Office of the Corrections OMBUDS

Monthly Outcome Report
September 2024

UNEXPECTED FATALITY REVIEWS: 6

CASE INVESTIGATIONS: 157

Assistance Provided: 35
Information Provided: 59
DOC Resolved: 21
Insufficient Evidence to Substantiate: 12
No Violation of Policy: 30
Substantiated: 0

INTAKE INVESTIGATIONS: 56

Administrative Remedies Not Pursued: 0
Declined: 1
Lacked Jurisdiction: 7
Person Declined OCO Assistance: 34
Person Released from DOC Prior to OCO Action: 6
Technical Assistance Provided: 8

Resolved Investigations:

219

Assistance Provided, Information Provided, or Technical Assistance Provided in

47%

of Investigations

OCO Casework Highlights

September 2024

Assistance Provided

Reported Concerns: Incarcerated person reported that he has a Health Status Report (HSR) that was ignored by DOC staff. This resulted in the person getting injured and requiring emergency medical care.
OCO Actions: OCO staff substantiated the reported event by contacting facility leadership in custody and health services and requested improvements be made in communicating when a person's needs have changed in a way that requires action by custody staff.
Negotiated Outcomes: The OCO is in discussions with DOC Health Services regarding updates to the Health Status Report (HSR) protocol and will continue to offer recommendations responsive to complaints received by the OCO.

Assistance Provided

Reported Concerns: Person reports concerns about their placement and wants to be considered for Residential Treatment Unit (RTU) for more access to mental health care.
OCO Actions: The OCO elevated the concerns through health services leadership and discussed RTU consideration with clinical mental health leadership. At this time, the patient was not approved for RTU level care. The OCO provided the patient with self-advocacy information and pathway for reconsideration.
Negotiated Outcomes: After OCO outreach, the patient was placed in a therapeutic community and approved for a 6-month single cell to assist with the patient's symptoms related to overstimulation from general population setting.

Assistance Provided

Reported Concerns: Incarcerated person reports that he could not move forward with his treatment while housed in receiving. The person states his resolution request was not handled as a medical request and that he had not had a medical appointment since arriving. The person requested to be transferred to receive medical care.
OCO Actions: The OCO provided assistance by contacting DOC resolutions staff and requesting the resolution be reopened.
Negotiated Outcomes: After OCO outreach, DOC agreed to overturn the resolution decision. The patient was transferred through the regular classification process. OCO staff reviewed the patient appointments and noted that several appointments had been scheduled since the person arrived at their new facility.

Information Provided

Reported Concerns: A loved one reported that her brother's eye was cut during a fight and since the injury, the DOC has not prioritized his healthcare requests.
OCO Actions: OCO reviewed the individual's resolution requests about his medical appointments and contacted health services regarding his medical kites. The OCO will continue to monitor the progress of this individual's eye appointments and encouraged him to contact our office if he does not receive his medical appointment
Negotiated Outcomes: After OCO outreach, DOC staff confirmed they were able to get him an Ophthalmology appointment.

Information Provided

Reported Concerns: Incarcerated person reports that their medical provider has not been acting in a timely manner regarding his consultations and requests for medication. The patient is requesting to be removed from that provider's caseload.
OCO Actions: The OCO provided information to the person regarding their specialist consultation status and the steps needed to request a change in medical providers. OCO staff reviewed the patient's appointments and verified they have been provided opportunities to update their care plan with their provider and confirmed the request consultation was scheduled.

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 24-004: The Unexpected Fatality Review Committee reviewed the unexpected death of a 43-year-old person in February 2024. The Unexpected Fatality Review Committee Report dated September 3, 2024 is a publicly available document. A Corrective Action Plan (CAP) was completed on September 13, 2024.

UFR 24-003: The Unexpected Fatality Review Committee reviewed the unexpected death of a 59-year-old person in January 2024. The Unexpected Fatality Review Committee Report dated August 15, 2024 is a publicly available document.

