Office of the Corrections OMBUDS

Monthly Outcome Report

June 2024

Unexpected Fatality Reviews: 3

Case Investigations: 179

Assistance Provided: 14

Information Provided: 78

DOC Resolved: 35

Insufficient Evidence to Substantiate: 9

No Violation of Policy: 43

Substantiated: 0

Intake Investigations: 12

Administrative Remedies Not Pursued: 1

Declined: 0

Lacked Jurisdiction: 0

Person Declined OCO Assistance: 5

Person Released from DOC Prior to OCO Action: 6

Resolved Investigations:

194

Assistance or Information Provided in

51%

of Case Investigations

OCO Casework Highlights

June 2024

Assistance Provided

Reported Concerns: Family members of an incarcerated person contacted the OCO with concerns related to an arrest and subsequent re-incarceration of a person who had previously received a Governor's commutation.
OCO Actions: The OCO elevated the concern through DOC leadership and the Governor's Office staff.
Negotiated Outcomes: After OCO outreach, this office confirmed that after the individual completed the requirements set out by the Governor, he was awarded an amended commutation and released from prison.

Assistance Provided

Reported Concern: A loved one reported that an incarcerated individual received a negative behavior observation entry (BOE) and an infraction for refusing a housing assignment that he felt uncomfortable with. They also expressed concern that this individual is being targeted and discriminated against.
OCO Actions: The OCO reviewed DOC records and met with facility leadership to discuss these concerns.
Negotiated Outcomes: DOC agreed to remove the negative BOE. The OCO was unable to negotiate for the infraction to be removed, because staff could not verify that this individual expressed safety concerns to the staff who issued the infraction. Facility leadership agreed to create a new process for unit and facility leadership to interview individuals that refuse housing to identify safety and security concerns.

Assistance Provided

Reported Concerns: Incarcerated individual reports concerns regarding DOC staff not acting to change his phone IPIN when it was stolen. The individual reports that because of the delay, he has not been able to order from commissary or use his free call. The individual requests the OCO assist him in getting his IPIN changed.

OCO Actions: The OCO spoke with DOC staff about the issue and ensured that DOC changed the individual's IPIN. The OCO also shared information about how to ensure a person's IPIN gets changed when it is required.
Negotiated Outcomes: DOC agreed to change the person's IPIN.

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-23-020: The Unexpected Fatality Review Committee reviewed the unexpected death of a 36-year-old person in November 2023. The incarcerated individual was housed in a federal Bureau of Prison facility while under DOC jurisdiction. The Unexpected Fatality Review Committee Report dated June 17, 2024 is a publicly available document.

UFR-23-019: The Unexpected Fatality Review Committee reviewed the unexpected death of a 56-year-old person in November 2023. The Unexpected Fatality Review Committee Report dated June 25, 2024 is a publicly available document.

UFR-24-005: The Unexpected Fatality Review Committee reviewed the unexpected death of a 45-year-old person in February 2024. The Unexpected Fatality Review Committee Report dated June 26, 2024 is a publicly available document.

The Office of the Corrections Ombuds has included this UFR report at the end of this Monthly Outcome Report.

Monthly Outcome Report: June 2024

	Complaint Summary	Outcome Summary	Case Closure Reason
Unexpected Fatality Reviews			
Coyote Ridge Corrections Center			
1.	Incarcerated individual passed away while in DOC custody.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-24-005 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The following consultative recommendation was included in the report: DOC should continue to pursue an electronic health record when full legislative funding becomes available.	Unexpected Fatality Review
Monroe Correctional Complex			
2.	An incarcerated individual passed away 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-23-019 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The following consultative recommendation was included in the report: DOC should continue to pursue an electronic health record when full legislative funding becomes available.	Unexpected Fatality Review
Other			
3.	An incarcerated individual passed away while in a federal Bureau of Prisons facility while under DOC jurisdiction.	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-23-020 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The following consultative remarks accompanied the report: 1. DOC should identify opportunities that support information sharing between custody and health services; 2. DOC should evaluate feasibility for developing an automated notification to Health Services when an individual tests positive for an illicit substance once an electronic system is implemented; and 3. DOC should evaluate projected resource impacts for Health Services to conduct a substance use assessment and identify possible treatment opportunities when an incarcerated individual tests positive for an illicit substance during incarceration.	Unexpected Fatality Review

Case Investigations			
Airway Heights Corrections Center			
4.	A loved one reported that an incarcerated individual received a negative behavior observation entry (BOE) and an infraction for refusing a housing assignment. They also expressed concern that this individual is being targeted and discriminated against.	The OCO provided assistance. The OCO reviewed DOC records and reached out to facility leadership, who removed the negative BOE. The OCO met with facility leadership regarding the infraction and were unable to negotiate for the infraction to be removed, because staff could not verify that this individual expressed safety concerns to the staff who issued the infraction. Facility leadership agreed to create a new process for unit and facility leadership to interview individuals who refuse housing to identify safety and security concerns.	Assistance Provided
5.	Incarcerated individuals shared concerns about facilities running out of essential toiletries.	The OCO provided assistance. The OCO met with DOC staff during a regularly scheduled meeting and informed them that the facility was running out of essential toiletries. DOC agreed they would review the concern further and address it if found. The OCO also shared information with the individual about following the internal resolution process prior to OCO involvement.	Assistance Provided
6.	Incarcerated individual reports concerns regarding DOC staff not acting to change his phone IPIN when it was stolen. The individual reports that because of the delay, he has not been able to order from commissary or use his free call. The individual requests the OCO assist him in getting his IPIN changed.	The OCO provided assistance. The OCO spoke with DOC staff about the issue and ensured that DOC changed the individual's IPIN. The OCO also shared information about how to ensure a person's IPIN gets changed when it is required.	Assistance Provided
7.	Person reports he has been waiting to be seen by the optometrist. The person wants to get his symptoms addressed before releasing.	DOC staff resolved this concern prior to OCO action. OCO staff reviewed the patient's appointments and noted that he was already scheduled to be seen by the optometrist. OCO reviewed the patient's referral and did not find evidence of a delay between the referral and scheduling the appointment.	DOC Resolved
8.	An incarcerated person asked for help with their classification and facility placement.	DOC staff resolved this concern prior to the OCO taking action on this complaint. This person's custody facility plan was completed and they were moved.	DOC Resolved
9.	An incarcerated person asked for information about reentry programs and reported that DOC staff were not giving him clear information.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO found that DOC transferred the individual into a reentry setting a short time after receiving this complaint.	DOC Resolved
10.	Incarcerated individuals shared concerns about DOC moving them from minimum custody to medium custody despite there being no documented reasons.	DOC staff resolved this concern prior to the OCO taking action on this complaint. DOC staff moved them due to potential safety concerns; once these concerns were resolved, they moved them back into a safe setting.	DOC Resolved
11.	Incarcerated individual shared concerns about DOC finalizing them for a reentry center but	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO found that the DOC released the individual into a reentry center shortly after the OCO received	DOC Resolved

	failing to place them into the program.	the complaint.	
12.	An incarcerated individual received a prescription for eyeglasses from an outside provider. The individual followed the process to have his glasses made by Correctional Industries, and the DOC lost his prescription.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed the individual's resolution requests and determined that this concern was resolved via DOC's resolution process. The level zero response indicated that this person had an appointment to pick out new frames for their glasses. The OCO advised this person to contact this office if he has not received the glasses.	DOC Resolved
13.	Incarcerated individual relayed concerns regarding an infraction.	DOC resolved this concern prior to OCO involvement. The OCO reviewed the individual's disciplinary record and saw the infraction was dismissed on appeal and no longer visible on the individual's record.	DOC Resolved
14.	Incarcerated individual relayed concerns regarding not receiving an appeal infraction response.	The OCO reviewed the infraction and confirmed that DOC did respond to the infraction appeal prior to OCO involvement.	DOC Resolved
15.	The individual is in segregation and reports that his emergency button is filled with hard toothpaste. He is concerned because he has seizures and is worried he will not be able to call for help. The individual also reports that if the DOC closes him out and he transfers, he will not have access to a level-one trauma hospital.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed this person's electronic file and verified that he is no longer in segregation and was not transferred.	DOC Resolved
16.	Incarcerated individual reports concerns regarding their placement and requests the OCO investigate their placement and ask DOC to follow their housing policies.	The OCO provided the individual with information regarding housing placement. The OCO reviewed the individual's housing placements and found that DOC followed DOC policy 300.380. The OCO shared information about how to report housing concerns to DOC staff and shared accurate information about what DOC protocols and policies state regarding placement.	Information Provided
17.	Incarcerated individuals reported a concern about being approved for graduated reentry (GRE) but the approval later being rescinded.	The OCO provided information relating to GRE policy and approval procedures. The discretion relating to GRE approval falls solely within the hands of the Headquarters Community Screening Committee (HCSC) and GRE administrator; along with this, it is important to note that the approval window for GRE is stringent and many past, current, or future incidents all play a critical role in an approval or denial.	Information Provided
18.	Individual reported Department of Enterprise Services (DES) owes him money for an approved tort claim.	The Office of the Corrections Ombuds has no part in the Tort Claim Process, and OCO complaints are not considered by DES when processing tort claims; however, this office was able to give the individual information on how to contact Department of Enterprise Services.	Information Provided
19.	Incarcerated individual expressed concerns about several infractions they received.	The OCO provided the individual information regarding the three infractions as one is already being reviewed in another OCO case, one involved is a general infraction which OCO does not review and one was dismissed on appeal.	Information Provided
20.	An incarcerated person reports some of their property was lost at a transfer between facilities	The OCO provided information on how to advocate for themselves internal to DOC prior to reaching out to the OCO.	Information Provided

