OFFICE OF THE
CORRECTIONS OMBUDS

Monthly Outcome Report
April 2024

UNEXPECTED FATALITY REVIEWS: 5

CASE INVESTIGATIONS: 146

- Assistance Provided: 22
- Information Provided: 43
- DOC Resolved: 28
- Insufficient Evidence to Substantiate: 17
- No Violation of Policy: 35
- Substantiated: 1

INTAKE INVESTIGATIONS: 62

- Administrative Remedies Not Pursued: 47
- Declined: 2
- Lacked Jurisdiction: 3
- Person Declined OCO Involvement: 7
- Person Released from DOC Prior to OCO Action: 3

Resolved Investigations:

213

Assistance or Information Provided in

45%

of Case Investigations

OCO Casework Highlights
April 2024

Assistance Provided

Reported Concerns: Incarcerated individual relayed concerns regarding a staff member making an unprofessional comment about veterans and the facility not allowing the Veterans' Pod to have fundraisers.
OCO Actions: For the first concern, the OCO reviewed the resolution for staff misconduct regarding staff's commentary that was removed from the grievance process to be investigated through another process. The OCO spoke with facility leadership about this concern who stated that the facility would be starting a process to notify an individual when a grievance is pulled for an internal investigation. For the second concern, the OCO reviewed the resolution about the fundraiser prohibition. The OCO spoke with DOC staff about this concern who put out a proposal and request for clarification of the policy requirements on the Veteran's fundraisers, thus they are on hold until there is further direction on the policy.
Negotiated Outcomes: The facility will be starting a process to notify an individual when a grievance is pulled for an internal investigation.

Assistance Provided

Reported Concerns: External person reports concerns about their loved one's access to pain management after surgery.
OCO Actions: The OCO elevated the concern through DOC staff. The patient's case was reviewed by the Care Review Committee for consideration of a six-month pain management plan due to the 30-day opioid prescription limit in DOC. More information was provided directly to the patient as far as next steps and health coverage. The patient did not follow up to report additional details to the OCO, so this office provided general information about how to contact OCO to open a case if new issues arise in the future.
Negotiated Outcomes: The OCO confirmed the patient's dose was reduced via tapering and after OCO outreach, the patient was approved and scheduled for an appointment with the DOC pain management specialist.

Assistance Provided

Reported Concerns: The individual reports that a DOC staff member took his coat and forced him to walk back to his unit in the rain because he would not follow a directive. At the time this person called to report the incident, he had not been given a new coat to replace the one that was taken from him.

OCO Actions: The OCO reviewed the video footage from the chow hall and confirmed this individual's coat was taken by a DOC staff member. The OCO reviewed the resolution request and verified that this person was given a replacement coat.
Negotiated Outcomes: The DOC conducted an investigation surrounding this incident. OCO staff spoke with facility leadership who confirmed the staff member was addressed for taking the individual's coat.

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-23-023**:** The Unexpected Fatality Review Committee reviewed the unexpected death of a 69-year-old person in December 2023. The Unexpected Fatality Review Committee Report dated April 12, 2024.

UFR-23-024: The Unexpected Fatality Review Committee reviewed the unexpected death of a 45-year-old person in December 2023. The Unexpected Fatality Review Committee Report dated April 25, 2024.

UFR-23-025: The Unexpected Fatality Review Committee reviewed the unexpected death of a 71-year-old person in December 2023. The Unexpected Fatality Review Committee Report dated April 4, 2024 is a publicly available document, and the Unexpected Fatality Review Correction Action Plan (CAP) dated April 14, 2024, are publicly available documents.

UFR-23-026: The Unexpected Fatality Review Committee reviewed the unexpected death of a 37-year-old person in December 2023. The Unexpected Fatality Review Committee Report dated April 29, 2024.

UFR-24-006: The Unexpected Fatality Review Committee reviewed the unexpected death of an 83-year-old person in January 2024. The Unexpected Fatality Review Committee Report dated April 30, 2024.

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
April 2024

	Complaint Summary	Outcome Summary	Case Closure Reason
		UNEXPECTED FATALITY REVIEWS	
	Airway Heights Corrections Center		
1.	Incarcerated individual reports the death of a person 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-24-006 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 nursing leadership should provide additional training on performing respiratory evaluations and clinical monitoring, 2. DOC Health Services should consider gathering information on the number of individuals declining facility infirmary admission and the reason for the declination, with the goal of decreasing declination rates, 3. DOC Health Services should continue implementation of the Patient Centered Medical Home model and include proactive outreach to individuals with known care needs who are not engaged, and 4. The committee recommends staff clearly document in the health record the information and guidance provided to the incarcerated individual when there is a care declination.	Unexpected Fatality Review
2.	Incarcerated individual died 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-23-023 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 review current religious and person-centered practices regarding end-of-life care and final wishes for their body after death; 2. DOC should explore options to expand access to written material and language translation services for non-English speakers including translating the statewide orientation handbook; 3. DOC should explore options for chaplain resources in multiple language and religions; 4. DOC HS should provide feedback to the community hospital regarding end-of-life decision making for DOC patients; 5. DOC should contact the DOH POLST registry program to explore options for DOH inclusion; 6. DOC should continue to request resources for an electronic health record that supports documentation, scheduling, and electronic communication with community care providers; 7. DOC should develop an informational brochure for community care providers regarding incarcerated individuals' right to direct care decisions; 8. The committee requests the report highlight the need for guardianship resources for Washington state residents and processes/guidelines for individual cases to be expedited.	Unexpected Fatality Review

	Coyote Ridge Corrections Center		
3.	Incarcerated individual died 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-23-025 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 provide education to DOC Health Services (HS) facility staff on the process to evaluate decisional capacity, 2. DOC HS should use a multidisciplinary care team meeting that includes primary care, nursing, and behavioral health team members for individuals with complex medical and mental health needs, 3. DOC ensure appropriate catheter care is being provided to all incarcerated individuals housed in prison facilities, 4. DOC should ensure that all nursing documentation is contained in the health record, 5. DOC should request the residential treatment unit workgroup require a multidisciplinary team when transferring an individual and develop an orientation and training to address impacts of transfer to other settings, and 6. DOC should continue to pursue an electronic health record to support care transitions.	Unexpected Fatality Review
	GRE/CPA		
4.	Incarcerated individual died 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-23-024 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 request funding of substance use disorder treatment services to expand options for incarcerated individuals with a diagnosis of opioid use disorder to receive medication assisted therapy during their incarceration; 2. As funding allows, DOC should continue to expand options for incarcerated individuals with a diagnosis of opioid use disorder to receive medication assisted therapy prior to reentering the community; 3. DOC Health Services should explore the possibility of utilizing the Behavioral Health Administrative Services Organization recovery navigators to offer additional sobriety support for GRE participants.	Unexpected Fatality Review
	Washington State Penitentiary		
5.	Incarcerated individual died 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-23-026 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 update the mental health intake process to ensure an incarcerated individual has a mental health appraisal for further evaluation if they report a suicide attempt within the last year; 2. DOC should expedite the release of the new Critical Incident Review Policy to support the critical	Unexpected Fatality Review

incident review teams; 3. DOC should continue to advocate for an electronic health record to facilitate communicate with community and jail providers; 4. DOC should retain hand-held incident response video per the department's record retention schedule.

CASE INVESTIGATIONS

Airway Heights Corrections Center

6.	Person reports that he was injured. The person states he is not sure he received appropriate medical care and is requesting his care be reviewed.	The OCO provided assistance. OCO staff reviewed the patient's medical records, including the emergency room records. OCO staff verified the patient received the community standard of care for the reported injury. OCO staff provided information to the patient regarding the treatment that was provided during that time.	Assistance Provided
7.	An individual reports he is having issues with his cellmate and has requested a courtesy move but is worried the bed move will be denied.	DOC staff resolved this concern prior to the OCO taking action on this complaint by screening this person for a new cellmate and addressing his concern.	DOC Resolved
8.	Person reported that he has been trying to get prescribed medications for a health condition, but staff have not been responsive.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reached out to DOC staff, who said that this individual has met with his provider regarding medications, and the OCO verified this in DOC records. The OCO also reviewed DOC records to confirm that he was prescribed medications for this concern.	DOC Resolved
9.	Person reported that his medical consult was cancelled and was told that he was going to have a medical assessment first and would have the consult afterwards. Person said that he refused the medical assessment because he wanted to have the consult first. Person said that he also wants a Health Status Report (HSR) to not do extra duty at work, because he is in pain.	The OCO provided information. The OCO reviewed and tracked multiple appointments relating to this condition and found that the specialist wanted this patient to have the assessment before seeing him for a consult. The OCO could not find that medical scheduled a new assessment or consult but was able to confirm with DOC staff that he has been seen by his primary care provider, who would determine the need for further consults. The OCO spoke with DOC staff, who said that the specialist in the community would not schedule a consult without doing the assessment first, and the patient was not willing to be rescheduled for the assessment. The OCO provided information about the process to get this assessment if he wants this assessment in the future and provided information about the Patient Care Navigator. The OCO found from DOC medical staff that this individual received extra duty at work as a sanction from an infraction and said that he was cleared by medical and there were no physical limitations preventing him from performing his extra duty.	Information Provided
10.	An incarcerated individual reports that he has never been able to receive his stimulus covid check because he does not know his social security number (SSN), and the number in his electronic file is wrong. This individual has repeatedly contacted the Social	The OCO provided information about other methods to obtain a social security number because DOC policy 380.550 only assists incarcerated individuals close to their release date with the Social Security card replacement. This person can reach out to a family member who may have paperwork that contains his SSN, or he may contact a previous employer who could provide records containing his SSN.	Information Provided

	Security office, and worked with DOC to send identifying paperwork, but the issue has not been resolved.		
11.	Incarcerated individual reports concerns regarding the mailroom and their application of copying mail. The individual reports that mailroom staff photocopied pictures and he wants the originals.	The OCO provided information regarding DOC copying mail. DOC is still copying regular mail to mitigate the entry of contraband on paper. The OCO spoke with DOC staff regarding this protocol and they report they are not willing to discontinue the practice. DOC shared photos are not copied as long as they are sent in on glossy photo paper. Photos printed onto regular copy paper will be copied before it is provided to the incarcerated person.	Information Provided
12.	Incarcerated individual reports concerns regarding facility rules. The individual reports that the rules are very strict.	The OCO provided information about how to report staff concerns. This office also spoke with leadership at the facility regarding this concern and they were aware of the reports. The OCO shared with the individual the process for reporting staff concerns through the resolution program and shared that DOC staff have received the reported concern and were unable to verify that there are issues with the rules at the facility.	Information Provided
13.	Incarcerated individual relayed concerns regarding DOC staff throwing away their Quran.	The OCO reviewed the individual's grievance that informed the individual they will need to submit a tort claim for monetary compensation of the Quran. The OCO reached out to DOC who states they tried offering the individual the English version they have but the individual refused as they wanted theirs back that was written in. DOC then offered to try to get them an Arabic Quran but said that the individual did not want it. DOC staff looked for their Quran but were unable to locate it. The reason it was taken is because policy states it must have the individual's name and DOC number on the book but the individual states they are unable to write them in the book per their religion. DOC staff states that if they are to get a new Quran, DOC is willing to work on a solution to prove ownership.	Information Provided
14.	Person called with a complaint about DOC and wanted to know what he had to do with the resolutions process for the OCO to review his case.	The OCO provided information. The OCO spoke with this individual over the hotline and assessed what kind of concern it was and encouraged him to appeal his resolutions request to level 3. 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.	Information Provided
15.	Incarcerated individual relayed concerns regarding a DOC staff member sexually harassing individuals and inappropriately touching them.	The OCO contacted facility leadership about these concerns and DOC staff came to speak to the individual about the concerns. However, when the DOC staff member came to do that, the individual stated that they never reported this information. As a result, the OCO was unable to further investigate this concern due to insufficient evidence. The OCO informed the individual that if they are still having ongoing concerns about this staff person’s conduct, they can file a PREA complaint.	Insufficient Evidence to Substantiate
16.	Incarcerated individual relayed concerns regarding getting in	The OCO reviewed the individual's infraction history and confirmed that they were serving a confined to cell sanction	Insufficient Evidence to

	trouble for going to a video visit when they thought they were allowed to do so.	meaning that they are not allowed to have video visits until those 30 days of sanction have passed. The OCO was unable to identify any evidence indicating they were allowed to have video visits during this sanction time.	Substantiate
17.	Incarcerated individual relayed concerns regarding staff conduct in the food factory as they state staff are demoting levels only for people of certain races.	The OCO reviewed available records related to this complaint but could not find a resolution request regarding staff conduct. The OCO also confirmed the individual resigned from their position. Because of this, there was insufficient evidence to substantiate the concern of staff conduct.	Insufficient Evidence to Substantiate
18.	Incarcerated individual reports concern regarding an infraction they received after an investigation was completed. The individual reports that the infraction is unjust and the investigation was not completed correctly.	The OCO was unable to substantiate a violation of DOC policy. The OCO reviewed the investigation and the evidence available and found that the investigation was completed per confidential protocol. The evidence DOC was able to review supports DOC's decision to infract the individual. Evidence the individual requested DOC review was deleted due to the method the concern was reported. DOC was not aware to hold the video evidence until after it was discarded per regular retention protocols.	No Violation of Policy
19.	Incarcerated individual relayed concerns regarding not being able to get into SOTAP.	The OCO reviewed the individual's records and found that because the individual misrepresented information in their interview with SOTAP staff prior to approval for acceptance, they will not be accepted into the program as this is a requirement for admission.	No Violation of Policy
20.	Incarcerated individual reports concern regarding a visitor's termination from visiting. The individual also reported concerns about retaliation because of the incident.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the incident and found the termination complies with DOC policy 450.300, which states, "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." The OCO reviewed the individual's file and found no indication of retaliation including no infraction related to the incident.	No Violation of Policy
21.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
22.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
23.	Incarcerated individual relayed concerns regarding the protocol for quitting a correctional industries (CI) job.	The OCO reviewed the individual's grievance which states the correct procedure for submitting a two-week notice was not followed and resulted in the infraction as the proper method is completing a computer-generated form signed by the individual and the CI Supervisor. The OCO also reviewed both DOC policy 700.000, 710.400 and RCW 72.09.100(2)(f) and spoke with DOC staff and confirmed that per DOC policy 710.400(II)(E) "workers will give 2 weeks written notice to their case manager and work crew supervisor when voluntarily leaving a work program."	No Violation of Policy
	Clallam Bay Corrections Center		
24.	Incarcerated individual reports concerns regarding a pending	The OCO provided assistance. The OCO spoke with DOC staff regarding the move, DOC stated that because the	Assistance Provided

