.09.770.
Assistance Provided	The OCO achieved full or partial resolution of the person's complaint.
Information Provided	The OCO provided self-advocacy information.
DOC Resolved	DOC staff resolved the concern prior to OCO action.
Insufficient Evidence to Substantiate	Insufficient evidence existed to substantiate the concern.
No Violation of Policy	The OCO determined that DOC policy was not violated.
Substantiated	The OCO verified the concern but was unable to achieve a resolution to the concern.
Administrative Remedies Not Pursued	The incarcerated person did not yet pursue internal resolution per RCW 43.06C.040(2)(b).
Declined	The OCO declined to investigate the complaint per WAC 138-10-040(3).
Lacked Jurisdiction	The complaint did not meet OCO's jurisdictional requirements (typically when complaint is not about an incarcerated person or not about a DOC action).
Person Declined OCO Involvement	The person did not want the OCO to pursue the concern or the OCO received no response to requests for more information.
Person Left DOC Custody	The incarcerated person left DOC custody prior to OCO action.

All published monthly outcome reports are available at
https://oco.wa.gov/reports-publications/reports/monthly-outcome-reports.

Abbreviations & Glossary

ADA: Americans with Disabilities Act

AHCC: Airway Heights Corrections Center

ASR: Accommodation Status Report

BOE: Behavioral Observation Entry

CBCC: Clallam Bay Corrections Center

CCCC: Cedar Creek Corrections Center

CI: Correctional Industries

Closed Case Review: These reviews may be conducted by the OCO when a complainant whose case was closed requests a review by the supervisor of the original case handler.

CO: Correctional Officer

CRC: Care Review Committee

CRCC: Coyote Ridge Corrections Center

CUS: Correctional Unit Supervisor

DES: Department of Enterprise Services

DOSA: Drug Offender Sentencing Alternative

EFV: Extended Family Visit

ERD: Earned Release Date

GRE: Graduated Reentry

HCSC: Headquarters Community Screening Committee

HSR: Health Status Report

IIU or I&I: DOC's Intelligence and Investigations Unit ("Intelligence & Investigations")

J&S: Judgment and Sentence

MCC: Monroe Correctional Complex

MCCCW: Mission Creek Corrections Center for Women

OCC: Olympic Corrections Center

Pruno: Alcoholic drink typically made by fermenting fruit and other ingredients.

PULHES-DXTR codes: Washington DOC assigns health services codes to every individual incarcerated in its system. These codes, known as PULHES or PULHES-DXTR codes, are meant to note the presence and severity of various health-related factors, such as medication delivery requirements, mobility limitations, developmental disability, and use of mental health services.

SCCC: Stafford Creek Corrections Center

SOTAP: Sex Offender Treatment and Assessment Program

SVP: Sexually Violent Predator

TC: Therapeutic Community

WaONE: Washington ONE ("Offender Needs Evaluation")

WCC: Washington Corrections Center

WCCW: Washington Corrections Center for Women

WSP: Washington State Penitentiary