21.	Incarcerated individual shared a concern about DOC denying a book due to claims it contains explicit imagery.	The OCO provided information about DOC's unauthorized mail policies and the guidelines that books, images, and any other piece of mail must follow upon arrival at a DOC facility.	Information Provided
22.	Person reports DOC is not housing him in a way that accommodates his Health Status Reports. The person is asking to be moved to a specific unit. The person also requested information on how to access his personal healthcare provider for his care.	The OCO provided information to the person regarding the Patient Paid Healthcare policy and how to initiate the process. Patients can access the self-paid healthcare process by kiting their Health Services Manager at their facility. OCO staff contacted DOC staff and verified the patient is being accommodated for his Health Status Reports (HSRs) within the ability of the facility. There is insufficient space in the unit he requested to also accommodate his HSRs. OCO staff verified the HSR does not specify the patient must be in a certain unit.	Information Provided
23.	External individual reports concerns regarding staff behavior during an interview with their incarcerated loved one. The individual requests the OCO review the actions of staff and review the denial of Extended Family Visits (EFVs).	The OCO provided information regarding the appeals process for EFV denials. The OCO found that the EFV denial has not been appealed to DOC. To appeal EFV denials, the denied visitor can appeal the decision. The OCO reviewed the incident with DOC staff and spoke with DOC leadership about the concern. DOC was unable to find evidence that the staff's behavior in the interview was inappropriate or violated policy. The interview was not recorded, therefore, a lack of evidence exists to determine what occurred.	Information Provided
24.	An incarcerated individual reports they are missing property.	The OCO provided information on how to advocate for themselves internal to DOC prior to reaching out to the OCO.	Information Provided
25.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the individual's infraction record and were unable to identify any infraction as described based on the WAC number or date given. As a result, there was insufficient evidence to investigate the concern further.	Insufficient Evidence to Substantiate
26.	Incarcerated individual shared concerns about DOC restricting their access to images due to the content.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the documents in question and spoke with DOC staff in relation to the nature of the images as well as the reason for rejection. We found no violation of policy as the material in question falls within DOC policy 440.100(a)(4) guidelines for rejection.	No Violation of Policy
27.	An incarcerated individual reported to the OCO that they believe the placement decision made by DOC is incorrect and they are targeting them by overly infracting them.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The OCO found that DOC staff properly cited the individual following DOC policy 460.050(a)(2) and properly held a hearing per DOC policy 460.140.	No Violation of Policy
Cedar Creek Corrections Center			
28.	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
29.	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
Clallam Bay Corrections Center			
30.	Incarcerated individual shared concerns about DOC restricting out of cell recreation time despite	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO found that DOC staff provided information to the incarcerated individual relating to reasons for	DOC Resolved

	that time already being heavily restricted.	yard closure, provided programming opportunities, and all the out of cell activities that incarcerated individuals can participate in while in a higher custody level.	
31.	Incarcerated individual relayed concerns regarding an infraction.	DOC resolved this concern prior to OCO involvement. The OCO reviewed the individual's disciplinary record and saw that there are no serious infractions on their record as DOC dismissed this infraction.	DOC Resolved
32.	An incarcerated person reports issues with a commissary order.	The OCO provided information on how to advocate for themselves internal to DOC prior to reaching out to the OCO.	Information Provided
33.	Incarcerated individual relayed concerns regarding appropriate housing and a need to be labeled as a gang dropout.	The OCO reviewed the individual's custody facility plan and confirmed that DOC moved them to more appropriate housing. The OCO informed the individual that in order to be labeled as a gang drop out, they must work with headquarters to complete the debriefing process and the Intelligence and Investigations unit and can speak to their counselor or CUS about this process.	Information Provided
34.	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
35.	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
36.	Incarcerated individual reports staff concerns and reports that staff used force against him. The individual reports that staff used force on him as retaliation for using DOC's internal resolution program. The individual also reports concerns accessing the resolution program and shared that DOC always sides with their staff's word.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the incident when force was used, and DOC staff complied with the DOC restricted policy that outlines use of force protocol. DOC staff used force due to the individual's unsafe behavior towards staff. The OCO could not substantiate that the use of force was enacted as retaliation. To substantiate retaliation, the OCO must be able to prove that a negative action from a DOC staff member is not only linked close in time to an incarcerated individual’s protected action but there must be evidence of a clear relationship between the two acts. The OCO also found that DOC is providing the individual with access to the resolution program.	No Violation of Policy
37.	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
38.	Incarcerated individual relayed concerns regarding a use of force.	The OCO reviewed the materials related to the use of force including the information packet and video of the incident that occurred and did not see any forceful movements like the individual alleges and the use of force information packet does explain that the force used was appropriate for the situation. Thus, there was no violation of DOC policy. Additionally, the OCO informed the individual that this office cannot assist in getting monetary compensation, but the individual can try filing a tort claim for this concern.	No Violation of Policy
Coyote Ridge Corrections Center			
39.	Incarcerated individuals shared concerns about DOC approving their release address and then rescinding their approval a few days before their release date.	DOC staff resolved this concern prior to the OCO taking action on this complaint. DOC staff removed their approval due to there being safety concerns at the original approved address but promptly secured housing for the individual.	DOC Resolved

40.	Incarcerated individual shared concern about DOC closing yard and cancelling a fitness program.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO found that DOC staff substantiated the claim regarding fitness programs and agreed to start up a structured fitness program.	DOC Resolved
41.	Person reports that he contracted an infection from items that were issued in his unit. The person is requesting specific diagnostics for the infection.	The OCO provided information to the patient regarding how items are maintained and issued by the DOC. The OCO also provided self advocacy information to the person to assist in requesting follow up with his medical provider.	Information Provided
42.	An Incarcerated person reported they are experiencing difficulty with a member of staff.	The OCO provided information on how to advocate for themselves internal to DOC prior to reaching out to the OCO.	Information Provided
43.	An incarcerated person asks for help with programming.	The OCO provided information regarding how to advocate for themselves internal to DOC prior to reaching out to the OCO.	Information Provided
44.	An incarcerated person reports they believe their time has not been calculated correctly.	The OCO provided information on how to advocate for themselves utilizing the internal administrative remedies DOC has available prior to reaching out to the OCO.	Information Provided
45.	Person reports a concern with inmate banking.	The OCO provided information on how to advocate for themselves internal to DOC prior to reaching out to the OCO.	Information Provided
46.	Incarcerated individual expressed concerns about an infraction they were given and stated that the amount of time they had to provide a urinary analysis (UA) impacted this.	The OCO reviewed the infraction materials and confirmed the individual had the proper amount of time to provide a urine sample in accordance with DOC policy 420.380(VII)(E)(3) which states individuals will have an hour to provide a urine sample.	No Violation of Policy
47.	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
Mission Creek Corrections Center for Women			
48.	External person reports concerns about the handling of their loved one's treatment assessment. The person requested their loved one be transferred to receive treatment at a different facility.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed the persons screenings and noted that the initial assessment had occurred in a timely manner. The person was transferred to a facility that is appropriate for their custody level per DOC policy 300.380. OCO staff verified that the necessary treatment is available at the person's assigned facility.	No Violation of Policy
49.	Incarcerated individual shared complaints about DOC giving them an infraction and not allowing them to review policy to properly appeal due to their facility placement.	The OCO was unable to substantiate a violation of policy by DOC. The OCO was also unable to substantiate staff misconduct claims. Per DOC policy 460.140 as well as WAC 137-37-380, the hearing and appeal processes were followed. This includes allowing the individual to file the appeal, holding a proper hearing, and allowing the individual to state their reason for the appeal with supporting evidence. This office found that the hearing was held properly per policy.	No Violation of Policy
Monroe Correctional Complex			
50.	Patient reports pain and bleeding after surgery; he requested a second opinion and pain medication.	The OCO provided assistance by elevating the concern to DOC health services leadership. After OCO outreach, the patient's post-operation care and communication was reviewed by clinical leadership, an additional post-op appointment was scheduled. The OCO confirmed the additional appointment occurred and the patient's concerns were addressed.	Assistance Provided