	transfer to another facility. The individual reports he and staff at the facility DOC is going to transfer him to cannot be at the same facility.	individual was moving to a segregation unit, the concerns regarding separations could be managed. Shortly after this conversation, the individual's transfer was cancelled. The OCO also verified the individual has access to reentry services and release planning with his assigned classification counselor.	
25.	A loved one reported that an incarcerated individual cannot send messages from his Securus tablet. They reported that when they contacted Securus, Securus stated DOC deactivated his messages, and DOC stated that this is a Securus issue.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reached out to the Intelligence and Investigations Unit at his current facility, who confirmed that there is no restriction on this individual's messages, and that he has been able to send and receive messages on his tablet.	DOC Resolved
26.	Person reported the mailroom is applying visiting room standards and rejecting his videograms. Person said an OCO report quoted the DOC Secretary saying videograms do not have to meet visiting room standards.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reached out to DOC staff, who said that he reviewed the videograms and found they have all been approved and released to the individual.	DOC Resolved
27.	The individual is concerned that they will not release on graduated reentry (GRE) because they were unable to complete an intensive outpatient (IOP) class.	The DOC resolved this concern prior to the OCO's involvement by allowing the individual to release on GRE.	DOC Resolved
28.	Individual reports that after speaking with this office, his room was searched, and all of his belongings were thrown around the cell and broken.	The OCO contacted facility leadership upon receipt of this concern. The DOC stated that they did address this incident. It was not just this individual who was searched, it was the whole unit. While there is no evidence to substantiate retaliation, staff were reminded of proper search protocols. The OCO informed the individual that, moving forward, if he feels that a cell search was done inappropriately, he needs to speak with the Sergeant or the CUS.	Information Provided
29.	External person states her loved one was labeled as a security threat group (STG) and was placed in restrictive housing and his tablet removed.	The OCO reviewed the restrictive housing placement. The individual was placed per DOC policy 320.200 due to an ongoing investigation. The individual will still have access to the phones in the unit.	Information Provided
30.	A family member reports that their loved one is going to reenter DOC custody and is not being allowed to take previously issued Correctional Industries (CI) items back in with them. Person also reports issues with property handling in the past and not receiving gate money.	At the time of the phone call to the OCO the caller's loved one was not in DOC custody. The OCO provided information regarding the need to write to DES and DOC headquarters regarding this property concern.	Information Provided

31.	Incarcerated individual reports concerns regarding his placement and reported safety concerns.	The OCO provided information regarding the individual's facility placement. The OCO spoke with DOC headquarters and requested the individual's placement be reviewed for a different unit. After OCO outreach, DOC reviewed his placement and determined that the individual met the criteria to be placed on a maximum custody program. The OCO shared information with the individual about how to work with staff to review other placement options as DOC reviews his classification determination in future custody facility plans.	Information Provided
32.	Incarcerated individual relayed concerns regarding safety concerns.	The OCO reviewed the individual's approved custody facility plan (CFP) in which the individual did not indicate any safety concerns and does not have any keep separates or prohibited placements. The OCO informed the individual that they will need to work with the intelligence and investigation unit (IIU) or their counselor to specifically name those posing a safety risk to them.	Insufficient Evidence to Substantiate
33.	Incarcerated individual relayed concerns regarding an infraction they received as well as the sanctions.	The OCO contacted DOC regarding the lack of details in the infraction narrative as there is no information indicating where the contraband was found, whether it was in a shared area meaning this is a cell tag infraction or not, and if either individual was asked whether the contraband belonged to them. DOC stated that the report did capture the elements necessary for the hearings officer to find sufficient evidence to support a guilty finding. DOC also stated staff are instructed that based on constructive possession, control over items or property without actual possession or custody of it, all incarcerated individuals should be infracted and scheduled for a hearing where each incarcerated individual must establish a lack of involvement at the hearing. As a result, DOC was unwilling to dismiss the infraction as there is no violation of DOC policy 460.000.	No Violation of Policy
34.	Incarcerated individual relayed concerns regarding denial of due process rights by not being allowed to attend their facility risk management team (FRMT) outside of their cell that resulted in a MAX custody decision.	The OCO reviewed the individual's custody facility plan and confirmed that the individual was able to attend their FRMT and present concerns about the MAX custody consideration. The individual was placed on MAX custody due to participation in a fight, which is in accordance with DOC policy 300.380. Additionally, there is no specification in DOC policy 320.250 that states an FRMT must occur outside of an individual's cell.	No Violation of Policy
35.	Incarcerated individual relayed concerns regarding an infraction they received as well as the sanctions.	The OCO contacted DOC regarding the lack of details in the infraction narrative as there is no information indicating where the contraband was found, whether it was in a shared area meaning this is a cell tag infraction or not, and if either individual was asked whether the contraband belonged to them. DOC stated that the report did capture the elements necessary for the hearings officer to find sufficient evidence to support a guilty finding. DOC also stated staff are instructed that based on constructive possession, control over items or property without actual possession or custody of it, all incarcerated individuals should be infracted and scheduled for a hearing where each incarcerated individual must establish a lack of involvement	No Violation of Policy

		at the hearing. As a result, DOC was unwilling to dismiss the infraction as there is no violation of DOC policy 460.000.	
Coyote Ridge Corrections Center			
36.	An external person reported their loved one was being retaliated against by the DOC staff.	The OCO attempted to contact the family member for more information. This office did not hear back from the reporter; however, this office did reach out to DOC staff for more information. DOC staff thought the complaint could be regarding visitation and shared that the facility had just approved a visiting provision for this individual and his family. The OCO will continue to monitor this individual's care.	Assistance Provided
37.	Incarcerated individual relayed concerns regarding a staff member making an unprofessional comment about veterans and the facility not allowing the Veterans' Pod to have fundraisers.	For the first concern, the OCO reviewed the resolution for staff misconduct regarding staff's commentary that was removed from the grievance process to be investigated through another process. The OCO spoke with facility leadership about this concern who stated that the facility would be starting a process to notify an individual when a grievance is pulled for an internal investigation. Thus, the OCO was able to provide assistance for this concern. For the second concern, the OCO reviewed the resolution about the fundraiser prohibition. The OCO spoke with DOC staff about this concern who put out a proposal and request for clarification of the policy requirements on the Veteran's fundraisers, thus they are on hold until there is further direction on the policy. Thus, the OCO was able to provide information about this concern.	Assistance Provided
38.	Person reported that he has a Health Status Report (HSR) for Durable Medical Equipment (DME) to treat an injury. Person said that the HSR was renewed months ago, but when he went to pick up his new DME, health services said that he already had DME and does not need a new one. Person said that his old DME is falling apart.	The OCO provided assistance. The OCO reached out to DOC staff at the facility asking about the DME and substantiated that there was a delay in him receiving the DME. After the OCO's outreach, DOC staff then scheduled him to receive the new DME.	Assistance Provided
39.	Incarcerated individual reports concerns regarding an assessment. The individual attempted to appeal the assessment through DOC headquarters and never received a response. The individual requests OCO assist him in getting a response to his appeal. The individual also reported concerns with the timeliness of his custody facility plan and his classification counselor.	The OCO provided assistance. The OCO spoke with DOC staff and were unable to find the individual's appeal documents that he reported were sent to DOC headquarters. The OCO reviewed the appeal process for the assessment and found that the Superintendent of the facility reviews these assessment appeals. The OCO reached out to DOC staff at the facility and asked if they would accept an appeal to this assessment, to which they agreed. The DOC staff shared with the individual that the facility would accept their appeal, after OCO requested it and the individual will now have meaningful access to this appeals process. The OCO also reviewed the individual's custody facility plan and did not find evidence to substantiate that it was late. This office also did not locate evidence to prove staff misconduct.	Assistance Provided

40.	External person reports that their loved one has been being bullied in their unit and was recently assaulted, taken to the hospital, then placed in restrictive housing. They requested he move to a safer location.	The OCO received this concern and contacted the facility immediately regarding the assault and restrictive housing placement. The individual was moved into the restrictive housing unit for their own safety and the transfer process was initiated. This office then contacted DOC headquarters to request a transfer to a safer location. The individual will be transferring as soon as possible.	Assistance Provided
41.	Person reported that his prescription for medication was never filled per the provider's instructions.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reached out to DOC staff at the facility, who confirmed that this person's prescription was filled and that he has received refills since then. The OCO substantiated that there was a delay in filling the prescription.	DOC Resolved
42.	An individual reports he was transferred to another facility and his tablet did not come with him. He reported that he gave the tablet to DOC staff before he left, but they never put it with his belongings.	The OCO reviewed this person's resolution request and determined that his tablet did not follow him because he traded it with someone prior to his departure from the facility. The OCO verified with DOC staff that this person received a new tablet earlier this month.	DOC Resolved
43.	The person reports that his graduated reentry (GRE) bed date has been delayed and subsequently DOC removed him from Thinking for a Change. This individual is required to complete the class before they release on GRE, however, the facility is not providing the program.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed this person's electronic file and verified the individual was placed back into Thinking for a Change.	DOC Resolved
44.	External individual reports concerns regarding an incarcerated individual's gluten free diet, reporting that the diet does not provide as many calories as the regularly provided diet, known as mainline.	The OCO provided information regarding this office's actions and DOC's response to our recommendation. The OCO reviewed the calories in the mainline diet and compared them to the gluten free diet and found the gluten free diet does have less calories. The OCO brought this information to leadership at Correctional Industries (CI) and requested that a small food item be added to supplement the calories missing from the gluten free diet. CI leadership shared that the calorie difference was not substantial and met the guidelines for daily caloric intake. CI staff are unwilling to add products to that menu at this time. If the individual is experiencing weight loss as a result of this, they can kite their medical provider to be assessed and potentially prescribed a snack to manage unwanted weight loss. The OCO will continue to have conversations regarding food quality, amount and other issues as they are reported.	Information Provided
45.	Person reported concerns about receiving medical treatment and said that each visit he has had so far was very short, and	The OCO provided information. The OCO reviewed DOC records and found a level three resolution request that substantiated delays to this individual's medical treatment. The OCO reached out to DOC staff and reviewed DOC	Information Provided

	one appointment was cancelled and not rescheduled. Person said that not all of his injuries that required treatment had been addressed, and that the security requirements for offsite appointments are hindering treatment. Person also expressed concern about his HIPPA rights being violated.	records and confirmed that he had a follow-up appointment scheduled. DOC staff said that they are trying to hire an on-site provider, which would eliminate the need for the off-site security requirements, and in the interim are working with custody to verify the requirements to ensure he can fully participate in his treatment. The OCO asked about his injuries that have not been addressed yet, and DOC staff said that they can only address one issue per appointment, and that the clinician will prioritize which issues to address first. The OCO provided information about how to file a HIPPA complaint with the US Department of Health and Human Services.	
46.	Incarcerated individual relayed concerns regarding not being presented with a behavior observation entry (BOE) after it was written.	The OCO reviewed the BOE and saw that it was documented that the individual received a copy of the BOE on the day it is written. For that reason, there is not enough evidence to substantiate the individual's statement that they did not receive it.	Insufficient Evidence to Substantiate
47.	A loved one reports that their family member was in segregation for two months due to refusing a cell assignment and was transferred to a maximum custody prison. This person reports that the incarcerated individual has not had a write-up or been in trouble for years and this is a harsh punishment.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. This person refused housing twice, was infracted, and then transferred to another facility. DOC policy 300.380 (VI) F says that if a person refuses a housing assignment, they will be infracted and given other transfer opportunities until the custody review score (CRS) no longer allows placement at the intended custody level.	No Violation of Policy
48.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
49.	The incarcerated individual reports they were given a urine analysis (UA) and tested positive for Suboxone. This individual said they should not have been infracted because they were prescribed a Sublocade shot within the last year which is why their UA was positive. Additionally, this person reported that they were given another UA more recently, and the results were positive. However, DOC staff said that the most recent positive UA would not impact their ability to leave on Graduated Reentry (GRE).	The OCO was unable to substantiate a violation of policy by DOC. This office requested this person's medical records and verified that the individual did receive a Sublocade shot within the last year. However, this person's UA was sent to a lab, and the drug analysis determined that the level of Suboxone in this person's system was higher than it would be from just the Sublocade shot. The OCO reviewed the second UA this person mentioned in their concern and verified the results of that test were negative. This office found no violation of DOC policy 460.000 because the individual's behavior met the infraction elements.	No Violation of Policy
Mission Creek Corrections Center for Women			
50.	The person reports that she attempted to send items she	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Incarcerated	No Violation of Policy