UFR 24-008: The Unexpected Fatality Review Committee reviewed the unexpected death of a 25-year-old person in April 2024. The Unexpected Fatality Review Committee Report dated August 22, 2024 is a publicly available document. A Corrective Action Plan (CAP) was completed on September 1, 2024.

UFR 24-001: The Unexpected Fatality Review Committee reviewed the unexpected death of a 46-year-old person in January 2024. The Unexpected Fatality Review Committee Report dated August 2, 2024 is a publicly available document. A Corrective Action Plan (CAP) was completed on August 12, 2024.

UFR 24-009: The Unexpected Fatality Review Committee reviewed the unexpected death of a 39-year-old person in May 2024. The Unexpected Fatality Review Committee Report dated August 30, 2024 is a publicly available document.

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

Monthly Outcome Report: September 2024

	Complaint Summary	Outcome Summary	Case Closure Reason
Unexpected Fatality Reviews			
GRE/CPA			
1.	An incarcerated individual died while on Graduated Reentry (GRE).	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-24-009 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The UFR Committee provided the following consultative remark: DOC should provide education to staff on the importance of documenting a care plan for follow-up on abnormal lab results.	Unexpected Fatality Review
Other			
2.	An incarcerated individual died while in DOC custody.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-24-003 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The UFR Committee provided the following consultative remarks: DOC should continue to pursue funding for an electronic health record (EHR) to replace paper files and allow interface with community care providers.	Unexpected Fatality Review
Washington State Penitentiary			
3.	Family member reports concerns about their loved one after he was moved to solitary confinement. The incarcerated person died while in DOC custody.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-24-008 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The UFR Committee provided the following recommendations: 1. DOC should provide direction regarding nursing restrictive housing assessments; 2. DOC should update nursing protocol to direct a scheduled nurse visit when there	Unexpected Fatality Review

		is a missed dose of MOUD medication; 3. DOC Health Services should propagate a culture of heightened diagnostic curiosity and effective clinical decision making when faced with patient whose vital signs, labs, or symptoms are not completely explained by the working diagnostic hypothesis, further a culture of shared responsibility where teams actively discuss patients is highly recommended; DOC should update the MOUD protocol to include recommended clinical responses when there is a positive toxicology result, provide education to staff on the changes to protocol and offer ideas for engaging incarcerated individuals diagnosed with substance use disorder in their care planning; 5. DOC should provide clear direction on how to perform and document a wellness check for incarcerated individuals in a restricted housing unit. Three additional consultative remarks were also included in the final UFR report.	
4.	Incarcerated individual died while in DOC custody.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-24-004 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The UFR Committee provided the following recommendations and consultative remarks: 1. until an electronic health record system is implemented, DOC should provide education and care management guidelines that augment current prescribing practices and facilitate medication monitoring; and 2. DOC should develop a written guidelines for the tier check process that will clarify the purpose and function; 3. DOC Health Services should work toward proactively offering an annual wellness exam visit for each incarcerated individual housed in a prison facility; 4. DOC should continue to pursue an electronic health record when full legislative funding becomes available to support care delivery.	Unexpected Fatality Review
5.	Incarcerated individual died while in DOC custody.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-24-008 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The UFR Committee provided the following recommendations: 1. DOC should provide direction regarding nursing restrictive housing assessments; 2. DOC should update nursing protocol to direct a scheduled nurse visit when there is a missed dose of MOUD medication; 3. DOC Health Services should propagate a culture of heightened diagnostic curiosity and effective clinical decision making when faced with patient	Unexpected Fatality Review