51.	External person reports their loved one has a medical condition that affects his immune system and needs to be housed in a different setting.	DOC staff resolved this concern prior to OCO action. OCO staff confirmed that the person was moved into an appropriate setting.	DOC Resolved
52.	External person reports concerns about their loved one being transferred away from a medical specialist clinic, from which he has been receiving necessary care.	DOC resolved this concern prior to OCO action. OCO reviewed the person's facility plan and noted that the transfer was not approved and the patient will be staying where they are currently housed.	DOC Resolved
53.	An incarcerated individual has an open court case and reports that he does not have access to the law library, despite being eligible for the callout.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed the individual's resolution request regarding this issue and contacted DOC staff to ensure this individual was given access to the law library. DOC confirmed that the individual is on the approved list, and attends the law library regularly.	DOC Resolved
54.	Person reports he has a medical condition that affects his immune system and needs to be housed in a different setting.	DOC staff resolved this concern prior to OCO involvement. OCO staff confirmed that the person was moved into an appropriate setting.	DOC Resolved
55.	Patient reports concerns related to an open wound.	DOC resolved this concern prior to OCO outreach. DOC submitted an urgent patient referral for urology specialist. The OCO confirmed the appointment occurred and the patient's concerns were addressed.	DOC Resolved
56.	Person reported concern about DOC not letting him wear his shoes out on the yard while in the solitary confinement unit. Person also reported concern about not being able to appeal his resolution request on the issue.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed this individual’s resolution request and found that he withdrew his complaint because he was transferred to a different facility.	DOC Resolved
57.	Incarcerated individual shared concerns about not being able to promote custody levels due to their single cell requirement.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO found that there was a delay in the transfer, but the individual was successfully transferred.	DOC Resolved
58.	Incarcerated individual shared concerns about being stuck in intensive management unit (IMU) despite being told by DOC they were going to be transferred to a lower custody level.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO found that DOC staff transferred this individual shortly after the OCO received this complaint.	DOC Resolved
59.	Incarcerated individual shared concerns about potentially moving into minimum custody despite their wishes to maintain current custody status.	The OCO provided information about the sentencing process and working with a counselor to help maintain current custodial placement.	Information Provided
60.	Incarcerated individual relayed concerns regarding placement in IMU and not getting physical therapy.	The OCO reviewed the individual's custody facility plan and confirmed that DOC is working to find them placement outside of an IMU setting. This office also spoke with DOC and confirmed that they have several appointments to attend physical therapy.	Information Provided
61.	Person reports issues getting an	The OCO provided information to the person regarding self	Information

	access assistant assigned to him.	advocacy steps to resolve this issue at the lowest level. The OCO also provided information to the person about how the access assistant's work is organized.	Provided
62.	An incarcerated person reports issues with DOC staff behavior.	The OCO provided information on how to advocate for themselves internal to DOC prior to reaching out to the OCO.	Information Provided
63.	An incarcerated person reported a concern related to not receiving something they have paid for.	The OCO provided information on how to advocate for themselves internal to DOC prior to reaching out to the OCO.	Information Provided
64.	Person reported that staff are harassing him by bringing him cold food. Person also said that because of one of his Health Status Reports (HSR) for a food allergy, he is unable to get approved for a religious diet.	The OCO provided information. The OCO reviewed this individual's resolutions request investigation and found that DOC substantiated that staff brought him cold food that was incorrect for his diet, and DOC talked with the staff and gave the individual instructions with how to address similar concerns with staff in the future. Regarding this individual wanting a religious diet, DOC policy 610.400 states, "B. Recommended therapeutic diets will take precedence over a religious diet unless the individual declines during the medical encounter where it is recommended." The OCO is in ongoing conversation with DOC about handling special diet requests.	Information Provided
65.	Person reports she has not been able to access mental health treatment since being moved to restrictive housing. The person reports concerns about her housing review not being completed, keeping her in restrictive housing.	OCO provided information to the person regarding mental health access at their current facility. The person's housing concerns were addressed in a separate OCO case.	Information Provided
66.	Incarcerated individual relayed concerns regarding appealing several infractions but not hearing back.	The OCO spoke with DOC and confirmed that DOC received several documents from them stating they appeal all infractions related to a particular WAC number, but no infraction group numbers, dates or additional information were included. DOC sent them back to the individual for clarification and never received anything back. Thus, DOC will process the appeals as received.	Information Provided
67.	Incarcerated individual relayed concerns regarding a desire to have a regular classification review.	The OCO reviewed the individual's custody facility plans (CFP) and confirmed that they are occurring as they should. The OCO informed the individual when the approximate month of their next CFP is as per DOC policy 300.380(IV)(C)(1)(c) they are to be done every 6 months.	Information Provided
68.	Person reports issues accessing the Medication Assisted Therapy (MAT) program before release. The person reports he was told the facility could only offer treatment to a limited number of people.	The OCO provided information to the person regarding his current facility's limitations in offering the Medication Assisted Therapy (MAT) program. The OCO substantiated that some facilities do not have the staffing power to support the MAT program. OCO staff contacted DOC Health Services staff and were informed of the steps DOC is taking to eliminate the limitations to treatment. The OCO is in ongoing discussions with DOC Health Services Leadership about this issue.	Information Provided
69.	Person reports issues accessing the MAT program. The person reports they are within 60 days of release and have not been started on the medication.	The OCO provided information to the person regarding the program limitations at the previous facility. Due to a deficit in space and staff availability the facility is currently limited to the number of people they can place on the medication. DOC is actively recruiting to fill those vacancies and the program is	Information Provided

		undergoing updates that may change the availability of the program in certain facilities.	
70.	Person reports frustration with DOC medical not being transparent about what his long-term plan is for pain management. The person also requested an item from medical and was denied.	The OCO provided information to the person regarding the limitations placed on medication order duration per the DOC Pharmaceutical Management and Formulary Manual. OCO also recommended the person contact the Patient Care Navigator with questions about his treatment plan.	Information Provided
71.	Incarcerated individual shared concerns regarding DOC staff providing false information to headquarters in turn not allowing them to file a resolution request on an issue.	The OCO provided information on how to properly appeal infractions, follow the internal resolution process outlined by the DOC, as well as when the OCO can step in and assist with staff conduct complaints.	Information Provided
72.	Incarcerated individual shared concerns regarding still being in the intensive management unit (IMU) despite completing necessary programming and does not know whether or not their custody facility plan (CFP) is being completed.	The OCO provided information regarding their current CFP and confirmed it is being actively worked on.	Information Provided
73.	An incarcerated person asked the Office of the Corrections Ombuds to review their reentry center denial.	The OCO provided information on how to advocate for themselves internal to DOC prior to reaching out to the OCO.	Information Provided
74.	Incarcerated individual relayed concerns regarding what property will transfer with them to their new facility.	The OCO spoke with DOC and confirmed that all of their property was transferred to their new facility and no property remains at their former facility.	Information Provided
75.	Person reported that staff are harassing him by bringing him food that he is allergic to. Person requested that DOC renew his Health Services Report (HSR) for this food allergy.	The OCO provided information. The OCO reviewed DOC records and reached out to DOC staff, who stated that this individual declined the test to confirm his allergy and renew the HSR. The OCO encouraged this individual to kite health services and take the required allergy test. This office verified in DOC records that this individual has been moved to a different facility. The OCO is continuing to review this individual's concerns in a separate case.	Information Provided
76.	Incarcerated individual relayed concerns regarding a facility transfer.	The OCO spoke to DOC and confirmed that the reasons for the move include that facility being closer to the individual's release county allowing for easier release planning and because the individual told staff they were requesting that location to be closer to family. Because DOC believes the individual requested this facility placement and there is justification of the release county, there are no further actions this office can take to assist with this concern as there is no violation of DOC policy 300.380.	Information Provided
77.	Person reports he was denied access to care during a medical emergency. The person states that DOC changed his medical records to avoid responsibility.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff reviewed the patient's records and noted multiple assessments were completed within policy and the person was sent to the community hospital as a result of those assessments. OCO staff also reviewed records from the community hospital that DOC would not have the ability to alter.	Insufficient Evidence to Substantiate