	made to a friend whose wife is incarcerated. The mailroom rejected the outgoing mail for lending, borrowing, or trading items to another incarcerated individual. However, she was not sending it directly to the incarcerated individual, just to their home address, and did not think that rule would apply.	individuals are not allowed to send items to other incarcerated individuals through outgoing mail. DOC policy 440.000 (1) D. states individuals may not trade, sell, buy, loan, receive, possess, or give away any personal property to another incarcerated individual.	
51.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
Monroe Correctional Complex			
52.	Incarcerated individual expressed concerns about having a loss of earned time when they were housed in segregation due to a medical hold.	The OCO spoke with DOC staff who verified that the individual did lose earned time in error and as a result reversed the error.	Assistance Provided
53.	The OCO received multiple communications from various stakeholder groups expressing dissatisfaction with a recent Extraordinary Medical Placement denial.	The OCO provided assistance by requesting that DOC reconsider the EMP denial as the individual has a terminal condition and meets the requirements for EMP approval. DOC agreed to re-review this request and ultimately approved it. The OCO confirmed that the individual is now on EMP.	Assistance Provided
54.	Person reported that the kosher diet receives smaller portions of salad dressing and is offered a much smaller variety of options.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed this individual's resolution request, which was reviewed by DOC headquarters. DOC headquarters substantiated his concern and worked with the statewide dietician to change the statewide menu and approve kosher salad dressings for use by Food Services at the same portion size as the mainline dressings portions. DOC headquarters directed the facilities to begin using these increased portions of new kosher dressings.	DOC Resolved
55.	Person reported that he cannot make any phone calls from his tablet or the wall phones and hears an automated message when he tries to make a call. Person said he has filed a resolution request and spoken with the Securus representative and the Intelligence and Investigations Unit (IIU), who confirmed that DOC and Securus have not blocked any numbers.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed this individual's resolutions request, which was reviewed by DOC headquarters. DOC headquarters found that his account had a Personal Allowed Number (PAN) list, which could cause issues when calling specific numbers, and since it is not a requirement, they removed it from his account, which should resolve his concern.	DOC Resolved
56.	Incarcerated individual relayed concerns regarding placement in IMU.	The OCO confirmed that DOC resolved this concern prior to OCO involvement as the individual has been released from IMU and transferred facilities.	DOC Resolved

57.	Person reports he was told by a provider that he needed surgery and states he has not received it. The person is requesting to have the surgery before he releases.	DOC staff resolved this concern prior to OCO action. OCO staff reviewed the patients consults and noted that the surgery was already scheduled. OCO staff monitored the appointment on the OCO's appointment tracker until the surgical appointment was completed.	DOC Resolved
58.	Person reports not being able to access medical since arriving at his current unit, two months ago. The person states he has requested sick call but has not gotten a response.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff contacted DOC staff and were informed the patient had met with his provider and his reported concerns were addressed.	DOC Resolved
59.	Person reports he was injured at work and has faced retaliation for reporting the injury. The person stated he received a behavior observation entry with false statements that put the blame on him for the actions of DOC staff. He is requesting treatment for his injury.	The OCO provided information to the person regarding how to request an independent medical exam through Labor and Industries. OCO staff reviewed the patient's medical records and did not find evidence of delayed or denied care. OCO staff confirmed the patient was treated in a community hospital the day of injury and had follow up with multiple medical providers regarding his treatment. OCO staff verified the behavior observation entry was removed from the person's record.	Information Provided
60.	Loved one relayed concerns regarding a desire for an incarcerated individual to have a single cell.	The OCO reviewed the related records and confirmed that the individual has not had a single cell screening for several years. The OCO informed the individual that they will need to work with their counselor to request an updated single cell screening.	Information Provided
61.	Incarcerated individual relayed concerns regarding staff threatening them and making up false infractions.	The OCO reviewed the individual's most recent grievances and found it was closed per the resolution program manual restrictions as they have five active grievances already. The OCO informed the individual that they will need to file a new grievance about this once one of the grievances is closed. Without further information regarding this grievance or investigation, the OCO is not able to further investigate. The OCO confirmed that the individual has not appealed any of their recent infractions but confirmed that each was substantiated as the behavior met the infraction elements. The OCO informed the individual that they will need to provide more information regarding the staff conduct and pursue this concern through the grievance process, as well as appeal the infractions if they disagree with the outcomes.	Information Provided
62.	Incarcerated individual relayed three concerns, the first regarding being sent to a facility where they do not feel safe, the second regarding nothing occurring after filing a trans housing protocol, and the third regarding not wanting a single cell.	For the first concern, the OCO reviewed the individual's custody facility plan and found no violation of DOC policy 300.380 as there are no active keep separates or other safety concerns impacting a transfer. For the second concern, the OCO confirmed that the individual previously had a PREA hold as the trans housing protocol was being investigated. For the third concern, the OCO confirmed that a single cell was not issued.	Information Provided
63.	Incarcerated individual expressed concerns about a	The OCO confirmed the individual has an in-review custody facility plan (CFP) and informed the individual that, if DOC	Information Provided

	desire to transfer to camp.	decides not to transfer the individual to a camp facility, in accordance with DOC policy 300.380(VI)(H)(3)(a) the individual may appeal the custody assignment upon receipt of a copy of the plan.	
64.	A loved one reports that her son was at American Behavioral Health Systems (ABHS) and was supposed to release to her home after he graduated. However, the day he graduated he was sent back to the prison due to an administrative decision.	The OCO provided information regarding this person's next steps to re-apply for graduated reentry (GRE). This office verified that the individual was removed from ABHS due to health concerns. DOC staff report they will reengage with this individual about GRE after he has completed Thinking for a Change.	Information Provided
65.	Incarcerated individual relayed concerns regarding possibly being discharged from the residential treatment unit (RTU) level of care.	The OCO reviewed the materials associated with the infraction the individual believes was the reason for the potential discharge and verified that the individual is not being discharged from the RTU.	Information Provided
66.	Incarcerated individual relayed concerns regarding staff being racist and writing infractions.	The OCO reviewed the individual's related grievance that was due for a rewrite, but it was never received from the individual. Thus, the concern was not further investigated. For the OCO to further investigate this, the OCO informed the individual that they will need to file a grievance and allow it to go through the resolution process. A previous OCO case addressed the infraction concerns expressed.	Information Provided
67.	Loved one relayed concerns regarding how to open a medical case on an incarcerated individual's behalf.	OCO staff were able to provide information to the loved one at the time of the call to the OCO hotline to address the concern raised with staff. The OCO informed the incarcerated individual that if they have other concerns, they may contact the office for additional assistance.	Information Provided
68.	Incarcerated individual reported concerns regarding the resolution program and requested OCO assist in recommending DOC implement a requirement of response from DOC regarding resolution requests.	The OCO provided information regarding the resolution program, including updates to the Resolution Program Manual in 2023. The OCO has been in ongoing conversations with facility leadership and headquarters leadership in an effort to review issues with the resolution program. The resolution program added updates to their program manual, and addressed this individual's concerns regarding receiving responses from DOC after a resolution request is pulled for an outside investigation. The Resolution Program Manual also details how an incarcerated individual can navigate the resolution program’s rule of accepting five active resolution requests at a time and will allow individuals to choose the most important resolution requests requiring review if they have more than five active requests pending. Also, medical concerns will be reviewed even if the individual has five active resolution requests.	Information Provided
69.	Person reports that her specialist consults for gender affirming care have been delayed multiple times. The person states that she was	The OCO provided information to the patient regarding her consult status. The OCO contacted DOC staff and were informed that DOC staff were able to get an earlier appointment for the patient which altered the treatment schedule. OCO staff verified the necessary pre-procedure	Information Provided

	supposed to have a procedure to prep for surgery and that was not completed, further delaying care.	appointments were scheduled.	
70.	Person reported concerns about not being able to access behavioral programming.	The OCO provided information. The OCO reviewed DOC records and found that this individual was assessed by DOC staff, who determined that this programming is not appropriate for this individual at this time. The OCO encouraged this individual to write to DOC headquarters requesting to be reconsidered for the program.	Information Provided
71.	Person reported that he is supposed to receive Durable Medical Equipment (DME) for a health condition but has not been given all of the supplies he needs. Person said he was told he can only get some of these supplies through Union Supply.	The OCO provided information. The OCO reviewed DOC records and reached out to DOC staff asking about the DME. DOC staff confirmed that this individual received most of his supplies, and he did not receive certain items because they are available in the commissary and encouraged him to purchase those items there. DOC policy 650.040 states, "OTC items that are not considered medically necessary per the Washington DOC Health Plan will be available for purchase at the commissary, based on product availability."	Information Provided
72.	Incarcerated individual relayed concerns regarding not being able to enroll in SOTAP.	The OCO spoke with DOC staff and informed the individual that historically, individuals do not enroll in SOTAP until their final year of incarceration. Thus, the individual will have to wait until that time to be enrolled in SOTAP.	Information Provided
73.	Person reported that he is diabetic and is on the diabetic diet. Person said that he received a negative behavioral observation entry (BOE) for going to the diet line at mealtime and wants to be able to go to the diet line in the future for meals.	The OCO provided information. The OCO reviewed DOC records and reached out to facility leadership, who said that the diabetic diet is not treated the same as the other special diets and are allowed to be served with the regular mainline. Facility leadership also said that the negative BOE was written before this individual got his Health Status Report (HSR) for the diabetic diet, which the OCO verified in DOC records.	Information Provided
74.	Incarcerated individual relayed concerns regarding being placed in IMU by mistake.	The OCO reviewed the individual's custody facility plan (CFP) that states the individual is an influential member of a security threat group (STG) which is the basis for the placement in IMU. The OCO informed the individual that if this is not true, they will need to work with their counselor and the Intelligence and Investigation Unit (IIU) to show that they are not an active STG member.	Information Provided
75.	Incarcerated individual relayed concerns about not getting their medication for a month.	The OCO reviewed records related to the individual's medication administration and found that they were given their medication nearly every day during the specified month. As a result, there was insufficient evidence to substantiate the individual's claim.	Insufficient Evidence to Substantiate
76.	Incarcerated individual relayed concerns regarding getting a 752 (positive drug test) infraction for an incident they were already infracted for.	The OCO reviewed the individual's disciplinary record and was not able to identify any recent 752 infractions, thus there was insufficient evidence to substantiate the concern.	Insufficient Evidence to Substantiate
77.	Person reported that he is in solitary confinement and staff have been harassing him by not	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO spoke with DOC staff, who said that he could not find any mail being withheld by the	Insufficient Evidence to Substantiate

	giving him his mail. Person said that he wanted to be transferred to a different facility.	mailroom. DOC staff said that first- and third-class mail is not tracked and said there is no way to know if something happened to that mail before it reached the mailroom. If this individual wants to be transferred, he will need to talk to his classification counselor and it will be addressed during his custody facility plan review.	
78.	Incarcerated individual relayed concerns regarding filing a PREA and not hearing anything from the investigation.	The OCO was unable to locate any PREA investigations that the individual filed during the given timeframe, or any grievances related to an officer's conduct during this time. There was insufficient evidence for this office to substantiate this concern.	Insufficient Evidence to Substantiate
79.	Incarcerated individual relayed five concerns. First, they were not provided breakfast prior to going on a medical trip. Second, they requested witnesses for an infraction but were denied. Third, all legal possessions were taken by DOC and not given back. Fourth, they were assaulted by a DOC staff member and never got the recommended physical therapy after the alleged incident. Fifth, after requesting a PREA safety plan, their dinner was taken away.	For the first concern, the OCO reviewed all grievances the individual filed during this timeframe and found none discussing this concern, thus, there was insufficient evidence to substantiate this concern. For the second concern, the OCO informed the individual that their infraction concerns are being looked at in another OCO case that is still under investigation. For the third concern, DOC resolved this concern as the individual received their property. For the fourth concern, the OCO confirmed that physical therapy has been put on hold for the individual, but there were no grievances filed about the alleged staff assault, thus there was insufficient evidence to substantiate this concern. For the fifth concern, a rewrite for clarification on the related grievance was never received from the individual, thus there was insufficient evidence to substantiate this concern.	Insufficient Evidence to Substantiate
80.	Incarcerated individual relayed concerns regarding an infraction and their release date.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements. The OCO also reviewed the individual's records and confirmed that DOC has audited the individual's sentence calculations several times recently and confirmed that the release date is correctly calculated.	No Violation of Policy
81.	Incarcerated individual relayed concerns regarding staff targeting them for cutting in line.	The OCO reviewed the related grievance. The resolution investigation found no sign of the individual being singled out and stated that the officer addressed the witnessed behavior. The OCO also reviewed the infraction materials and found there is information to substantiate the infraction as the officer gave the individual several directives to return to the back of the line after seeing them skip the line and then the individual responded by making racist and ageist remarks towards the officer. As a result, the individual's behavior met the infraction elements and there is no violation of DOC policy 460.000.	No Violation of Policy
82.	Incarcerated individual relayed concerns regarding a behavior observation entry (BOE).	The OCO reviewed the BOE and found that the individual had been addressed twice previously about their behavior prior to the issuance of the BOE, thus, the correct protocol was followed in the issuance of the BOE and there was no violation of policy.	No Violation of Policy
83.	Incarcerated individual relayed concerns regarding an infraction and their release	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements. The OCO also reviewed the	No Violation of Policy