		whose vital signs, labs, or symptoms are not completely explained by the working diagnostic hypothesis, further a culture of shared responsibility where teams actively discuss patients is highly recommended; DOC should update the MOUD protocol to include recommended clinical responses when there is a positive toxicology result, provide education to staff on the changes to protocol and offer ideas for engaging incarcerated individuals diagnosed with substance use disorder in their care planning; 5. DOC should provide clear direction on how to perform and document a wellness check for incarcerated individuals in a restricted housing unit. Three additional consultative remarks were also included in the final UFR report.	
6.	An incarcerated individual died while in DOC custody.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-24-001 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The UFR Committee provided the following recommendations and consultative remarks: 1. DOC should conduct physical assessment training for nurses and practitioners to include simulations; and 2. DOC should explore and when possible, increase the availability of on-site advanced practitioner coverage in their prison facilities.	Unexpected Fatality Review
		Case Investigations	
Airway Heights Corrections Center			
7.	External person reported concerns about an incarcerated person's placement into segregation. The OCO spoke to the incarcerated individual in person and they requested assistance accessing their legal property.	The OCO provided assistance. The OCO reviewed the person's segregation placement and found that it complied with DOC protocol, and the person had released from segregation when this office spoke with them. The OCO provided assistance by speaking with DOC staff in the property room to ensure that the person would receive their legal documents. The OCO reviewed the individual's file to verify they received their property.	Assistance Provided
8.	Incarcerated individual relayed concerns regarding appealing an infraction but not getting a response.	The OCO contacted DOC to see if there was any documentation of an appeal for the infraction. As DOC stated they did not receive an appeal, the OCO requested the individual be able to resubmit an appeal. DOC agreed to accept the appeal.	Assistance Provided
9.	Person reported that he has a Health Status Report that was ignored by DOC staff. This resulted in the person getting injured and requiring emergency medical care.	The OCO provided assistance. OCO staff substantiated the reported event. OCO staff contacted facility leadership in custody and health services and requested improvements be made in communicating when a person's needs have changed in a way that requires action by custody staff. The OCO is in discussions with DOC Health Services regarding updates to the Health Status Report (HSR) protocol and will continue to offer recommendations responsive to complaints received by the	Assistance Provided

		OCO. OCO staff confirmed that corrective action was taken in response to this incident after OCO outreach.	
10.	Anonymous individual reports concerns about a self-harm attempt in their unit. The person reported that the incident affected others in the unit and they hoped to get support after witnessing the incident.	The OCO provided assistance. The OCO reached out to DOC staff and requested that mental health staff be available to folks in the unit. DOC staff responded that mental health staff would be available by request. The OCO also confirmed that the person involved in the self-harm attempt was treated appropriately and has access to adequate care.	Assistance Provided
11.	A cultural group anonymously asked OCO for help in coordinating contact with the Secretary of State (SOS) Library within the facility.	The OCO mediated a resolution with DOC staff and were able to connect the volunteers for the cultural group to SOS Library information on the SOS website, and directly to SOS Library staff with permission from the SOS Librarian.	Assistance Provided
12.	Incarcerated individual expressed concerns about an infraction.	The OCO reviewed the individual's disciplinary record and found the infraction was dismissed by DOC prior to OCO involvement.	DOC Resolved
13.	Incarcerated individual shared concerns regarding DOC staff failing to work with them for their release.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO found that the individual has a planned release date and has an approved release plan from DOC.	DOC Resolved
14.	Person reported that his wife's visitation privileges were terminated without any proof after he was investigated for introducing contraband.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and verified this person was never infracted for this incident. This office reached out to DOC staff who said that his wife's visitation privileges were reinstated due to a lack of evidence that he and his wife introduced contraband.	DOC Resolved
15.	Incarcerated individual shared concerns regarding DOC holding them back from going into a reentry center and not telling them why.	The OCO provided information regarding this individual's approval to Graduated Reentry (GRE). This office was able to confirm that following a completed Custody Facility Plan (CFP), they were approved to go to out on GRE.	DOC Resolved
16.	Incarcerated individual shared concerns regarding DOC staff targeting them and mistreating them by wrongfully infracting them.	The OCO was unable to substantiate any staff misconduct by DOC. The incarcerated individual also did not appeal the infraction. This office provided information regarding the infraction appeal process and the timeline provided by DOC for appeals of infractions.	Information Provided
17.	Person reports that their medical provider has not been acting in a timely manner regarding his consultations and requests for medication. The patient is requesting to be removed from that provider's caseload.	The OCO provided information to the person regarding their specialist consultation status and the steps needed to request a change in medical providers. OCO staff reviewed the patient's appointments and verified they have been provided opportunities to update their care plan with their provider and confirmed the request consultation was scheduled.	Information Provided
18.	Incarcerated individual relayed concerns regarding not getting proper notification about when their infraction hearing was to be held.	The OCO reviewed the corresponding infraction materials and confirmed that the individual was given paperwork with the proper infraction date on it prior to the hearing.	Information Provided