78.	Incarcerated individual relayed concerns regarding not hearing anything about the outcome of their most recent infraction.	The OCO reviewed the individual's infraction history and were unable to locate a recent serious infraction as the last serious infraction on their disciplinary record occurred several years ago.	Insufficient Evidence to Substantiate
79.	Person reported a concern about staff conduct while he was waiting to enter the visiting room and said that staff yelled at him and made him wait in a hot room.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed this individual's resolution request, which was unsubstantiated at all levels of review. DOC interviewed all staff involved and said that Main Control gets busy managing multiple priorities, and that staff must speak loudly and lean forward to communicate through the soundproof booth, and they acknowledged that it can be frustrating when there are delays entering the visiting room. The OCO does not have sufficient evidence to substantiate that staff yelled at this individual or intentionally delayed him entering the visiting room.	Insufficient Evidence to Substantiate
80.	Person reported concern about racial bias among staff at the facility. Person also expressed concern about staff investigating other staff under their supervision in a resolutions investigation.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed this individual's resolutions request, which did not substantiate his concern at the facility and headquarters level and found that they did not find that staff intentionally treated him differently based on race. The Resolution Program Manual states on page 15, "Level 1 reviews will be assigned to the employee/contract staff with supervisory authority over the person(s) or area of the facility/office listed in the resolution. This will ensure accountability of employees/contract staff during reviews and the supervisory ability to make appropriate changes when required." The OCO gathered caseworkers together regarding allegations of racial bias at this facility and were unable to identify a systemic pattern at this time. This office is reviewing other concerns for this individual, and will continue to monitor allegations of racial bias at this facility.	Insufficient Evidence to Substantiate
81.	Incarcerated individual shared concerns about the denial of a visitor despite this individual meeting the requirements.	The OCO was unable to substantiate a violation of policy by DOC. Per DOC policy 450.300(III)(2), "Providing false/misleading information... on the visit application may result in denial of visit privileges." The OCO found that the DOC followed the denial process per policy.	No Violation of Policy
82.	Incarcerated individual shared concerns regarding not being able to promote to minimum custody so they can potentially move into graduated reentry because they refused a program they should not have to take.	The OCO was unable to substantiate a violation of policy by DOC. Despite the program never being mandated by the courts, it is up to the discretion of the programming administrators, who in this case, deemed the nature of the conviction as eligible for the program.	No Violation of Policy
83.	Incarcerated individual relayed concerns regarding a facility transfer.	The OCO reviewed the individual's custody facility plan (CFP) and find no violation of DOC policy 300.380 as the placement was due to infraction behavior that was not appropriate for a custody override to maintain previous housing.	No Violation of Policy
84.	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
85.	Incarcerated individual relayed concerns regarding placement in IMU.	The OCO reviewed the individual's administrative segregation placement that was due to an investigation into their involvement in a fight, The OCO confirmed the individual was	No Violation of Policy

		released from segregation once the investigation was complete, thus there is no violation of DOC policy 320.200.	
Olympic Corrections Center			
86.	Incarcerated individual shared a concern about DOC approving them for work release (WR), being denied graduated reentry (GRE), and then being denied for both WR and GRE because DOC would not provide a required assessment.	The OCO was unable to substantiate a violation of policy by DOC. The incarcerated individual did not participate in programming and has a history of violence which is prohibited in GRE and WR programs.	No Violation of Policy
87.	Incarcerated individual relayed concerns regarding termination of extended family visits (EFVs).	The OCO reviewed the EFV decision paperwork and found no violation of DOC policy 590.100 as the EFV privilege was terminated and further visits were denied due to a visitor refusing a search of their vehicle.	No Violation of Policy
Reentry Center - Brownstone - Spokane			
88.	An incarcerated person reported that they have a banking concern.	The OCO provided information on how to advocate for themselves internal to DOC prior to reaching out to the OCO.	Information Provided
Reentry Center - Helen B. Ratcliff - King			
89.	Incarcerated individual shared concerns about a work assignment that endangers them and reentry staff refused to give them a different chore.	The OCO provided information regarding utilizing the internal administrative process to resolve complaints within reentry centers. The OCO also found that the incarcerated individual moved facilities upon review of this case.	Information Provided
Stafford Creek Corrections Center			
90.	Person reports that he was not treated in a timely manner resulting in a terminal condition. The person is requesting an extraordinary medical placement approval.	The OCO provided assistance. Due to the severity of the concern, OCO staff reviewed the patient's entire DOC medical record to verify the timeliness of care. OCO staff confirmed that DOC medical has taken appropriate action in this person's care since receiving him. The OCO does not have jurisdiction to investigate the county jail where the person should have had access to care and did not receive it. OCO staff provided the person with information regarding his Extraordinary Medical Placement request. OCO staff also provided information to the person regarding who to contact with concerns about the county jail.	Assistance Provided
91.	Person states he is waiting for a specialist consult and he needs a pain management plan until he is able to see the specialist.	OCO staff provided assistance by contacting DOC Health Services staff and requesting the patient be scheduled for follow up appointment with their provider. OCO staff monitored the patient's specialist appointment on the health services tracker to verify completion.	Assistance Provided
92.	Incarcerated individual shared concerns about DOC mislabeling their mail which led to damaging the contents.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO found that DOC staff substantiated and apologized for the inconvenience caused by the situation.	DOC Resolved
93.	Incarcerated individual relayed concerns regarding not being seen by medical for foot problems.	The OCO confirmed the individual was seen by a surgeon for a surgery consult regarding this concern. The concern was resolved by DOC.	DOC Resolved
94.	Person reports having waited over a year for a comprehensive	DOC resolved this issue prior to OCO action. OCO reviewed the patient's appointment and noted that he was already scheduled	DOC Resolved

	dental exam. He was told that he could have to wait another year for a dental appointment because his previous referral timed out.	for the requested exam. OCO staff monitored the appointment on the Health Services tracker until it was completed and verified follow-up care has been scheduled.	
95.	A loved one reported that they have been denied visitation.	The OCO provided information to the incarcerated person on how their family will need to appeal the denial.	Information Provided
96.	Loved one relayed concerns regarding the handling of a previous OCO case.	The OCO informed the incarcerated individual that a closed case review form was sent to them regarding this. If a decision is made to reopen the case based on the closed case review form the individual has completed, they will receive an updated closing letter at that time.	Information Provided
97.	Person reports DOC has not repaired an injury he sustained a few years ago from a substantiated delay in care.	OCO staff provided information to the person regarding tort claim information. OCO staff reviewed available documentation and noted that the specialist did not recommend surgical intervention. Individuals who have been harmed or who have suffered a loss as a result of negligent actions by a state employee or agency can submit a tort claim to the Office of Risk Management (ORM). ORM is required by law (RCW Chapter 4.92) to receive these claims.	Information Provided
98.	Incarcerated individual shared concerns regarding the failure to properly mix cleaning solution to clean the unit.	The OCO provided information regarding incarcerated individuals having an open line of communication with the DOC staff about issues that they have on the unit. The OCO encourages individuals to report issues to staff as they arise.	Information Provided
99.	Person reports falling from an upper bunk and suffering injuries for which DOC have delayed providing care. The person is requesting financial compensation and treatment for his injuries.	The OCO provided information to the person regarding the reason for the delay in part of his recommended treatment. OCO verified the patient did receive treatment for the injury. Due to a community clinic's availability, the patient was not able to receive all the recommended treatments prior to release. OCO staff also provided information to the person regarding tort claims. Individuals who have been harmed or who have suffered a loss as a result of negligent actions by a state employee or agency can submit a tort claim to the Office of Risk Management (ORM). ORM is required by law (RCW Chapter 4.92) to receive these claims. Tort claim forms can be requested from unit staff or the legal library.	Information Provided
100.	An incarcerated person reported a concern related to DOC staff behavior.	The OCO provided information on how to advocate for themselves internal to DOC prior to reaching out to the OCO.	Information Provided
101.	Patient reports concerns about his current access to medical care. The person states he has a consult with an outside provider but has waited a long time for it. The person wants to make sure he is getting the right medical care in a timely manner.	The OCO provided information to the person regarding his consult status. OCO staff confirmed the patient was scheduled for the requested appointment and contacted DOC Health Services staff to ensure specialist recommended studies were scheduled. OCO also provided information to the person regarding the scheduling process. DOC must wait for the outside clinic to have an available date. Currently there is a significant wait for non-urgent appointments with many medical specialties in the community.	Information Provided
102.	Incarcerated individual shared concerns about DOC staff refusing to release emails, videos, and pictures sent to them by their partners.	The OCO provided information regarding reaching out to Securus to resolve technical issues, when an incarcerated individual will receive mail rejection notices, and when the OCO can assist.	Information Provided