	date.	individual's records and confirmed that DOC has audited the individual's sentence calculations several times recently and confirmed that the release date is correctly calculated.	
84.	Person reported they are upset about the DOC memo which states all procedures that were changed in restrictive housing during Covid-19 have been rescinded.	The OCO reviewed the memo and update to DOC procedure in Restrictive Housing. The DOC has rescinded COVID-19 procedures and has moved back to normal operations. The DOC is within policy 320.200, 320.250, and 320.255.	No Violation of Policy
85.	Incarcerated person reports that he has been told that he is being held in IMU by DOC staff due to staff assault and says DOC staff have told him directly that he is going to be put on the out of state transfer list with no intention of ever being transferred and says DOC staff are intentionally not prioritizing sending out packets and says he personally is trying to change his behavior but staff antagonize him due to his past behavior and lack of mental health support.	The OCO requested a copy of the out of state transfer packet and documentation of what states the packet has been sent to. This office verified that the packet has been sent out multiple times, as recently as last month. The OCO could not find a violation of DOC policy 330.600.	No Violation of Policy
Olympic Corrections Center			
86.	Incarcerated individual relayed concerns regarding a search report not being filed when Native American medicines were taken.	The OCO spoke with facility leadership about this concern and confirmed that because the confiscated property was found in a common area and did not belong to a particular individual, a search report did not need to be provided. The OCO also reviewed the related grievance the individual filed which reiterated this information.	Information Provided
87.	Incarcerated individual relayed concerns regarding being infracted for expressing their religious views and feeling this is discrimination and retaliation.	The OCO reviewed the infraction and found the individual utilized a derogatory term to refer to an officer's sexual orientation which resulted in the infraction. The OCO was unable to find evidence that this was retaliation or discrimination as the individual used the term to describe a staff member and that resulted in the infraction.	Insufficient Evidence to Substantiate
88.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
Reentry Center - Olympia -			
89.	Incarcerated individual relayed concerns regarding denial of a graduated reentry (GRE) decision.	The OCO confirmed the individual was approved for GRE prior to the OCO investigation in this case and is currently on the GRE program.	DOC Resolved
Stafford Creek Corrections Center			
90.	External person reports concerns about their loved one's access to pain	The OCO provided assistance by elevating the concern through DOC staff. The patient's case was reviewed by the Care Review Committee for consideration of a 6-month pain	Assistance Provided

	management after surgery.	management plan due to 30-day opioid prescription limit in DOC. More information was provided directly to the patient regarding next steps and health coverage. The OCO confirmed the patient's dose was reduced via tapering and after OCO outreach, the patient was approved and scheduled for an appointment with the DOC pain management specialist. The patient did not follow up to report additional details to the OCO, so this office provided general information about how to contact OCO to open a case if new issues arise in the future.	
91.	A loved one reports that an incarcerated individual is being targeted at their current facility and the loved one wishes to advocate to have their loved one moved.	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
92.	Individual reports that the DOC is trying to transfer them to a close custody unit where they think they will be harmed. They have been housed in the IMU since January awaiting a housing protocol.	The OCO reviewed the custody facility plan and contacted DOC staff. Due to their crimes of conviction, the OCO agreed that this individual should not be housed in general close custody. The individual was screened for Safe Harbor instead and has transferred.	Assistance Provided
93.	Family member reports concerns about their loved one's symptoms and access to medical care.	The OCO provided assistance by contacting DOC staff and requesting follow up with the patient. The patient was then scheduled with a specialist for testing and follow up with his primary care provider. He was provided a wedge pillow, updated medications, and scheduled for another follow up for continued monitoring. The OCO also provided the patient with additional information about next steps he can take if symptoms worsen or current treatment is ineffective.	Assistance Provided
94.	External person reports their loved one has been trying to get hearing aids for over a year. They reported that the patient was told the hearing aids were being shipped, then was told he was not approved for them. The person requested the patient get information on why the hearing aid was denied and what else he can do to get one.	The OCO provided assistance. OCO staff contacted DOC staff and requested the patient be scheduled with a provider to explain why he does not meet criteria for hearing aids. OCO staff provided information to the patient regarding the Patient Paid Health plan option to self-pay.	Assistance Provided
95.	Person reports concerns about their incarcerated loved one's medical care.	The OCO provided assistance by contacting the patient directly and elevating the concerns through DOC staff. The patient was then seen by a provider and prescribed antibiotic treatment. The patient followed up to report improvements in his symptoms and requested that OCO confirm a cardiology follow up. The OCO added this case to the OCO appointment tracker. The OCO also received an update about medications and reached out about that issue as well.	Assistance Provided

96.	Incarcerated individual relayed concerns regarding pain management.	The OCO confirmed that the individual was seen by the Care Review Committee (CRC) prior to OCO involvement. The OCO also noted that he will be considered for a consultation with a doctor for further pain management.	DOC Resolved
97.	Person reported that he was approved for a job but has not started the job yet. Person said that he has reached out to the job coordinator multiple times and has not heard back, and that that he has been delayed starting the job for almost a month.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and found that this individual has started working in the position he was approved for.	DOC Resolved
98.	The individual reports that DOC rejected his mail due to violence and advocating for violence. This person also reports that he was allowed to receive the same image on his Securus tablet and does not understand why it was rejected in the mail.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The individual appealed their mail rejection and the facility overturned the initial mailroom decision allowing this person to have their rejected mail.	DOC Resolved
99.	Incarcerated individual relayed concerns regarding concerns about mandatory sanctions for drug infractions.	The OCO reviewed the infraction the individual expressed concerns about and found that it was a 752 infraction for a positive drug test, however, the only mandatory drug related infraction sanctions are for a 603 unauthorized possession of drugs. Thus, the individual was not subject to any mandatory drug sanctions.	Information Provided
100.	Individual reports his tablet was taken due to security threat group (STG) activity, however he has been in restrictive housing for three years.	The OCO reviewed this concern and contacted DOC headquarters for more information. The OCO substantiated that this individual has been held in restrictive housing for multiple years due to safety issues and recently was given a security enhancement plan stating he could not have his tablet due to STG activity. The DOC headquarters stated they plan on having a conversation with this individual and after that, his security enhancement plan will be reviewed.	Information Provided
101.	Incarcerated individual relayed concerns regarding concerns about mandatory sanctions for drug infractions.	The OCO reviewed the infraction the individual expressed concerns about and found that it was a 752 infraction for a positive drug test, however, the only mandatory drug related infraction sanctions are for a 603 unauthorized possession of drugs. Thus, the individual was not subject to any mandatory drug sanctions.	Information Provided
102.	Incarcerated individual reports bone matter was found in his meal. The individual reported tooth damage as a result of the bone matter found and requested the OCO ensure DOC resolves this issue.	The OCO provided information regarding how to file a tort claim. The OCO also shared information about what was found in the OCO's investigation. The OCO spoke with correctional industries (CI) regarding the incident and reviewed the investigative reports by CI. CI found that this was an isolated incident and was not able to substantiate a larger issue with the food quality. The OCO spoke with multiple CI staff including leadership at the CI food factory. This office also reviewed labels showing the food grade and	Information Provided

		type and were unable to substantiate that bone matter in the food was a reoccurring incident. The OCO is unable to substantiate where the bone matter came from even after reviewing how the meat products are manufactured, made into meals, and distributed. The OCO will continue to have conversations with DOC regarding food. Due to the tooth damage the individual experienced, the OCO shared with the individual how to file a tort claim to request compensation for those damages. The OCO confirmed the individual received dental care.	
103.	Incarcerated individual relayed concerns about a desire to stop the uses of force during movements from cell to callouts, shower, yards, etc. as this is negatively impacting them.	The OCO reviewed the records for the related grievance with a DOC response that states officers are trained to place one hand on the individual's elbow and the other on the back of an individual's hand for adequate control and safety. The video of the escort the individual expressed concerns about was also reviewed in the grievance investigation and showed the officer doing an appropriate escort. There were no use of force packets included in the records related to the date as none existed. Thus, it does not appear there was a use of force and there is insufficient evidence to substantiate the concern.	Insufficient Evidence to Substantiate
104.	Person reported that mail he sent to a loved one internationally was getting lost because staff at the facility put an inadequate amount of postage on it.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed this individual's resolution request. The response from DOC headquarters stated that they cannot assume the mail was lost and did not reach its international destination because it did not have adequate postage, because if it did not have adequate postage, it would have been returned to the facility, which did occur on two occasions. DOC staff made attempts to locate the missing mail and reached out to the local post office, who said that once the mail leaves the United States Postal Service, it becomes the issue of the country it is sent to. The OCO lacks jurisdiction over the United States Postal Service and could not find a violation of DOC policy 450.100.	Insufficient Evidence to Substantiate
105.	External person reports their loved one was infracted for saying something he did not say. The person said that their loved one's cellmate needs mental health help and caused the issue that led to the infraction.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed the infraction and found it to meet the "some evidence" standard and comply with DOC 460.140 Hearings and Appeals.	No Violation of Policy
106.	An incarcerated individual reports that a DOC staff filed a PREA report and named him as the victim of another DOC officer. The individual reports that they are not a victim, and never engaged in inappropriate behavior with staff. The individual is requesting that the DOC staff member who initiated the complaint be	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Per DOC policy 490.800 the Department has established procedures for recognizing, preventing, and reporting incidents of sexual misconduct and retaliation. The DOC staff member who reported the complaint was within their scope to initiate the PREA concern. This office noted that DOC determined that the allegations were unfounded. The OCO does not have the authority to discipline DOC staff and cannot help this individual achieve their desired resolution.	No Violation of Policy

	disciplined and relocated.		
107.	An individual reports that the DOC staff are racist and targeting him by repeatedly searching his cell.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. DOC policy 420.320 states that cells/dorms/living areas will be inspected daily to ensure cleanliness and compliance with facility regulations and identify any safety hazards. This person's infraction behavior has contributed to DOC staff regularly searching his cell which is not against DOC policy.	No Violation of Policy
108.	The individual reports that she would like the OCO to investigate a PREA concern. She says a nurse sexually assaulted her and the DOC claims that she lied and gave false testimony. This person reports the DOC gave her an infraction and it should be overturned because she did nothing wrong.	The OCO reviewed the infraction and PREA investigation and found no violation of DOC policy. Per DOC policy 490.860(V)(B)(2)(a), alleged victims are not subject to disciplinary action related to violating PREA policies except when the formal PREA investigation resulted in a determination that the allegation was unfounded, a 549 violation may be written and served upon completion of the investigation. In this instance, the PREA case the individual filed was found to be unfounded and as a result, was infracted according to policy.	No Violation of Policy
109.	An incarcerated person reported a staff behavior issue related to a DOC staff's tone, attitude, and general demeanor including improperly citing the incarcerated person with an infraction.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC as the infraction was overturned at the initial hearing.	No Violation of Policy
110.	Incarcerated individual relayed concerns about an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
111.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials for the WAC 654 counterfeit/forgery and examined the photograph of the individual's ID. The OCO noted that the barcode on the ID had not been obscured in any way. In addition, the OCO found the individual's behavior did not meet the required elements of a WAC 654 as substantiated by the witness statement. The OCO attempted negotiations at the facility leadership level by expressing these concerns and reviewing the lack of evidence that met the WAC elements. However, the facility was unwilling to dismiss or lower the infraction to a general WAC violation. The OCO then elevated this concern through three levels of headquarters' leadership that also was unsuccessful. As a result of these unsuccessful negotiations, the OCO substantiated the individual's concern without resolution from the DOC.	Substantiated
Washington Corrections Center			
112.	Incarcerated individual expressed concerns about staff conduct, including being targeted for identifying as a transgender individual.	The OCO spoke with facility leadership about these concerns and as a result, the facility moved the individual to a different location. This change would limit the frequency this person has with that DOC staff member.	Assistance Provided
113.	The individual reports that a DOC staff member took his coat	The OCO provided assistance. The OCO reviewed the video footage from the chow hall and confirmed this individual's	Assistance Provided

	and forced him to walk back to his unit in the rain because he would not follow a directive. At the time this person called to report the incident, he had not been given a new coat to replace the one that was taken from him.	coat was taken by a DOC staff member. The OCO reviewed the resolution request and verified that this person was given a replacement coat, and the DOC conducted an investigation surrounding this incident. OCO staff spoke with facility leadership who confirmed the staff member was addressed for taking the individual's coat.	
114.	Person reports staff conduct concerns and a delayed transfer.	The OCO provided assistance by elevating the concern through DOC leadership. The person's housing protocol was finalized and approved for transfer. The OCO confirmed the person transferred facilities after the housing approval. The person later called the OCO hotline and asked that the case be closed.	Assistance Provided
115.	Incarcerated individual relayed concerns regarding a delayed transfer.	The OCO confirmed that the individual transferred facilities prior to OCO involvement.	DOC Resolved
116.	A loved one reports that an individual is in the receiving units and was told that he would be transferred to another facility. However, several weeks have passed and he has not been transferred yet.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed this person's electronic file and determined that he was transferred to his desired facility and is closer to his family.	DOC Resolved
117.	An incarcerated person reports that their sentence was calculated incorrectly, and they should have a pending release date (PRD) without community custody.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The person reached out to OCO prior to DOC completing their sentence calculation and setting an earned release date (ERD). The person filed a grievance on the issue through the resolution program and their sentence was calculated and a planned release date (PRD) was set.	DOC Resolved
118.	Incarcerated individual relayed concerns about their property and having difficulty getting all of it transferred due to a facility adding additional boxes.	The incarcerated individual contacted the OCO and requested this case be closed as DOC resolved the concern prior to OCO involvement.	DOC Resolved
119.	Person reports delays with his transfer and his counselor giving him “the run around”. This individual does not understand why it is taking so long considering he has been approved, classified, and had a physical.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed this person's electronic file and determined that he was transferred to the facility he wanted and is closer to his family.	DOC Resolved
120.	Incarcerated individual relayed concerns regarding a delayed trans housing protocol.	The OCO confirmed the individual's trans housing protocol was completed and their custody facility plan (CFP) was approved prior to OCO involvement.	DOC Resolved
121.	Incarcerated individual relayed concerns regarding officer conduct during a cell search.	The OCO reviewed the individual's related grievances and found DOC policy 460.200 states that a reasonable suspicion may result in an immediate search without assistance and DOC policy 560.200 states employees may empty the entire content of a religious item box and spread them on a flat,	Information Provided