103.	An Incarcerated person reported that at a transfer many months ago property was removed from their property boxes.	The OCO provided information on how to advocate for themselves internal to DOC prior to reaching out to the OCO.	Information Provided
104.	Incarcerated individual shared concerns about DOC staff taking purchased property during a search and failing to properly report it in search report.	The OCO provided information regarding DOC policies relating to incarcerated individuals having property and scenarios property can be seized.	Information Provided
105.	Incarcerated individual shared complaints regarding Securus not fixing their tablet due to a previous sanction.	The OCO provided information regarding Securus not being within DOC jurisdiction and DOC being unable to resolve resolution request regarding Securus.	Information Provided
106.	Person reports they suffered an injury and reported it to medical at that time, but was not evaluated by medical staff before being sent back to his unit. The person filed an emergency grievance and was given the same information from medical staff without an evaluation.	The OCO provided information to the person regarding submitting a tort claim. The OCO reviewed the patient's records and requested additional review by DOC Health Services staff. OCO staff substantiated that there was no medical evaluation documented for the time of injury. Per DOC policy 610.650, a patient reporting a health emergency will not be denied access to healthcare, including evaluation and clinically indicated treatment, even when there is suspicion or history of abuse of the medical emergency system. OCO staff discussed the error with DOC staff and were informed of changes made to operations to prevent this issue from reoccurring.	Information Provided
107.	Incarcerated individual shared a concern about air quality concerns at a facility.	The OCO provided information on the importance of utilizing the internal administrative process and submitting resolution requests on issues like this.	Information Provided
108.	Person reports issues he had with a medical provider's treatment. He requested to have a complaint submitted to the medical board.	The OCO provided information by providing the person with the address and process to submit a complaint against a medical provider's license. Those complaints must be received by the Washington Medical Commission.	Information Provided
109.	Incarcerated individual relayed concerns regarding staff conduct about a female officer who they state pressured them for attention.	The OCO reviewed the associated records including a PREA complaint and an infraction and found insufficient evidence to substantiate staff misconduct.	Insufficient Evidence to Substantiate
110.	Incarcerated individual relayed concerns regarding staff conduct about a female officer who they state pressured them for attention.	The OCO reviewed the associated records including a PREA complaint and an infraction and found insufficient evidence to substantiate staff misconduct.	Insufficient Evidence to Substantiate
111.	Incarcerated individual relayed concerns regarding staff not doing their job regarding care review committee needs.	The OCO spoke with DOC and confirmed that the care review denial and appeal were sent to the individual and the individual even sent a kite thanking staff for doing this. Thus, there is insufficient evidence that staff are not doing their job regarding care review committee needs.	Insufficient Evidence to Substantiate
112.	Incarcerated individual shared concerns about DOC refusing to release them to their support system and instead release them as homeless in a county further away.	The OCO was unable to substantiate a violation of policy by DOC. DOC staff discovered that the individual the incarcerated individual wanted to be released to is the victim of a former offense, and per DOC policy 350.200, this is not permitted.	No Violation of Policy

113.	A loved one reached out about Extended Family Visits (EFV) being denied with an incarcerated individual. They stated that a new review committee would review their appeal.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the decision from the review committee and found that this individual's EFV application was denied due to a domestic violence indicator with a similar relationship to the family member who applied for the EFV. The OCO met with DOC staff to discuss this case and verified the domestic violence indicators. DOC policy 590.100 states, "An individual may be denied EFV privileges: Based on the nature of the crime, documented criminal history (e.g., history of domestic violence as defined in RCW 7.105.010), and current/prior behavior".	No Violation of Policy
114.	Incarcerated individual relayed concerns regarding an infraction and not being able to send the test to the lab.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual had an opportunity to send the mail that resulted in a presumptive positive test to an outside lab for confirmation testing but refused to answer questions from the intelligence and investigations unit (IIU) including whether or not the individual wanted it sent to the lab.	No Violation of Policy
115.	Incarcerated individual relayed concerns regarding an infraction and not being able to send the test to the lab.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual had an opportunity to send the mail that resulted in a presumptive positive test to an outside lab for confirmation testing but refused to answer questions from the intelligence and investigations unit (IIU) including whether or not the individual wanted it sent to the lab.	No Violation of Policy
116.	Incarcerated individual relayed concerns regarding an infraction and not being able to send the test to the lab.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual had the opportunity to speak with the intelligence and investigations unit (IIU) to have the contraband tested by an outside lab but refused to speak to IIU and told them to write the infraction.	No Violation of Policy
117.	Incarcerated individual shared concerns about not being able to participate in graduated reentry (GRE) despite being eligible.	The OCO was unable to substantiate a violation of policy by DOC. The discretion relating to GRE approval falls solely within the hands of the HCSC and GRE administrator; along with this, it is important to note that the approval window for GRE is stringent and many past, current, or future incidents all play a critical role in an approval or denial.	No Violation of Policy
118.	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
119.	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
120.	Incarcerated individual relayed concerns regarding an infraction as they state at the time of the incident they were only facing a class B but then the policy changed and now they are facing a class A and want to be infracted for what the classification was on the date of the incident, not what the policy changed to.	The OCO reviewed DOC policy 460.000 and 460.050 and see the policy has not changed any categorization or classification of infractions from class A to class B.	No Violation of Policy

Washington Corrections Center

121.	Family members of an incarcerated person contacted the OCO with concerns related to an arrest and subsequent re-incarceration of a person who had previously received a Governor's commutation.	The OCO provided assistance by elevating the concern through DOC leadership and the Governor's Office staff. After OCO outreach, this office confirmed that after the individual completed the requirements set out by the Governor, he was awarded an amended commutation and released from prison.	Assistance Provided
122.	Incarcerated individual reports concerns about their placement into segregation. The individual is releasing soon and has concerns about releasing from segregation.	The OCO provided assistance. The OCO spoke with DOC leadership about the individual's placement and expressed concern about the individual releasing from segregation. After this conversation, DOC moved him to a less restrictive custody area.	Assistance Provided
123.	An incarcerated person contacted the OCO with concerns related to his arrest and subsequent re-incarceration after receiving a commutation from the Governor. Additionally, he requested the OCO review his drug assessment.	The OCO provided assistance by elevating the concern through DOC leadership and the Governor's Office staff. After OCO outreach, this office confirmed that after the individual completed the requirements set out by the Governor, he was awarded an amended commutation and released from prison.	Assistance Provided
124.	Incarcerated individual reports concerns regarding an investigation and requests the OCO review the investigation for policy compliance.	The OCO provided assistance. The OCO reviewed the investigation and reported concerns to DOC administration. As a result of the concerns reported, DOC opened a new investigation in an effort to resolve the concerns.	Assistance Provided
125.	Person reports having waited a long time for a consult that was approved at a previous facility. The person requested follow up with his provider for a discussion about his treatment plan and to receive the surgery that was already approved.	The OCO provided assistance. OCO reviewed the patient's consults and were unable to substantiate that a surgery was already approved. OCO staff contacted DOC staff and requested that the person be scheduled for an update on his treatment plan and explanation of his consultation status. DOC staff agreed to have the person scheduled.	Assistance Provided
126.	Anonymous person reported safety concerns and the illegal activities of another incarcerated individual.	The OCO reported these concerns to facility leadership to follow up on.	Assistance Provided
127.	Loved one made a complaint on behalf of an incarcerated individual regarding DOC withholding their mail.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO found that DOC mail staff substantiated the concern and apologized for the inconvenience.	DOC Resolved
128.	Incarcerated individual shared concerns about receiving an infraction without supporting evidence and not being able to receive a review due to the infraction.	DOC staff resolved this concern prior to the OCO taking action on this complaint. DOC staff did review the submitted resolution request and upon level two review, deemed the claim substantiated and as a result vacated the infraction and loss of good conduct time (GCT).	DOC Resolved
129.	An Incarcerated person reported they were concerned that their time has not been calculated correctly.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO found that DOC staff provided information relating to calculating time spent and how to take action to resolve a time issue.	DOC Resolved

130.	An incarcerated individual reports she is supposed to have a court date next week and the legal liaison is not being helpful. DOC staff have told her to contact the courts or call in on the day of, but she lost the paperwork and does not have the phone number.	DOC staff resolved this concern prior to the OCO taking action on this complaint. This office made contact with the DOC who verified that the incarcerated individual attended the virtual hearing a couple of months ago, while housed at another facility.	DOC Resolved
131.	Incarcerated individual shares concerns relating to DOC refusing to move him to a safe unit.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO found that DOC staff agreed to transfer the individual to a different facility to meet their safety needs and so they can receive necessary programming.	DOC Resolved
132.	Incarcerated individuals shared concerns about DOC potentially moving them into a situation where their safety is at risk.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO found that DOC staff put in the separatee to help maintain the individual's safety.	DOC Resolved
133.	Incarcerated individual shared concerns regarding facility placement and risk to their safety.	The OCO provided information on custody level promotions, custody facility plans, and what factors into DOC's choice to demote or promote an incarcerated individual.	Information Provided
134.	Person states they had to wait an extended time for staff to respond to a dental emergency. The person reports being denied access when he called a medical emergency the next day.	The OCO provided information to the person regarding the DOC Health Services staff decision. OCO staff reviewed the patient's records and verified that the appropriate staff determined the level of response based on patient's reported concerns, per DOC dental emergency protocol. Per DOC policy 600.000, clinical decisions are the sole province of the responsible health care practitioner and are not countermanded by non-clinicians.	Information Provided
135.	Incarcerated individual relayed concerns regarding DOC staff referring to them using offensive language that led to unfair treatment at a hearing.	The OCO provided information regarding DOC's investigative process and how to appeal resolution request. The OCO spoke with DOC staff who shared details of their investigation and the OCO confirmed appropriate action was taken. The OCO also found this individual did not appeal the resolution request within the appropriate time frame. The OCO shared specific information about the resolution process.	Information Provided
136.	Incarcerated individual shared concerns about being housed in a facility's receiving unit as long-term housing.	The OCO provided information obtained from DOC about delayed transfer times due to numerous factors. The OCO substantiated the individual was held in receiving for an extended period of time before being moved. The OCO is aware of this situation and taking action on a case-by-case basis. This individual was moved prior to OCO action.	Information Provided
137.	Incarcerated individual relayed concerns regarding a grievance being sent back for a rewrite when they state it should not have been.	The OCO reviewed the grievance response and confirmed that the reason for the rewrite was within the guidelines set out in the resolution program manual and informed the individual of the reason for the rewrite.	Information Provided
138.	Person reports programming requirements are contrary to their Judgement &Sentence.	The OCO provided information on how to advocate for themselves internal to DOC prior to reaching out to the OCO.	Information Provided
139.	Incarcerated individual made a complaint regarding their significant other being wrongfully suspended from visitation and	The OCO was unable to substantiate a violation of policy by DOC. DOC staff explicitly stated that any sexual activity including touching one another is strictly prohibited during visitation time.	No Violation of Policy

	also receiving an infraction.		
140.	Incarcerated individual relayed concerns regarding infraction sanctions.	The OCO reviewed the infraction and found no violation of policy as DOC policy 460.050 states a WAC 603 includes mandatory sanctions of 180 days loss of phone privileges, excluding legal calls.	No Violation of Policy
141.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and discussed the concerns with DOC and requested the infraction be dismissed, however, DOC declined to do so as the infraction met the WAC elements.	No Violation of Policy
142.	Person reports issues with staff conduct while on hospital watch in a community hospital.	The OCO could not substantiate a violation of policy by DOC. OCO staff reviewed restricted DOC policy and noted the staff's actions were supported by DOC policy.	No Violation of Policy
Washington Corrections Center for Women			
143.	Person reported concerns about medical equipment and getting adequate privacy while using that equipment.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed the resolutions request investigation, which stated that this concern was processed per the Prison Rape Elimination Act (PREA) policy, and that senior management at the facility have been made aware of the issue and are looking into resolving the concern. The OCO spoke with DOC staff, who described the steps that were taken to increase this individual's privacy and access to her medical equipment. The OCO also confirmed that this individual is no longer in custody at this facility.	DOC Resolved
144.	Incarcerated individual relayed concerns about DOC staff failing to provide the equal opportunity for all to search through canteen bags.	DOC staff resolved this concern prior to the OCO taking action on this complaint. DOC staff stated that they resolved this issue at level zero and will forward this message to staff.	DOC Resolved
145.	A family member reports to the OCO a concern regarding their loved one's lack of access to healthcare and DOC staff responses to their requests.	The OCO provided information on how to advocate for themselves internal to DOC prior to reaching out to the OCO.	Information Provided
146.	Incarcerated individual submitted an inquiry to the OCO requesting information on discriminatory action taken by the DOC against members of the LGBTQIA+ community.	The OCO provided information on public OCO reports and the DOC's minimum requirements to give an infraction to an incarcerated individual.	Information Provided
147.	An incarcerated person reported to the OCO a concern regarding lack of access to healthcare and DOC staff responses to their requests.	The OCO provided information on how to advocate for themselves internal to DOC prior to reaching out to the OCO.	Information Provided
148.	Person reported that she has not received a teeth cleaning in years and needs durable medical equipment (DME) that has been denied. Person reported concern about the dentist she saw in the past at the facility.	The OCO provided information about the process to have her request for DME reviewed by the Care Review Committee. The OCO reviewed DOC records and spoke with DOC staff and could not confirm that this individual filed a resolution request or kited Health Services regarding the DME. DOC staff stated that the facility only currently has one dentist, and that this individual declined an appointment for an exam with that dentist.	Information Provided

149.	Incarcerated individual relayed concerns regarding reporting a PREA incident to an officer who did not file it when they reported it.	The OCO reviewed all related materials including grievances and PREA records. The individual did not file a grievance about this concern until several months after it occurred, so the grievance was not accepted due to timeframes. Without any further grievance records or other documentation, there was insufficient evidence for this office to investigate to substantiate the concern.	Insufficient Evidence to Substantiate
150.	External person reports concerns about the handling of their loved one's treatment assessment. The person requested their loved one be transferred to receive treatment at a different facility.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed the persons screenings and noted that the initial assessment had occurred in a timely manner. The person was transferred to a facility that is appropriate for their custody level per DOC policy 300.380. OCO staff verified that the necessary treatment is available at the person's assigned facility.	No Violation of Policy
151.	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
Washington State Penitentiary			
152.	Incarcerated individual relayed concerns regarding a previous OCO case that stated DOC agreed to dismiss an infraction, but the infraction is still visible on the individual's record.	The OCO spoke to DOC several times about this concern at the facility leadership level as well as at headquarters and confirmed that at the time of this writing, the infraction has been removed from the individual's record and is no longer visible.	Assistance Provided
153.	Person reported concern about not receiving healthcare for chronic conditions and not receiving proper release planning.	The OCO provided assistance. The OCO reached out to the Reentry Navigator and upon the OCO's request, DOC staff connected this individual with Reentry Navigation services. The OCO also reached out to multiple DOC staff to confirm that he has received healthcare for different chronic conditions and confirm that DOC staff are working on his release planning.	Assistance Provided
154.	External person reports safety concerns with their loved one's current housing assignment.	DOC staff resolved this concern prior to OCO action. OCO staff verified the person had been moved after reporting safety concerns.	DOC Resolved
155.	Incarcerated individual shared concerns about not being able to prepare for release due to their intensive management unit (IMU) placement and their inability to utilize a tablet, TV, or radio despite their infraction being non-violent.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO found that the DOC moved the individual out of IMU and has completed release planning.	DOC Resolved
156.	Incarcerated individuals relayed concerns about DOC staff restricting their access to and limiting the amount of legal documents they can have.	DOC staff resolved this concern prior to the OCO taking action on this complaint. DOC staff granted the individual an exception on the amount of legal documents they can possess in storage due to the open legal cases they're litigating.	DOC Resolved
157.	Incarcerated individual relayed concerns regarding not having access to the levels system in IMU.	The OCO spoke with DOC regarding this concern and confirmed that as the individual's safety concerns cannot be verified by DOC, they do not have access to the levels program per DOC policy 320.200. However, once their MAX plan is in effect they will have level access.	Information Provided
158.	Incarcerated individual shared concerns regarding facility	The OCO provided information on custody level promotions, custody facility plans, and what factors into DOC's choice to	Information Provided

	placement and risk to their safety.	demote or promote an incarcerated individual.	
159.	External person reports safety concerns with their loved one's current housing assignment. They also reported that their loved one needs to have an assessment to access programming.	OCO provided information to the incarcerated person regarding their facility plan and self-advocacy steps to resolve the issue at their new facility. OCO staff verified the person had been moved by DOC prior to OCO action.	Information Provided
160.	Incarcerated individuals shared concerns regarding wanting DOC to expedite their court ordered transfer due to safety concerns.	The OCO provided information relating to custody facility plans and factors that influence DOC's facility choice for incarcerated individuals. DOC staff took their comments into consideration concerning the next facility placement. The OCO also shared how to be active in the custody facility planning.	Information Provided
161.	Person reported concern about receiving a negative behavioral observation entry (BOE) after reaching out to health services regarding a prescription.	The OCO provided information. The OCO reviewed DOC records and found that this BOE is from several years ago. The OCO encourages this individual to reach out to health services regarding this prescription.	Information Provided
162.	Person reported concerning symptoms to medical and received treatment, but did not need the treatment he was given. The person is requesting to see a specialist to figure out the source of the problem.	The OCO provided information to the patient on how to access a specialist consult. OCO staff contacted DOC Health Services staff and were informed the patient had been evaluated and tested multiple times and there is not a clinical indication for a specialist evaluation at this time. If a person would like a second option outside of DOC medical providers, they can use the Patient Paid Healthcare process to self-pay for a specialist consultation. This process can be started by kiting the Health Services Manager at their facility.	Information Provided
163.	Person reports that he needs to have an assessment to access programming.	OCO provided information to the incarcerated person regarding self advocacy steps to resolve the issue and access programming at their new facility.	Information Provided
164.	An Incarcerated person is concerned about accessing law library.	The OCO provided information on how to advocate for themselves internal to DOC prior to reaching out to the OCO.	Information Provided
165.	Incarcerated individual reported concerns about not receiving prescribed drug treatment while in the therapeutic communities (TC) program.	The OCO provided information regarding properly interacting with OCO to resolve issues, GRE, and program requirements.	Information Provided
166.	An incarcerated person asked the OCO for information on how to appeal a classification decision.	The OCO provided information on how to advocate for themselves during the hotline call at intake.	Information Provided
167.	An incarcerated person reached out to the OCO for assistance with a medical concern that they have not yet informed the department about.	The OCO provided information to the individual on how they can access medical care while in the community.	Information Provided
168.	Incarcerated individual shared concerns about DOC staff moving them and DOC staff mishandling their resolution request forms.	The OCO provided information related to the reason for their facility placement as well as how to properly utilize the resolution request service.	Information Provided
169.	Incarcerated individual shared	The OCO provided information relating to DOC ensuring the	Information