		clean surface so items can be easily observed and searched without touching. To seek compensation for the lost or damaged items, the OCO informed the individual that they will need to file a tort claim and if they are unhappy with the outcome of the staff conduct investigation, they will need to appeal the level 0 grievance response.	
122.	An incarcerated individual reports that his tort claim had been moved to the Attorney General's Office (AGO) and this person could not get ahold of any staff from that office for an update on his tort claim.	The OCO provided information to this person about their tort claim information. This office verified the individual's tort claim number with the AGO's office and gave the individual updated contact information.	Information Provided
123.	Incarcerated individual relayed concerns regarding staff conduct in which the individual reports a staff member was using derogatory racist names.	The OCO reviewed the individual's grievances related to this concern that were investigated at the facility leadership level, but it was determined by DOC that no staff misconduct occurred. Because the grievance decisions were not appealed, no further investigation took place into this concern. As a result, there was insufficient evidence for the OCO to substantiate the individual's reported staff misconduct.	Insufficient Evidence to Substantiate
124.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
125.	A loved one reports that their family member was in segregation for two months due to refusing a cell assignment and was transferred to a maximum custody prison. This person reports that the incarcerated individual has not had a write-up or been in trouble for years and this is a harsh punishment.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. This person refused housing twice, was infracted, and then transferred to another facility. DOC policy 300.380 (VI) F says that if a person refuses a housing assignment, they will be infracted and given other transfer opportunities until the custody review score no longer allows placement at the intended custody level.	No Violation of Policy
	Washington Corrections Center for Women		
126.	Person reports that she has a health status report (HSR) to accommodate a health condition and that classifications could not find a cell and unit that accommodated her HSR appropriately for her custody level.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and reached out to unit leadership and confirmed that this individual has been moved to a unit that accommodates her HSR and is appropriate for her custody level.	DOC Resolved
127.	An incarcerated individual reports she is having difficulty getting DOC to block her family from contacting her. She reports that she contacted the internal investigation unit (IIU) and incarcerated individual	The OCO provided information about trust accounts for incarcerated individuals. If this individual receives additional funds from her family, she can return the funds by completing a request to transfer funds and have the money sent back to her family. This office followed up with the facility to ensure they are aware of her request and DOC staff confirmed.	Information Provided

	banking, but her family has still been allowed to send her money. She would like to limit all contact with her family and does not want any money from them.		
128.	Incarcerated individual relayed concerns regarding staff misconduct that occurred after an infraction when staff made a derogatory statement about transgender individuals.	The OCO reviewed the infraction materials and found the incarcerated individual's behavior does meet the elements of the WAC per DOC policy 460.000. The OCO informed the individual that the concern about staff discrimination will need to be addressed by filing a grievance for staff misconduct.	Information Provided
129.	Incarcerated individual relayed concerns regarding staff misconduct that occurred after an infraction when staff made a derogatory statement about transgender individuals.	The OCO reviewed the infraction materials and found the incarcerated individual's behavior does meet the elements of the WAC per DOC policy 460.000. The OCO informed the individual that the concern about staff discrimination will need to be addressed by filing a grievance for staff misconduct.	Information Provided
130.	Incarcerated individual relayed concerns regarding believing someone filed a PREA against them.	The OCO reviewed the individual's records and was unable to find a PREA that had been filed against the individual. Thus, there was insufficient evidence to substantiate the concern.	Insufficient Evidence to Substantiate
131.	Incarcerated individual relayed concerns regarding a desire to be released from IMU to general population.	The OCO reviewed the individual's custody facility plan (CFP) that states that due to continuing to present a significant threat towards staff, and having behavior that is significant and unmanageable, there are no general population housing options available. For this reason, there is no violation of DOC policy 300.380.	No Violation of Policy
	Washington State Penitentiary		
132.	Person reports there are no OCO or Disability Rights Washington (DRW) posters or phone numbers in the Close Observation Area (COA) in WSP. Person said that staff are aware, and that staff said they intentionally took the OCO and DRW numbers down. Person said that the PREA number is the only number posted in the COA.	The OCO provided assistance by elevating this concern through DOC staff. After OCO outreach, DOC staff visited the COA and confirmed that no OCO or DRW posters or numbers were posted in the COA. English and Spanish OCO posters and contact information were added that day and photos showing their placement were sent to the OCO to confirm resolution.	Assistance Provided
133.	Incarcerated individual is trying to get recordings of hearings and states they are being "sent in circles". He wants DOC to provide recordings of hearings he has requested and wants DOC to provide clear, honest instructions on how to request the hearings recordings.	The OCO provided assistance by explaining to this individual how to request public records from the Department of Corrections.	Assistance Provided
134.	Patient reports concerns about	The OCO provided assistance by elevating this concern	Assistance

	the mental health provider assigned to their case.	through DOC staff. The patient is no longer assigned to the named mental health staff person and was assigned to a new therapist.	Provided
135.	Patient reports concerns about access to Residential Treatment Unit (RTU) for mental healthcare.	The OCO provided assistance by elevating the concern through DOC staff. The patient was approved and moved to RTU.	Assistance Provided
136.	Loved one relayed concerns regarding an incarcerated individual not being allowed to transfer facilities due to staff interference.	The OCO reviewed the individual's records and saw that the individual was able to successfully transfer facilities.	DOC Resolved
137.	Loved one relayed concerns regarding an incarcerated individual not being allowed to transfer facilities due to staff interference.	The OCO reviewed the individual's records and saw that the individual was able to successfully transfer facilities.	DOC Resolved
138.	An incarcerated person reports their sentence is incorrectly calculated per their judgment and sentence (J&S).	DOC staff resolved this concern prior to the OCO taking action on this complaint. The incarcerated person appropriately utilized DOC internal processes and DOC responded appropriately to grievances filed through the resolution program. The person's early release date (ERD) was calculated appropriately.	DOC Resolved
139.	Person reported concern about being referred to maximum custody and does not know why he was referred. Person said he wanted to go back to close custody.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and found that DOC headquarters denied the referral to maximum custody and transferred him to closed custody.	DOC Resolved
140.	Person reported having multiple medical issues and requested information about Extraordinary Medical Placement (EMP).	The OCO provided information about Extraordinary Medical Placement and encouraged him to ask for the EMP form 14-148. Per DOC policy 350.270, the Chief Medical Officer/designee will review pertinent medical records and EMP related materials to determine if the individual meets the criteria, and if they meet the criteria, the EMP coordinator will forward the referral to the Headquarters Community Screening Committee (HCSC) for review. The OCO informed this individual that they can request DOC policy 350.270 at the law library or view it on their tablet for more information.	Information Provided
141.	Incarcerated individual reports concerns regarding the resolution program at the facility.	The OCO provided information regarding this office’s actions to report concerns regarding the resolution program. This office is actively in conversation with facility and DOC headquarters leadership regarding concerns related to the resolution program, working to report and resolve issues as they arise. The OCO will continue to have these conversations as issues are reported.	Information Provided
142.	Incarcerated individual relayed concerns regarding getting the same infraction as another individual but their infraction was dismissed.	The OCO reached out to DOC staff at the facility leadership and headquarters level regarding the infraction. The OCO informed the individual that the reason their infraction was upheld was due to the severity of their actions and contributions to the infraction behavior while the other	Information Provided

		individual's behaviors did not rise to that same level.	
143.	Incarcerated individual reports concerns regarding DOC staff conduct.	The OCO provided information regarding actions being taken and next steps for the individual. The OCO spoke with DOC staff, and they are aware of the concerns and working to remedy the issue. The OCO recommends that the individual continue to report these concerns with DOC staff as they arise.	Information Provided
144.	Individual reports they have been in restrictive housing since 2018 and had their tablet taken due to safety concerns but they do not understand why.	The OCO reviewed this concern and contacted the DOC headquarters regarding this issue. The DOC has issued tablet sanctions as a safety protocol after a staff assault occurred that was linked to security threat group (STG) activity. The tablets will be returned after DOC concludes their investigation. The OCO is advising individuals to contact this office if they do not get out of cell time to use the phones.	Information Provided
145.	Incarcerated individual relayed concerns regarding therapeutic recreation programming not being offered in the unit, officers shutting down programming and specific targeting of individuals involved in therapeutic recreation programming.	The OCO reached out to DOC about these concerns, but DOC needed more information to substantiate this concern. Because the individual has not filed a grievance about this concern, there was no further information to provide DOC. The OCO informed the individual that they will need to pursue this concern through the grievance program first.	Insufficient Evidence to Substantiate
146.	Incarcerated individual expressed safety concerns about a potential transfer.	The OCO reviewed the individual's approved custody facility plan which states their safety concerns were noted but were not able to be validated.	Insufficient Evidence to Substantiate
147.	A loved one reported that an incarcerated individual was placed in solitary confinement and was not allowed to have his tablet. They reported that this individual’s infractions were dismissed, and he still has not been released from solitary confinement.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed DOC records and found that this individual was held in solitary confinement pending the infraction investigation and has since been released. DOC is allowed in policy to hold someone in solitary confinement and suspend privileges, such as tablets, while an investigation is taking place. The OCO could not find a violation of DOC policy 460.000.	No Violation of Policy
148.	Person said that he was not provided with his legal papers after being moved to solitary confinement despite having priority access.	The OCO was unable to substantiate a violation of policy by DOC. DOC policy 590.500 III. states that the Superintendent may limit access to legal pleadings and personal legal materials, depending upon behavior, security, and rules of the housing unit. The OCO reviewed DOC records and found that this individual is no longer in solitary confinement.	No Violation of Policy
149.	Incarcerated individual relayed concerns regarding having shy bladder that has resulted in an infraction.	The OCO reviewed the individual's infractions and related medical records and it was determined by DOC that the individual did not meet the criteria for paruresis (shy bladder). If an individual does not meet the criteria for the diagnosis, they will not be given any accommodations for it. There is no violation of DOC policy 460.000 in the issuance of the infraction.	No Violation of Policy
150.	Individual reported concerns regarding an extended	The OCO reviewed the concern and requested the out-of-state transfer packet for review. This office verified that the	No Violation of Policy

	placement in IMU due to a pending transfer out of state. They would like to be transferred out of solitary or moved back to the general population.	packet had been sent to other states. However, none of the states that received the packet were willing to accept a transfer. The DOC will continue to try and find suitable housing in another state but has determined that they must remain in IMU at this time for the safety of other incarcerated individuals. The DOC is acting per policy 330.600; there is no timeline for an out-of-state transfer.	
151.	An individual reports that since she filed a PREA against a DOC staff member, a campaign of retaliation has been started against her. The individual reports that she has been harassed by DOC staff about not wearing a shirt outside and was given an infraction when she was attacked by other incarcerated individuals.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Incarcerated individuals who identify as female are required to wear a shirt during yard because individuals are not allowed to expose their breasts/genitalia. The OCO reviewed the individual's infraction and determined this person threw punches back to defend herself. There is no violation of DOC policy 460.000 because it meets the elements of a 633 ("assaulting another 'offender'").	No Violation of Policy

INTAKE INVESTIGATIONS

Airway Heights Corrections Center

152.	Incarcerated individual relayed concerns regarding staff conduct, infractions and transferring facilities.	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
153.	Incarcerated individual relayed concerns regarding not being allowed to have property or commissary in a four-man cell.	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
154.	Incarcerated individual relayed concerns regarding making proposals such as getting condiments in the chow hall and being able to take packaged foods out of the chow hall but DOC has not implemented these changes.	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
155.	Incarcerated individual relayed concerns regarding a DOC staff member who picks and chooses who is allowed to go into the transfer pod and rarely chooses people of color.	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
156.	An incarcerated person reports they are needing access to specific medication and have been told they will receive it but the last few times they were	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

	called out for the treatment the call out was canceled by medical staff without providing the treatment or an alternative.		
157.	Incarcerated individual relayed concerns regarding needing replacement headphones.	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
158.	Incarcerated individual relayed concerns regarding making proposals such as allowing email addresses, allowing certain vendors from other states and allowing more variety of DVD players and TVs but DOC has not implemented these changes.	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
159.	Incarcerated individual relayed concerns regarding having to send out curio property rather than DOC storing it in long-term storage.	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.	Incarcerated individual expressed concerns about denial of a visitor.	The OCO confirmed that the visitation denial has not yet been appealed and in order for the OCO to further investigate, an appeal is needed.	Administrative Remedies Not Pursued
161.	Incarcerated individual relayed concerns regarding being transferred to a different facility.	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 relayed concerns regarding the Veteran's Pod shutting down.	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 being aggressive towards people of color.	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.	Loved one relayed concerns regarding staff conduct during a visit.	The OCO sent the individual an Ombuds Review Request form to ensure this was a concern they wanted investigated but never received confirmation from the individual. As a result, this case was closed without further investigation.	Person Declined OCO Assistance
165.	Loved one relayed concerns regarding about an incarcerated individual's approval process for graduated reentry (GRE).	The incarcerated individual contacted the OCO and requested this investigation be closed as they are not having any troubles with the GRE process.	Person Declined OCO Assistance
166.	Loved one relayed concerns regarding an infraction an	The OCO did not receive any notification from the incarcerated individual verifying that this was a concern	Person Declined OCO

	individual received and a possible custody demotion.	they wanted investigated. Thus, the case was closed without further investigation. The OCO informed the individual that if this is something they would like investigated, to please contact the OCO via the hotline or mail.	Assistance
Cedar Creek Corrections Center			
167.	Incarcerated individual relayed concerns regarding access to programming.	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
168.	Incarcerated individual relayed concerns regarding access to programming.	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
Clallam Bay Corrections Center			
169.	A loved one reported that an incarcerated person's property was removed by DOC staff and the reason given was due to an infraction which was still under investigation/appeal.	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 regarding not getting a property package delivered.	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 regarding legal access during lockdown.	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
172.	An incarcerated person reports they had property removed by facility staff as a result of 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
173.	Incarcerated individual relayed concerns regarding a desire for OCO to help overturn the denial of a tort claim.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint. The OCO does not have jurisdiction over DES and cannot aid in the overturning of the tort claim denial.	Lacked Jurisdiction
174.	Loved one relayed concerns regarding an infraction.	The OCO sent the individual an Ombuds Review Request Form to ensure that this was a concern they wanted investigated, however, the OCO never received the form back from the individual. As a result, this case was closed without further investigation.	Person Declined OCO Assistance
Coyote Ridge Corrections Center			
175.	Incarcerated individual relayed concerns regarding time	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot	Administrative Remedies Not

	calculation.	investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Pursued
176.	Incarcerated individual relayed concerns regarding a counselor's 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
177.	Incarcerated individual relayed concerns regarding issues with a cellmate.	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
178.	Incarcerated individual relayed concerns regarding DOC staff opening their locker without them present, staff possibly messing with their food and possible staff retaliation.	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
179.	Incarcerated individual relayed concerns regarding access to a knee sleeve and back brace.	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			
180.	Incarcerated individual relayed concerns regarding what type of jumpsuit transgender individuals are allowed to wear during transport.	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
181.	Incarcerated individual relayed concerns regarding DOC computers shutting down resulting in individuals not being allowed to access cleaning supplies to clean their cells.	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
182.	Incarcerated individual relayed concerns regarding 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
183.	An individual reports he has been moved to a psychiatric hospital and is concerned that this is retaliation for all the grievances and OCO complaints he submitted.	The OCO lacks jurisdiction to investigate this complaint because the complaint does not involve a person committed to the physical custody of the DOC. This individual is currently housed at a county jail, and the OCO cannot impact change in their situation.	Lacked Jurisdiction
184.	Loved one relayed concerns regarding staff conduct during a visit.	The OCO sent the individual an Ombuds Review Request form to ensure this was a concern they wanted investigated but never received confirmation from the individual. As a	Person Declined OCO Assistance

		result, this case was closed without further investigation.	
185.	Incarcerated individual relayed concerns regarding mailroom staff rejecting pictures unfairly.	The OCO confirmed that the individual released from DOC custody prior to OCO involvement in this case. As a result, this case was closed without further investigation.	Person Released from DOC Prior to OCO Action
186.	Incarcerated individual relayed concerns regarding a DOC computer glitch that impacted the cell doors and frequency individuals were allowed to leave their cells.	The OCO confirmed that the individual released from DOC custody prior to OCO involvement in this case. As a result, this case was closed without further investigation.	Person Released from DOC Prior to OCO Action
Olympic Corrections Center			
187.	Incarcerated individual relayed concerns regarding not being allowed to bring fruit back into the unit from mainline.	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
188.	Incarcerated individual relayed concerns regarding staff misconduct that resulted in several behavioral observation entries (BOEs) and 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
189.	Incarcerated individual relayed concerns regarding DOC targeting individuals who are Native American.	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
190.	Incarcerated individual relayed concerns regarding not getting funds transferred after transferring facilities.	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
191.	Incarcerated individual relayed concerns regarding the facility moving people in the unit unnecessarily and not considering courtesy moves.	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
192.	Incarcerated individual relayed concerns regarding staff making fun of their personal appearance and another incarcerated individual's weight.	The OCO confirmed that the individual released from DOC custody prior to OCO involvement in this case. As a result, this case was closed without further investigation.	Person Released from DOC Prior to OCO Action
Other			
193.	Individual expressed concerns about what occurred in a jail facility.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Declined
194.	Incarcerated individual relayed concerns regarding being placed in a gang unit during a	The OCO declined to investigate the concern per WAC 138-10-040(3)(f) as the alleged violation is a past rather than ongoing issue.	Declined

	prior incarceration and concerns about DOC staff.		
195.	Person reported discrimination by jail officials at King County Correctional Facility and 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, but provided the individual with the contact information for the King County Ombuds.	Lacked Jurisdiction
Stafford Creek Corrections Center			
196.	Incarcerated individual relayed concerns regarding not getting commissary money transferred after transferring facilities.	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
197.	Incarcerated individual relayed concerns regarding access to medical care.	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
198.	Incarcerated individual relayed concerns regarding missing property.	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
199.	An incarcerated person reports they have been punished unfairly and removed from educational programming.	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
200.	Incarcerated individual relayed concerns regarding a desire to have a dental cleaning and be seen for feet, back and shoulder pain.	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
201.	Incarcerated individual relayed concerns regarding staff abusing authority and writing numerous infractions.	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
202.	Incarcerated individual relayed concerns regarding searches.	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
203.	An incarcerated person called to report another incarcerated person was not receiving appropriate treatment.	The incarcerated individual did not respond to the OCO’s request to provide additional information. The OCO encouraged this person to contact this office if they would like to request assistance. The OCO needs consent and a release of information to review this concern.	Person Declined OCO Assistance

Washington Corrections Center			
204.	Incarcerated individual relayed concerns regarding termination of visiting privileges with a visitor.	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
205.	Incarcerated individual relayed concerns regarding not being allowed to eat in the dayroom for Ramadan.	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
206.	Incarcerated individual relayed concerns regarding a desire to be compensated as an access assistant.	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
207.	Incarcerated individual relayed concerns regarding 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
Washington Corrections Center for Women			
208.	Incarcerated individual relayed concerns regarding the job environment in the kitchen.	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
209.	Incarcerated individual relayed concerns regarding a desire to have a do not resuscitate order put on file but DOC does not know where to notate this on the individual's ID.	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
210.	Incarcerated individual relayed concerns regarding DOC allowing scabies to spread.	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
211.	External person reports concerns about their incarcerated loved one's medical care.	The OCO attempted to schedule a 1:1 phone call with the patient but the patient did not complete the call. The incarcerated individual did not respond to the OCO’s request to provide additional information within 30 days. This person was released on GRE prior to the OCO taking action on the complaint.	Person Declined OCO Assistance
Washington State Penitentiary			
212.	Incarcerated individual relayed concerns regarding DOC not assisting in getting a replacement headset.	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

213.	Incarcerated individual relayed concerns regarding one of the unit phones not working.	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-23-023

Report to the Legislature

As required by RCW 72.09.770

April 12, 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-23-023 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 March 7, 2024, and March 13, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Zain Ghazal, Administrator – Health Services
- Rae Simpson, MSN, Director – Quality Systems
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Page Perkinson, Correctional Operations Program Manager

DOC Risk Mitigation

- Mick Pettersen, Director

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Ellie Navidson, MSN, Nursing Consultant, 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: 1954 (69-years-old)

Year of Incarceration: 1992

Date of Death: December 2023

During his incarceration, he was housed in a prison facility and died while being cared for in a community hospital. The cause of death was hypoxic respiratory failure, post obstructive pneumonia, and metastatic lung cancer. 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
10 days prior	• The incarcerated individual began coughing up blood at work and a medical emergency response was requested. • 911 was called. • Community emergency medical services (EMS) arrived and assumed care and transported him to the community hospital. • Testing at the hospital showed a large bleeding mass in his left lung.
8 days prior	• Procedure performed to reduce the size of the lung mass and stabilize the airway passage. • Pathologic testing confirmed the mass was cancerous.
7 days prior – 1 day prior	• DOC Seriously Ill Notification process was initiated. • DOC and community hospital's attempts to reach next of kin were unsuccessful. • His condition continued to deteriorate. • He was not able to discuss his wishes regarding care. • Community hospital ethics, hospitalist, oncology, and palliative care teams concurred that he would not benefit from further aggressive treatment and would suffer undue harm. • Community hospital provided updates to the facility medical director who assented to the hospital's decision to remove him from the ventilator.
Day of death	• He was removed from the ventilator, and he passed away at the community hospital.

UFR Committee Discussion

The UFR Committee met on two occasions 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 MRC found:

    a. The incarcerated individual was not a frequent utilizer of medical services. His last visit with a primary care provider was August of 2021.
    b. He was from Africa and English was his second language. It was not documented whether he was able to effectively communicate and discuss his care needs without translation although medical notes indicated he was able to participate in decision-making for previous medical care and at the beginning of this hospitalization.
    c. He was a former smoker but there is no clear documentation of when he stopped smoking, though DOC banned smoking in 2004.
    d. Based on effective date for the DOC smoking ban and the current U.S. Preventative Services Task Force (USPSTF) recommendations he would not be eligible for lung cancer screening by a low dose chest CT screening.
    e. He received mental health treatment until February of 2016. At the time of his death, he had a long history of needing minimal support services and was on no medication for his mental health symptoms.
    f. He had no Portable Order for Life Sustaining Treatment (POLST) or advanced directive on file and the emergency contact information he had listed was out of date.

2. The MRC committee recommended:

    a. Referral to the UFR committee for review.

    b. DOC include advanced care planning as part of the health services intake process.

    c. DOC request the Patient Centered Medical Home (PCMH) steering committee prioritize a process for an annual visit with the primary care team in 2024.

B. The UFR committee had a robust conversation on several topics related to this unexpected fatality.

1. Topic: DOC's process for scheduling follow-up appointments and documentation of cancellations.

    In the months before his death, the incarcerated individual had a nursing sick call visit for symptoms of all over body pain and skin dryness that worsened with cold weather. He was evaluated and scheduled follow-up appointment with his primary care provider. The schedule shows the follow-up appointment was cancelled but staff did not document the reason for the cancellation. The committee discussed the importance of documentation in the health record when recommended care visits are not completed as scheduled.

    Note: DOC has existing procedures that require documentation of cancelled appointments which was not followed by staff. DOC Health Services (HS) does not have an electronic health record or scheduling system that provides notification when a follow-up appointment has

been cancelled and not rescheduled. HS is continuing to explore options to ensure necessary follow-up occurs.

2. Topic: DOC's role in community hospital end-of-life care decisions.

   The committee reviewed the records and discussed the end-of life-care for the incarcerated individual. The committee asked about DOC's role in community hospital end-of-life care and whether advanced directives are provided by DOC to community care providers.

   Note: Incarcerated individuals have autonomy to make their own care decisions and DOC staff members do not hold surrogate decision-making capacity. If an incarcerated individual is unable to make decisions and there is no next of kin or an established surrogate decision maker, the hospital will follow their established process for medical decision-making. DOC works with the community hospital by sharing health information and advanced directives, attempting to reach next of kin, and providing support for transfer of care when needed.

   The committee recommended DOC connect with the DOH POLST registry to explore options to include DOC Health Services as part of the registry.

   The committee reviewed the community hospital records which documented the process to have a guardian appointed and the care decisions made with support of their ethics committee. The committee recommended DOC provide the community hospital ethics department information regarding DOC's role in care decision-making. The committee noted the lack of guardianship resources statewide and guardians frequently cannot be appointed timely to provide care decision support.

   The committee discussed the impacts of cultural and religious preferences in relation to end-of-life care and final wishes and concurred that this is part of holistic, person-centered medical care. The group recommends DOC document religious preferences and final wishes as part of their intake process and provide this information to community hospitals as part of sharing advanced directive information.

3. Topic: Language and translation services.

   The committee discussed language services for individuals with limited English proficiency in DOC health services. Discussion revolved around how incarcerated individuals know language services are available, how they obtain and decline care, and how informed consent is ensured. The committee recommended improvements for incarcerated individuals who have limited or no English proficiency.

   Note: DOC provides oral interpretation and written translation services at all facilities and DOC Health Services uses certified contracted medical interpreters. DOC is working on more avenues to request care. The patient education committee is working on documentation and forms including opportunities to improve primary language services.

   The committee recommends printing and distributing the "Point to Your Language" posters. Additionally, the committee recommends DOC explore options to make written information available in additional languages.

Committee Findings

The manner of the incarcerated individual's death was natural. The cause of death was acute hypoxic respiratory failure, post obstructive pneumonia, and metastatic lung cancer.

Committee Recommendations

The committee did not offer any recommendations for corrective action 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 review current religious and person-centered practices regarding end-of-life care and final wishes for their body after death.
2. DOC should explore options to expand access to written material and language translation services for non-English speakers including translating the statewide orientation handbook.
3. DOC should explore options for chaplain resources in multiple language and religions.
4. DOC HS should provide feedback to the community hospital regarding end-of-life decision making for DOC patients.
5. DOC should contact the DOH POLST registry program to explore options for DOH inclusion.
6. DOC should continue to request resources for an electronic health record that supports documentation, scheduling, and electronic communication with community care providers.
7. DOC should develop an informational brochure for community care providers regarding incarcerated individuals' right to direct care decisions.
8. The committee requests the report highlight the need for guardianship resources for Washington state residents and processes/guidelines for individual cases to be expedited.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-024

Report to the Legislature

As required by RCW 72.09.770

April 25, 2024

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
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Unexpected Fatality Review Committee Report

UFR-23-024 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. Federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying substance use 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 March 21, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Zainab Ghazal, Administrator
- Rae Simpson, MSN Director – Quality Systems
- Mark Eliason, Deputy Assistant Secretary
- Patty Paterson, MSN, Director of Nursing
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Chuck Anderson, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Program Manager

DOC Community Corrections Division

- Kelly Miller, Administrator – Graduated Reentry
- Michelle Eller-Doughty, Correction Specialist 4

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Deputy Director
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Ellie Navidson, MSN Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Charissa Fotinos, Medical Director
- Dr. Judy Zerzan, Medical Director

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

Fatality Summary

Date of Birth: 1978 (45-years-old)

Date of Incarceration: October 2022

Date of Death: December 2023

At the time of his death, the incarcerated individual was participating in the Graduated Reentry (GRE) program on electronic home monitoring.