	concerns regarding DOC staff withholding healthcare and not allowing them to see another medical provider.	individual has adequate healthcare upon their imminent release and why DOC cannot provide them with the requested assistance.	Provided
170.	An incarcerated person reached out to the OCO for assistance with a medical concern that they have not yet informed the department about.	The OCO provided information to the individual on how they can access medical care while in the community.	Information Provided
171.	An incarcerated person reports a concern with property being removed by DOC staff for safety when it had been allowed at a higher level of custody.	The OCO provided information on how to advocate for themselves internal to DOC prior to reaching out to the OCO.	Information Provided
172.	An incarcerated person reports their time served is not being calculated correctly.	The OCO provided information on how to advocate for themselves internal to DOC prior to reaching out to the OCO.	Information Provided
173.	An incarcerated person reports their property was damaged or destroyed at a facility transfer.	The OCO provided information on how to advocate for themselves and provided additional informational resources.	Information Provided
174.	Incarcerated individual shared concerns about DOC staff forcing him to eat although he is fasting for religious reasons.	The OCO provided information about properly utilizing the resolution request, and how to utilize the OCO once the resolution request is submitted and reaches a certain level.	Information Provided
175.	Incarcerated individual relayed concerns regarding placement in IMU.	The OCO reviewed the individual's placement in segregation and confirmed that it was due to safety concerns as well as an infraction and that the individual remains in segregation pending custody facility plan (CFP) approval to determine appropriate housing. There is no violation of DOC policy 320.200.	No Violation of Policy
176.	Incarcerated individual relayed concerns regarding an infraction and staff conduct.	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 was unable to investigate the staff conduct concern as the individual has not filed any grievances related to this.	No Violation of Policy
177.	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 behaviors met the infraction elements.	No Violation of Policy
178.	Incarcerated individual relayed concerns regarding placement in IMU.	The OCO reviewed the individual's custody facility plan and found no violation of DOC policy 300.380 as the individual is currently in the IMU due to a placement on a MAX program.	No Violation of Policy
179.	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
180.	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 "some evidence" standard utilized by DOC.	No Violation of Policy
181.	Incarcerated individuals shared concerns about DOC mishandling their property and violating Washington law.	The OCO was unable to substantiate a violation of policy by DOC. The OCO found that DOC handled the incarcerated individual's property correctly per DOC policy 440.000. The DOC requires incarcerated individuals to engrave their DOC number on items like bowls, plates, cups, or other like items.	No Violation of Policy

182.	Incarcerated individual shared concerns about DOC staff rejecting their mail and using incorrect policy to justify it.	The OCO was unable to substantiate a violation of policy by DOC. The OCO found that DOC staff properly rejected mail per DOC policy 440.100 as the mail fell within the rejection guidelines outlined.	No Violation of Policy
Intake Investigations			
Clallam Bay Corrections Center			
183.	Loved one relayed concerns regarding incarcerated individual's placement in a particular unit and safety concerns.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they wanted investigated but never received confirmation from them about their desire to have the concern investigated.	Person Declined OCO Assistance
Monroe Correctional Complex			
184.	Loved one relayed concerns regarding an incarcerated individual's placement in IMU due to an infraction.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they wanted investigated but never received confirmation from them about their desire to have the concern investigated.	Person Declined OCO Assistance
Other			
185.	Loved one relayed concerns regarding an individual's termination from graduated reentry (GRE).	The OCO sent the incarcerated individual an Ombuds review request form to ensure that this was a concern they wished for this office to investigate, however, the individual never returned the form or contacted this office to confirm the desire for the concern to be investigated.	Person Declined OCO Assistance
Stafford Creek Corrections Center			
186.	Loved one relayed concerns regarding an incarcerated individual's job and an infraction.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they wanted investigated but never received confirmation from them about their desire to have the concern investigated.	Person Declined OCO Assistance
Washington Corrections Center			
187.	Incarcerated individual shared concerns about DOC continually delaying their release.	This person was released from DOC prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
Washington Corrections Center for Women			
188.	A family member requested assistance for their loved one. The incarcerated person has also reported this issue and has not pursued appropriate administrative remedies internal to DOC.	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 shared concerns about DOC confusing them for someone else, moving them, and potentially delaying their release.	This person was released from DOC prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
Washington State Penitentiary			
190.	Incarcerated individual shared concerns about new DOC staff refusing to follow an established	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to	Person Declined OCO Assistance

	programming plan.	request assistance.	
191.	An incarcerated person reached out to the OCO for assistance with a banking concern.	This person was released from DOC prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
192.	An incarcerated person reached out to the OCO for assistance with a medical concern that they also have not yet informed the department about.	This person was released from DOC prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
193.	An incarcerated person reached out to the OCO for assistance with a medical concern.	This person was released from DOC prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
194.	An incarcerated person reached out to the OCO for assistance with a medical concern that they also have not yet informed the department about.	This person was released from DOC prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-019

Report to the Legislature

As required by RCW 72.09.770

June 25, 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-23-019 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 May 16, 2024:

DOC Health Services

- Dr. Frank Longano, Chief Medical Information Officer for the Chief Medical Officer
- Dr. Eric Dant, Facility Medical Director – Airway Heights
- Dr. Rae Simpson, Director – Quality Systems
- Patricia Paterson, Chief of Nursing
- Darren Chlipala, Administrator
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Charles Anderson, Deputy Assistant Secretary
- Rochelle Stephens, Men's Prisons Project Manager

DOC Risk Mitigation

- Mick Pettersen, Director

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

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

Health Care Authority (HCA)

- Dr. Sophie Miller, Associate Medical Director

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

Fatality Summary

Year of Birth: 1967 (56-years-old)

Date of Incarceration: April 2002

Date of Death: November 2023

At the time of death, this incarcerated individual was housed in a DOC prison facility.

The cause of death was arteriosclerotic and hypertensive cardiovascular disease. The manner of death was undetermined.

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

Day of Death	Event
0639 hours	• Tier check completed at his cell front.
0655 hours – 0711 hours	• He was found unresponsive. • Medical response requested and aid rendered.
0714 hours - 0747 hours	• Community Emergency Medical Services (EMS) arrived and took over life saving measures. • He was pronounced deceased by EMS.

UFR Committee Discussion

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

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

1. The committee found:

a. The death was unexpected.
b. He had a history of significant traumatic brain injury with seizure-like events. He was followed by a neurologist and taking seizure prevention medication.
c. There were no red flags that he was at high risk for sudden cardiac death.
d. His cardiovascular risk score was below the recommended level for treatment with a cholesterol lowering medication.
e. At times, his blood pressure was not optimally controlled. On several occasions he

declined to take medication for lowering his blood pressure.

f. DOC's paper health record makes trending and monitoring changes in vital signs hard to assess over time.

2. The Mortality Review Committee recommended.

   a. A referral to the UFR committee.

   b. DOC Health Services (HS) should identify a process to support the monitoring and management of individuals with chronic medical conditions while using a paper health record.

   c. DOC should continue to support current high blood pressure management work.

B. 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. There were missed tier checks that were logged as completed in the logbook. The missed tier checks were not communicated with the booth officer.

      b. The medical emergency response kit was missing items, and the manual suction device was ineffective.

   2. The CIR recommended:

      a. Forming a DOC workgroup with the specific aim of designing and executing a strategy to enhance compliance with tier checks and red bag inventory; and

      b. Conducting an evaluation of portable suction devices by the Health Services leadership team.

C. The UFR committee reviewed the unexpected fatality and discussed the following topics.

   1. Medical care and emergency response.

      Committee members noted CPR was provided quickly and Narcan was deployed.

      The incarcerated individual had appropriate work-up for reported shortness of breath and cardiovascular risk. Treatment options for blood pressure control were discussed and offered to him. He was involved in his care planning with his providers and due to perceived side effects, he inconsistently took his prescribed blood pressure medication.

      DOC Health Services clinical leadership is planning to replace current manual portable suction device with a battery powered unit.

Committee Findings

The manner of the incarcerated individual's death was undetermined. The cause of death was arteriosclerotic and hypertensive cardiovascular disease.

Committee Recommendations

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

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

1. DOC should continue to pursue an electronic health record when full legislative funding becomes available.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-020

Report to the Legislature

As required by RCW 72.09.770

June 17, 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-23-020 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 May 2, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Patricia Paterson, Chief Nursing Officer
- Dr. Rae Simpson, Director – Quality Systems
- Paul French, Administrator – Substance Abuse Recovery Unit
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Charles Anderson, Deputy Assistant Secretary
- Eric Jackson, Deputy Assistant Secretary
- Lorne Spooner, Director, Correctional Services
- Paige Perkinson, Correctional Operations Program Manager
- Rochelle Stephens, Men's Prison Project Manager

DOC Risk Mitigation

- Mick Pettersen, Director

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, 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 (36-years-old)

Dates of DOC Incarceration: August 2022 – May 2023

Date of Death: November 2023

At the time of death, this incarcerated individual was housed in a federal Bureau of Prisons facility.