His cause of death was acute buprenorphine, fentanyl, methamphetamine, and xylazine toxicity. The manner of his death was accidental.

A brief timeline of events prior to the incarcerated individual's death.

Approximate Weeks Prior to Death	Event
28 weeks prior	• Completed a substance use disorder (SUD) assessment through the DOC Health Services Substance Abuse Recovery Unit.
23 weeks prior	• Transferred to Graduated Reentry (GRE) with initial housing for inpatient SUD treatment.
13 weeks prior	• Successfully completed inpatient SUD treatment. • Transported to approved residence. • Seen at community clinic for continuation of medication assisted treatment after discharge from inpatient treatment.
12 weeks prior - 1 day prior	• Completed required check ins with GRE case manager. • All drug screens were negative for non-prescribed substances. • He secured and engaged in employment. • He reported that everything at his job and home was going well. • He continued with outpatient treatment support and had no known sobriety lapses.
Day 0	• Review of monitor report showed no movement alert, and he did not respond to text messages. • Transitional house staff called DOC to inform that he may be deceased and 911 was on the way. • Community fire department arrived and found him deceased.

UFR Committee Discussion

The UFR committee met to discuss the findings and recommendations from the DOC Mortality Review Committee and the DOC Critical Incident Review. The UFR committee 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. They did not identify any additional recommendations to prevent a similar fatality in the future.

1. The MRC found:

   a. He transferred from a prison facility directly to an inpatient admission in a community treatment program for substance use.

   b. After successfully completing the treatment program, he continued with community aftercare and support while participating in the graduated reentry (GRE) program.

   c. He appeared to be successfully managing his disease prior to the fatal overdose.

   d. Contracted community substance-use disorder treatment providers do not directly connect with DOC Health Services to leverage additional sobriety support as the current staffing does not include Health Services staff in GRE.

   e. Because he was directly admitted to a community substance use treatment facility, Health Services Reentry team did not provide additional post-prison outreach to him.

   f. There is a potential opportunity for expansion of Health Services Reentry or development of more collaborative community partnerships to enable enhanced sobriety support assistance for people transitioning into the community from prisons.

2. The MRC recommended:

   a. A referral to the UFR committee.

   b. Exploring opportunities to partner with community corrections reentry staff and community partners to assist people transitioning into the community.

   c. Continuing to implement the 1115 Medicaid waiver to enable connection to community resources 90 days prior to transition from prison.

   d. Continuing to pursue necessary funding to expand the use of medications for opioid use disorder (MOUD) treatment to ensure each individual who needs care has access.

   e. Offering an annual primary care visit to all incarcerated individuals to foster a trusting

relationship between DOC primary care teams and the persons in their care, thereby potentially increasing the lines of support for persons who are struggling.

C. Independent of the mortality review, the 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. All electronic home monitoring (EHM) and drug testing was conducted within the parameters of the GRE program.

      b. There were missing and late administrative documentation entries noted in the electronic and field case supervision files.

      c. A needs reassessment was not completed by the GRE case manager.

   2. The CIR recommendations did not directly correlate to the case of death and will be remediated per DOC Policy 400.110 Reporting and Reviewing critical incidents.

D. The UFR committee reviewed the unexpected fatality and discussed the following topics related to the fatality:

   1. Substance use treatment in prison facilities:

      The committee discussed the lack of resources to provide medications for treatment of opioid use disorder (MOUD) for all incarcerated individuals who need treatment continually during their incarceration. The current access is for three months at the beginning and end of incarceration for those whose sentence exceeds 6 months. Those with a six month or shorter sentence are maintained on their existing MOUD. Concerns were expressed that when people are tapered from MOUD during their incarceration, the science suggests that it may destabilize their recovery and impair their future ability to remain sober. The committee members support continuing to advocate for funding that support uninterrupted access to MOUD throughout incarceration.

   2. Graduated Reentry (GRE) participation:

      The committee discussed the criteria and process for transferring into the Graduated Reentry program. This incarcerated individual's substance use assessment determined he needed inpatient substance use disorder (SUD) treatment prior to residing on his own in the community. From the prison facility, he was transported to a contracted community SUD treatment facility. After successfully completing treatment, he resided in a transitional sober living house to complete the GRE program.

During his admission to the SUD treatment facility, he was prescribed medications to treat opioid use disorder and continued the medications while participating in the GRE program. He was given Narcan by his GRE case manager and overdose prevention education. Narcan was also provided to the transitional housing vendor.

The incarcerated individual had two DOC reentry staff members supporting his transition from prison through treatment and into the community transitional housing. They offered resources, assistance, and accountability to support his successful reintegration into the community. He was considered a model GRE participant. He was employed, in treatment, had family support and was doing well overall.

Committee Findings

He died as a result of acute buprenorphine, fentanyl, methamphetamine, and xylazine toxicity. The manner of his death was accidental.

Committee Recommendations

DOC should request funding of substance use disorder treatment services to expand options for incarcerated individuals with a diagnosis of opioid use disorder to receive medication assisted therapy during their incarceration.

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

1. As funding allows, DOC should continue to expand options for incarcerated individuals with a diagnosis of opioid use disorder to receive medication assisted therapy prior to reentering the community.
2. DOC Health Services should explore the possibility of utilizing the Behavioral Health-Administrative Services Organization recovery navigators to offer additional sobriety support for GRE participants.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-025

Report to the Legislature

As required by RCW 72.09.770

April 4, 2024

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
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Unexpected Fatality Review Committee Report

UFR-23-025 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. Federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying substance use 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 March 12, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Zainab Ghazal, Administrator
- Mark Eliason, Deputy Assistant Secretary
- Rae Simpson, Director – Quality Systems
- Patty Paterson, MSN, Director of Nursing
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Risk Mitigation

- Michael Pettersen, Director

DOC Prisons Division

- Jeffrey Perkins, Superintendent
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Program Manager
- Rochelle Stephens, Men's Prison Project Manager

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Deputy Director
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Ellie Navidson, RN Nursing Consultant Institutional, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Sophie Miller, Medical Officer

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

Fatality Summary

Year of Birth: 1952 (71-years-old)

Date of Incarceration: August 1995

Date of Death: December 2023

At the time of his death, this incarcerated individual was housed in a prison special needs unit.

His cause of death was due to complications of chronic kidney and bladder infection from kidney stones leading to hemorrhagic bladder rupture. The manner of his death was natural.

A brief timeline of events prior to the incarcerated individual's death.

Weeks before death	Event
1 week prior	• The incarcerated individual transferred from a prison inpatient unit to a prison special needs unit.
Day of Death	**Event**
1127 hours	• He was eating lunch in the unit day room when he became unresponsive. • 911 called. • CPR was initiated.
1142 hours	• Community emergency medical services (EMS) arrived on grounds.
1221 hours	• Community EMS pronounced his death.

UFR Committee Discussion

The UFR committee met to discuss the findings and recommendations from the DOC Mortality Review Committee. The UFR committee considered the information 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.

   1. The MRC found:

      a. The incarcerated individual with a history of calculi-associated kidney and bladder inflammation died of an extremely dilated urinary bladder leading to

hemorrhagic bladder rupture.

b. He carried serious chronic medical and mental health conditions, then experienced increased frailty and dependence for activities of daily living which necessitated a transfer from his residential care housing unit to the special needs unit. The referral specifically referenced the need for toileting support.

c. The review demonstrated that this individual experienced negative symptoms of schizophrenia and depression and had a history of frequent declinations of care. Staff did not document assessment of the incarcerated individual's decisional capacity to decline care during the transfer nor on arrival to the special housing needs unit. The committee discussed transitions of care creating higher vulnerability for persons with cognitive and receptive differences.

d. There was no documentation of multidisciplinary team meetings regarding his care management and the minutes of the Facility Medical Director transfer call indicate that his case was not managed via this care coordination venue.

e. He had an indwelling urinary catheter with a leg collection device that was covered by clothing. The Root Cause Analysis performed by nursing revealed that the absence of a plan for catheter care contributed to his death. Prior to this review, there existed no "nursing home like" intake process to systematically ensure urinary catheter and collection device care in the special needs unit.

f. For years to his final illness, he was housed in residential treatment unit with little interaction with other incarcerated individuals. He was transferred to an inpatient unit for several months, then to a dormitory setting in the special needs unit. These transfers may have exacerbated his lack of coping mechanisms for which the support in the residential treatment unit may have mitigated. The transfers themselves may have had a negative impact on his mental health symptoms. His interactions with health services staff remained consistent with little interaction and care declinations.

B. The MRC recommended:

1. Referring to the Unexpected Fatality Review Committee.

2. Additional Root Cause Analysis (RCA) with resultant action items by nursing leadership to examine and improve the following aspects of nursing care in special needs unit:

    a. Orientation to staff and patients for individuals transferring from a residential treatment unit to special needs unit housing.

   b. Educating nursing staff on need to chart elements of the evaluation that were completed and not just note “wellness check”.

   c. Requiring nursing assistants to document care provided in the health record.

   d. Development of treatment planning that more closely emulates “nursing home level” of care in the special care unit.

3. Providing education to DOC Health Services staff regarding the process to evaluate decisional capacity.

4. Encouraging the use of multidisciplinary care team meetings that include primary care, nursing, and behavioral health team members for individuals with complex needs.

C. The DOC discussed an additional finding out of the initial nursing RCA was that the certified nursing assistant (CNA) documentation was recorded on a log that is not part of the health record. The DOC Chief Nursing Officer (CNO) will be working with the facility to ensure all care is appropriately recorded in the health record. Additionally, the CNO will be educating staff regarding supporting incarcerated individuals that experience persistent mental health illness.

D. The Department of Health (DOH) representative offered that in healthcare, if “something is not documented in the health record, it did not happen”. The DOH representative recommends that an accountability process be established, as education is not enough to address the documentation deficiencies. The DOH representative also recommends a formal process to determine if an incarcerated individual’s care needs can be met in their current housing setting. The DOH representative asked when multidisciplinary teams occur and recommends a formal process for when they are mandated.

   Note: DOC currently has an established process for multidisciplinary team meetings. These meetings may include representatives from custody, primary care, nursing, and behavioral health. In this case, he was presented on the behavioral health transfer call. The discussion occurred several weeks prior to the individual transferring and a medical status update care handoff was not provided prior to his transfer.

E. The Health Care Authority (HCA) representative asked about the protocol for monitoring external medical devices and the definition of a “wellness check” in the setting. The HCA representative supports expanded decisional capacity discussions.

   Note: DOC stated that nursing orders and a care plan are developed for the management of medical devices like urinary catheters and are implemented. DOC acknowledged that wellness checks are not adequate documentation of care that is being provided.

F. The Office of the Correctional Ombuds (OCO) representative shares the concerns of the other

representatives that the lack of documentation does not allow for a thorough care review and acknowledges that recommendations will be based on the information available. The OCO representative asks what support for activities of daily living (ADL) the incarcerated individual required when he was transferred.

Note: DOC stated that his needs for support with activities of daily living included day-to-day grooming like prompts for face washing and shaving, help with toileting, and some assistance with dressing. He was able to complete these tasks independently once prompted. He was assessed as being frail and a fall risk.

The OCO representative stated there is an opportunity to look at how transfer discussions and transfer decisions happen. The representative recommends expanding the transfer calls to include anyone transferring from a residential treatment level of care to both the behavioral health and medical transfer calls. The OCO representative asks how care managers are being used and whether one was used in this case.

The OCO representative stated that the incarcerated individual was transferred due to need for care and does not believe the transfer was completed timely. The OCO representative requests that UFR discussions lead to actionable recommendations coming from the committee. The OCO highlighted that some records identified as being necessary in this UFR, including nursing encounters and nursing records, were not available. The OCO representative recommended that nursing staff document in the health record and have a clear transfer process with written protocols.

Note: DOC is currently working on a system redesign for the medical transfer call to create a more interdisciplinary and systematic process to ensure the appropriateness of transfer. This individual was transferred to a facility staffed to provide more nursing care support and passed away suddenly. Electronic transfer orders show there was a medical hold in place preventing a transfer until necessary care was completed. The individual was transferred the date the hold expired.

The way the special needs unit was documenting care is no longer occurring and records regarding care and assessments will be kept in the health record. DOC agrees there should always be care needs hand off communication, so staff are aware of mental health and medical conditions.

The OCO representative discussed how reevaluating decisional capacity is necessary, and continuity of care should be consistent. The representative asked the UFR committee to make a recommendation to the residential treatment unit workgroup to require a multidisciplinary team that includes members of the medical team when transferring an individual with mental health needs to another facility.

Committee Findings

The incarcerated individual died from complications of calculi-associated pyelonephritis and cystitis,

including hemorrhagic bladder rupture. The manner of death was natural.

Committee Recommendations

Table 1 presents the UFR Committee's recommendations to prevent similar fatalities and further strengthen safety and health protections for incarcerated individuals. As required, the DOC will develop, publish, and implement an associated corrective action plan within 10 days following the publishing of this report.

Table 1. ***UFR Committee Recommendations***
1. DOC should provide education to DOC Health Services facility staff on the process to evaluate decisional capacity.
2. DOC Health Services should use a multidisciplinary care team meeting that includes primary care, nursing, and behavioral health team members for individuals with complex medical and mental health needs.
3. DOC ensure appropriate catheter care is being provided to all incarcerated individuals housed in prison facilities.
4. DOC should ensure that all nursing documentation is contained in the health record.

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

1. DOC should request the residential treatment unit workgroup require a multidisciplinary team when transferring an individual and develop an orientation and training to address impacts of transfer to other settings.

2. DOC should continue to pursue an electronic health record to support care transitions.

Unexpected Fatality Review DOC Corrective Action Plan

Unexpected Fatality UFR-23-025

Report to the Legislature

As required by RCW 72.09.770

April 14, 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 review team under this section."

Unexpected Fatality Review Committee Report

The department issued the UFR committee report 23-025 on April 4, 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-23-025-1
Finding:	There is no documentation of a formal decisional capacity evaluation in the health record after the incarcerated individual declined recommended care several times.
Root Cause:	Staff did not recognize the mental health symptoms and recent illness may have impacted the incarcerated individual's capacity to make informed health care decisions.
Recommendations:	DOC should provide education to DOC Health Services staff regarding the process to evaluate decisional capacity.
Corrective Action:	DOC should develop a protocol for evaluating decisional capacity and a plan to provide education to DOC Health Services facility staff on the protocol.
Expected Outcome:	Support for incarcerated individuals' autonomy to make care decisions.

CAP ID Number:	UFR-23-025-2a
Finding:	This individual had complex care needs requiring both medical and mental health support.
Root Cause:	The behavioral health transfer call discussion regarding appropriate housing did not include input from medical providers.
Recommendations:	DOC Health Services should use a multidisciplinary care team meeting that includes primary care, nursing, and behavioral health team members for individuals with complex medical and mental health needs.
Corrective Action:	DOC Health Services will develop a plan and protocol for the use of multidisciplinary team meetings to improve transitions of care for individuals with medical and mental health needs.
Expected Outcome:	Improved continuity of care for transferring individuals.

CAP ID Number:	UFR-23-025-2b
Finding:	This individual had complex care needs requiring both medical and mental health support.
Root Cause:	The behavioral health transfer call discussion regarding appropriate housing did not include input from medical providers.
Recommendations:	DOC Health Services should use a multidisciplinary care team meeting that includes primary care, nursing, and behavioral health team members for individuals with complex medical and mental health needs.

Corrective Action:	DOC should update the behavioral health transfer call criteria to include a care needs review by the Facility Medical Director to ensure medical care needs can be met.
Expected Outcome:	Improved continuity of care for transferring individuals.

CAP ID Number:	UFR-23-025-2c
Finding:	This individual had complex care needs requiring both medical and mental health support.
Root Cause:	The behavioral health transfer call discussion regarding appropriate housing did not include input from medical providers.
Recommendations:	DOC Health Services should use a multidisciplinary care team meeting that includes primary care, nursing, and behavioral health team members for individuals with complex medical and mental health needs.
Corrective Action:	DOC should develop written guidelines for transferring incarcerated individuals to the special needs unit.
Expected Outcome:	Improved continuity of care for transferring individuals.

CAP ID Number:	UFR-23-025-3
Finding:	Nursing care was insufficiently documented in the health record
Root Cause:	Nurses were not sufficiently documenting their assessments and nursing assistants were not documenting the care they provided in the health record.
Recommendations:	DOC should ensure that all nursing documentation is contained in the health record.
Corrective Action:	The chief nursing officer will provide education and establish a systemic accountability process that will ensure all nursing care is appropriately documented in the health record.
Expected Outcome:	All nursing care provided will be accurately reflected in the health record.

CAP ID Number:	UFR-23-025-4
Finding:	The incarcerated individual’s urinary catheter was not properly managed.
Root Cause:	There was no care plan in place to support the individual with catheter care.
Recommendations:	DOC should ensure appropriate catheter care is being provided to all incarcerated individuals housed in prison facilities.
Corrective Action:	The Chief Medical Officer will verify with Facility Medical Directors that individuals with catheters have an appropriate care plan in place.
Expected Outcome:	Appropriate care support is provided to individuals with urinary catheters.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-026

Report to the Legislature

As required by RCW 72.09.770

April 29, 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-23-026 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 April 5, 2024:

DOC Health Services

- Dr. Frank Longano, Chief Medical Information Officer representing the Chief Medical Officer
- Dr. Karie Rainer, Director Behavioral of Health
- Dr. Zain Ghazal, Administrator
- Patty Paterson, MSN, Director of Nursing
- Mark Eliason, Deputy Assistant Secretary
- Rae Simpson, MSN, Director of Quality Systems
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Prisons Division

- Charles Anderson, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Program Manager
- Rochelle Stephens, Men's Prisons Project Manager

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Deputy Director
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Ellie Navidson, MSN, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Charissa Fotinos, Medical Director

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

Fatality Summary

Year of Birth: 1986 (37-years-old)

Year of Incarceration: 2023

Date of Death: December 2023

At the time of his death, the incarcerated individual was housed in a prison facility. His cause of death was asphyxia due to strangulation. The manner of his death was suicide.

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

Day of death	Event
0543 hours	• A tier check was conducted at his cell and no concerns were noted.
0625 hours - 0642 hours	• Custody officers found the incarcerated individual hanging. • They removed the ligature and lowered him to the floor. • Emergency response and CPR was initiated. • Community 911 response requested and assumed care upon their arrival.
0655 hours	• Community EMS pronounced time of death.

UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee and Critical Incident Review. The UFR Committee members considered the information from the 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. There were no gaps in care identified.

    b. The incarcerated individual reported a suicide attempt within the last year during the intake screening process and was not flagged for further mental health evaluation because he denied current suicidal thoughts or ideations.

    c. The incarcerated individual did not request medical or mental health services during his incarceration.

2. The Mortality Review Committee recommended:

    a. A referral to the UFR committee.

    b. Scheduling a mental health appraisal for further evaluation of suicide risk when an incarcerated individual reports a suicide attempt within one year.

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. Medical and mental health intake screenings were conducted according to policy.
    b. He reported a history of suicidal behaviors and denied current suicidal thoughts during intake screening.
    c. He was not referred or scheduled for follow-up with mental health.
    d. He did not request mental health treatment.
    e. Emergency response and treatment was conducted according to policy.
    f. He used the shelf in his cell to anchor the ligature.
    g. The hand-held video of the incident response was not retained.

2. The CIR recommended the DOC behavioral health department review criteria for scheduling mental health appraisals on intake when an incarcerated individual reports previous suicidal thoughts or actions.

C. The UFR committee reviewed the unexpected fatality and discussed the following topics related to the death:

1. DOC Intake process:

The intake process is designed to be completed in a short timeframe to maintain bed space and allow individuals to transfer from the reception center to their parent facility where they can access programming supports. The reception center receives 400 to 500 individuals every month from county jails. DOC does not always receive health information from transferring facilities which can make identifying needs difficult.

The committee discussed the mental health intake process for incarcerated individuals and how individuals are assessed for mental health and suicidality. Individuals are briefly screened by a mental health professional. Those identified as needing mental health services or higher risk for suicide are scheduled for a mental health appraisal for additional needs evaluation.

The committee discussed the medical intake process. Incarcerated individuals are briefly screened by the nurse for any concerns that need to be addressed immediately, if no urgent needs identified they are scheduled for the routine intake physical. The intake

physical documented no chronic medical conditions, and he was on no medication prior to incarceration. He did report a history of mental health symptoms and had not found previous treatment helpful.

This individual disclosed a previous suicide attempt within the last year but when asked he repeatedly denied current thoughts of suicide. The committee concurred that DOC should automatically target an individual reporting a recent suicide attempt for further evaluation.

2. Transfer to parent facility and housing assignments:

   The committee discussed the process of classification and housing determination in prison facilities. Based on his sentence, this individual was required to reside in a close custody unit for at least one year. A close custody unit provides a higher level of security, provides more supervision, less freedom of movement and has stricter limits on property and programming.

   This incarcerated was approved to be housed with another but at the time of his death he was housed without a cellmate. Cell assignments are determined at the unit level and many factors are considered.

   The committee also discussed the environment of close custody at the prison and what a day may like for an incarcerated individual living there.

Committee Findings

The manner of the incarcerated individual's death was suicide. The cause of death was asphyxia due to strangulation.

Committee Recommendations

DOC should update the mental health intake process to ensure an incarcerated individual has a mental health appraisal for further evaluation if they report a suicide attempt within the last year.

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 expedite the release of the new Critical Incident Review Policy to support the critical incident review teams.
2. DOC should continue to advocate for an electronic health record to facilitate communicate with community and jail providers.
3. DOC should retain hand-held incident response video per the department's record retention schedule.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-006

Report to the Legislature

As required by RCW 72.09.770

April 30, 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-24-006 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. Federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying substance use 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 April 4, 2024:

DOC Health Services

- Dr. Frank Longano, Chief Medical Information Officer representing the Chief Medical Officer
- Dr. Zain Ghazal, Administrator
- Patty Paterson, MSN - Director of Nursing
- Mark Eliason, Deputy Assistant Secretary
- Rae Simpson, MSN - Director – Quality Systems
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Prisons Division

- Charles Anderson, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Program Manager
- Rochelle Stephens, Men's Prisons Project Manager

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Charissa Fotinos, Medical Director

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

Fatality Summary

Date of Birth: 1946 (83-years-old)

Date of DOC Incarceration: April 1994

Date of Death: January 2024

At the time of his death, the incarcerated individual was housed at a prison facility and was a federal boarder.

His cause of death was viral pneumonia secondary to co-infection with SARS COV-2 (COVID-19), human rhinovirus and enterovirus. The manner of his death was natural.

A brief timeline of events prior to the incarcerated individual's death.

Prior to Death	Event
Day 1	• Cellmate reported the incarcerated individual was having difficulty breathing and he was sent to medical. • He received a medical assessment and was encouraged to be admitted to the facility infirmary. • He declined infirmary care and was counselled to declare a medical emergency if anything changed. • He returned to his living unit against medical advice.
Day 0	• Cellmate reports the incarcerated individual is unresponsive. • Officer responded. • CPR started and 911 called. • Emergency medical services (EMS) arrived and assumed care. • EMS pronounced him deceased.

UFR Committee Discussion

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

1. The DOC Mortality Review Committee (MRC) reviewed the medical record, the care delivered, and provided the following findings. The committee found:

    a. The incarcerated individual had several chronic medical conditions that placed him at high risk for a poor outcome from a COVID-19 infection.

    b. He received his last COVID-19 vaccination in April 2021 and received an influenza vaccine in the fall of 2023.

    c. He was not screened for respiratory infections when seen for shortness of breath.

    d. He declined admission to the facility infirmary.

2. The committee did not identify any additional recommendations to prevent a similar fatality in the future.

B. The committee reviewed the unexpected fatality, and the following topics were discussed.

1. COVID screening and protocols in the facilities:

The committee discussed the DOC COVID infection prevention guidelines, which align with the Centers for Disease Control recommendations. DOC described the current process for respiratory illness screening and notification of incarcerated individuals when there are active cases in the facility. Mass COVID testing is no longer recommended, and many incarcerated individuals choose not to be tested when there has been a possible exposure. DOC has reinforced with health services staff the requirement for testing when an incarcerated individual is showing symptoms. DOC continues to provide appropriate personal protective equipment for use by incarcerated individuals and staff.

COVID vaccines are offered to all incarcerated individuals and information on vaccines and clinics are posted in the units. Vaccine education is provided through infection prevention and primary care staff.

2. Facility infirmaries and declination of care:

In the hours before his death, this individual was assessed by nursing, and was encouraged to admit to the facility infirmary. He declined admission, was counselled to declare a medical emergency if his condition worsened, and then returned to his unit. This death highlights how quickly an individual can be overwhelmed by a COVID infection. DOC nursing leadership plans to provide additional training on performing respiratory evaluations, and clinical monitoring. The committee supports the additional training.

DOC described the process when an incarcerated individual declines care. In this case, the documentation did not fully describe the reason for admission to the infirmary and why he

declined. The committee recommends staff clearly document in the health record the information and guidance provided to the incarcerated individual when there is a care declination.

The incarcerated individual's medical record documented intervals of frustration with care provision and periods of disengaging from care during his lengthy incarceration. The committee discussed the value of maintaining a therapeutic relationship with incarcerated individuals who have care needs, even when they become frustrated and disengaged.

The committee discussed facility infirmaries and what level of medical care and treatment an incarcerated individual may receive. DOC infirmaries provide skilled care (e.g. focused nursing/complex wound care/intravenous antibiotics/post-surgical recovery). Incarcerated individuals requiring a higher level of care are transferred to a community hospital for care.

The committee also discussed the facility infirmary setting and why an incarcerated individual might decline admission. DOC reported some of the reasons including boredom, not being allowed to have their normal personal property, and less freedom of movement than their regular unit. DOC is looking at options for safely allowing some personal property in the infirmary.

Committee Findings

The incarcerated individual died as a result of viral pneumonia secondary to co-infection with SARS COV-2 (COVID-19), human rhinovirus and enterovirus. The manner of his death was natural.

Committee Recommendations

The UFR committee did not identify any recommendations to prevent a similar fatality in the future.

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

1. DOC nursing leadership should provide additional training on performing respiratory evaluations and clinical monitoring.
2. DOC Health Services should consider gathering information on the number of individuals declining facility infirmary admission and the reason for the declination, with the goal of decreasing declination rates.
3. DOC Health Services should continue implementation of the Patient Centered Medical Home model and include proactive outreach to individuals with known care needs who are not engaged.
4. The committee recommends staff clearly document in the health record the information and

guidance provided to the incarcerated individual when there is a care declination.

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