The cause of death was due to acute heroin, olanzapine, and mirtazapine intoxication. The manner of death was accidental.

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

Weeks prior to death	Event
23 weeks	• He was transported to a county jail from a DOC prison facility per court order.
10 weeks	• He was transferred by the county jail to the custody of the U.S. Marshals Service and transported to the federal Bureau of Prisons (BOP) facility.
6 weeks	• He was hospitalized and returned to the BOP facility.
3 weeks	• He was hospitalized and returned to the BOP facility.
Day of death	**Event**
Day of death	• He was found unresponsive at the BOP facility and emergency treatment was provided. • He was pronounced deceased by community emergency medical services.

UFR Committee Discussion

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

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

1. The committee found:

a. He was diagnosed with multiple mental health disorders and co-occurring substance

use disorder.

b. He tested positive twice in 2022 when screened for illicit drug use by DOC correctional staff.
c. There was no documentation of a notification to medical staff or a referral to the Substance Use Recovery Unit found in the records reviewed.
d. He had several facility moves for custody and behavior management reasons during his incarceration.

2. The Mortality Review Committee recommended:

    a. Continuing to work with interagency opioid taskforce to develop a DOC process for tracking and addressing when an incarcerated individual has positive drug screens.
    b. Further evaluation is needed regarding resource and system updates to support increased SUD referrals and treatment coordination needs.

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

1. The CIR found DOC policies and procedures were followed prior to transferring this incarcerated individual to federal custody.
2. The CIR had no recommended actions.

C. Although this incarcerated individual was in BOP custody for approximately 6 months prior to his death, the UFR committee reviewed the case records to identify any learning opportunities for DOC. The following topics were discussed:

1. UFR committee members appreciated the supporting documentation and wanted to thank the Bureau of Prisons for the cooperation with this review.
2. DOC's addiction medicine program and availability of medication for opioid use disorder (MOUD) treatment:

    The department is not funded at the level needed to provide the optimum level of support required for all who have opioid use disorder and other substance use needs. The Department of Health representative shared research with committee members showing that for individuals with opioid use disorder, counseling without MOUD treatment was ineffective to support long term sobriety. The committee discussed the importance of expanding MOUD treatment to meet current needs.

    DOC is moving forward to align policy and protocol for more effective utilization of existing resources and optimize available treatment. DOC Health Services was recently able to add a clinical staff member to the addiction medicine team to further support these efforts.

3. DOC's management of individuals with co-occurring serious mental illness and substance use disorder.

    DOC is aligning resources through integration of the substance use recovery unit into the

behavioral health program. Health Services is working with consultants to support development of the behavioral health and addiction care team with the goal to continue to unify medical and therapeutic addiction treatment services. The committee acknowledged a collaborative co-occurring management program is not available throughout Washington state and DOC is steps ahead by adding a dedicated Addiction Medicine Nurse to the care team.

Committee members recognized in a carceral setting, there are inherent challenges to maintain safety and provide medical treatment. Challenges include contraband introduction and prescription diversion. DOC Health Services and custody have implemented additional safety procedures during MOUD medication administration to decrease diversion opportunities. In an effort to improve care, the committee supported a standard notification to health services if an incarcerated individual has a drug screen result positive for a non-prescribed substance.

4. Transfers for court proceedings.

   The committee discussed procedures for transfer of incarcerated individuals to court proceedings including:

   a. The incarcerated individual cannot be notified of the specific date and time of transfer for safety and security reasons.
   b. DOC custody arranges for appropriate transportation to the receiving facility.
   c. DOC Health Services provides a transfer packet that contains a printed care summary, ten (10) days of prescription medication and a copy of the medication administration record.
   d. DOC provides a 24-hour service staffed by registered nurses that can assist the receiving facility with medical information and obtaining any additional medical records.

Committee Findings

The manner of the incarcerated individual's death was accidental. The cause of death was due to acute heroin, olanzapine, and mirtazapine intoxication.

Committee Recommendations

The committee did not offer recommendations for corrective action to prevent a similar fatality in the future.

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

1. DOC should identify opportunities that support information sharing between custody and health services.
2. DOC should evaluate feasibility for developing an automated notification to Health Services when an individual tests positive for an illicit substance once an electronic system is implemented.

3. DOC should evaluate projected resource impacts for Health Services to conduct a substance use assessment and identify possible treatment opportunities when an incarcerated individual tests positive for an illicit substance during incarceration.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-005

Report to the Legislature

As required by RCW 72.09.770

June 26, 2024

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
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Unexpected Fatality Review Committee Report

UFR-24-005 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 both May 16, 2024, and June 6, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Patty Paterson, MSN, Director of Nursing
- Dr. Eric Dant, Facility Medical Director
- Dr Frank Longano, Chief Medical Information Officer
- Darren Chlipala, Administrator
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Charles Anderson, Deputy Assistant Secretary

DOC Risk Management

- Michael Pettersen, Risk Mitigation Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Senior Corrections Ombuds – Policy
- EV Webb, Assistant Corrections Ombuds – Investigations
- Madison Vinson, Assistant Corrections Ombuds - Policy

Department of Health (DOH)

- Ellie Navidson, 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

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

Date of Incarceration: January 2021

Date of Death: February 2024

At the time of his death, this incarcerated individual was housed in a DOC prison facility.

His cause of death was severe atherosclerotic coronary vascular disease. The manner of his death was natural.

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

Day of Death	Event
0755 hours - 0758 hours	• The incarcerated individual was found unresponsive in his bunk. • A medical emergency was initiated, and lifesaving efforts started.
0818 hours	• Community emergency medical services arrived and assumed care.
0843 hours	• Death was pronounced by a DOC physician assistant.

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 and recommendations.

    1. The MRC committee found:

        a. There was no indication of acute illness.

        b. His high blood pressure was not well controlled, and treatment was complicated by his reluctance to take medications.

        c. There was no clear indication for additional medication management and nothing in medical history suggesting a full cardiac work up was necessary.

2. The MRC committee recommended:

    a. A referral to the UFR committee

    b. Continuing to support the current DOC Health Services hypertension management efforts.

    c. All individuals should have routine follow-up for chronic care management. If they decline to participate, reattempt engagement and provide chronic care education during urgent care appointments.

B. 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. DOC policies and procedures were followed, and no recommendations were identified to prevent a similar fatality in the future.

C. The UFR committee reviewed the work of the Mortality Review committee and the Critical Incident Review and discussed the following topics:

1. Emergency response:

    The DOC emergency response was acknowledged by committee members for the quick action by custody staff including the administration of Naloxone, placing the AED and initiating CPR prior to the arrival of medical staff. Per DOC policy and training, custody staff administer appropriate first aid and medical staff assume care when they arrive on scene.

    Discussed community emergency services (EMS) response and whether DOC can call 911 without the authorization of medical staff. DOC explained that custody officers are authorized and encouraged to activate 911 if they are aware the situation is life-threatening. The Chief Nursing Officer (CNO) shared that the response time was appropriate, and EMS arrival often depends on the facility location and how quickly custody is able to secure the scene.

    Discussed DOC emergency response equipment, including portable oxygen tanks. CNO explained that portable oxygen tanks are not currently required as part of the response equipment due to their weight and how quickly they drain during an emergency. DOC nurse leadership is currently reviewing the emergency response equipment and updating the emergency response protocol.

2. Hypertension treatment:

    The incarcerated individual was appropriately offered additional medication to assist with controlling his blood pressure during a primary care visit. He declined additional medications. Incarcerated individuals do not always agree with the recommended treatment plan and have the right to decline treatments. DOC providers meet them where they are in that moment and provide appropriate treatments that they are willing to accept. They do provide encouragement, education and attempt to reengage them during future visits.

The updated DOC hypertension treatment protocol is now in place and medical staff have been trained. In addition, the protocol includes guidance on patient education and engagement. The DOC Chief Medical Office shared Panel Management Dashboard which is a case management tool used to coordinate and monitor care needs for incarcerated individuals identified with certain chronic medical conditions such as hypertension and diabetes. This dashboard is being developed to support clinical care and positively impact the health of our population until an electronic health record that supports panel management has been implemented.

3. Electronic Health Records.

   An electronic health record (EHR) will allow tracking and trending of vital signs and lab results to support clinical care for incarcerated individuals. The EHR is at least one year out from implementation.

Committee Findings

The incarcerated individual died as a result of atherosclerotic coronary vascular disease. The manner of death was natural.

Committee Recommendations

The committee did not offer recommendations for corrective action to prevent a similar fatality in the future.

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

DOC should continue to pursue an electronic health record when full legislative funding becomes available.

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