19.	Incarcerated individual reports concerns related to an individual who passed away while in DOC custody.	The OCO provided information about the Unexpected Fatality Review committee process.	Information Provided
20.	Incarcerated individual shared concerns regarding DOC staff failing to wear body cameras despite the increased safety they would provide.	The OCO provided information on why DOC staff are not mandated to wear body cameras. The OCO informed the individual that they could contact their local legislator regarding this issue as there is no RCW (Revised Code of Washington) or WAC (Washington Administrative Code) mandating DOC staff to obtain and wear body cameras.	Information Provided
21.	Incarcerated individual shared concerns regarding DOC taking extended periods of time to provide medical boots.	The OCO provided information regarding how to properly utilize the internal administrative process provided by DOC and how to properly utilize the OCO's services. This office also provided pertinent information regarding the resolution program within DOC.	Information Provided
22.	Incarcerated individual shared concerns regarding not being able to obtain a transfer.	The OCO provided information regarding DOC policy 300.380, which is the DOC policy that provides guidelines for an individual's transfer request as well as custody level and facility placement, and why individuals' lateral transfer requests are not always honored.	Information Provided
23.	Incarcerated individual shared concerns regarding a DOC policy which improperly imposes sanctions, does not allow them to return to work in a timely manner and diminishes the rehabilitative goal of programming.	The OCO provided information regarding the purpose of DOC policy 700.000 which has a six (6) month infraction free incentive after a guilty infraction outlined to promote a safe and infraction free environment. This office also shared why the six (6) month clock is started after the guilty finding and not after accusation of an infraction.	Information Provided
24.	Incarcerated individual shared concerns regarding DOC not reimbursing their cost of supervision (COS) despite state law getting rid of COS requirements and still paying legal financial obligations (LFOs) despite their belief they are all paid.	The OCO provided information regarding Second Substitute House Bill (SSHB) 1818, which directly eliminated COS payments, and why there are no reimbursements. This office also shared information pertinent to paying LFOs.	Information Provided
25.	An incarcerated individual reports that he was denied an MRI to help diagnose his sciatic nerve damage.	The OCO reviewed the individual's resolution request and spoke with DOC staff regarding this issue. This person needs to ask their provider to submit their request for an MRI to the care review committee (CRC). If their provider does not help them, they can write a resolution request asking the CRC to review their request for an MRI. If the CRC denies their request, they can appeal that decision. The OCO provided this information to the individual and encouraged this person to follow this process.	Information Provided
26.	Incarcerated person reports concerns about DOC restoring good conduct time (GCT). The person reports they completed the directives of the good time restoration pathway, but DOC staff will not restore the GCT.	The OCO provided information about the actions taken by the OCO. This office reviewed the GCT restoration plan and founds the person met the requirements to have the GCT restored. This office spoke with DOC staff who were unwilling to honor the GCT due to a clerical error. DOC awarded the person the good conduct time at his next custody facility plan meeting and the GCT has been restored, however the OCO	Information Provided

		substantiates that the GCT restoration was delayed due to DOC staff error.	
27.	Incarcerated individual shared concerns regarding DOC incorrectly denying their mail.	The OCO provided information regarding why the requested material was rejected. This office also shared other pertinent information regarding the rejection process.	Information Provided
28.	Person reports delays in getting seen by the dentist. The person reports he missed one appointment and was told that there is a several month waitlist for dental appointments.	The OCO provided information to the person regarding the current staffing issues being experienced by his current facility. OCO contacted DOC Health Services staff and were informed of the steps the facility is taking to get more dental care access available.	Information Provided
29.	Incarcerated individual shared concerns regarding DOC rejecting their requested books and not providing an answer to their appeal.	The OCO provided information to the individual regarding why the material was rejected and will not be heard on appeal as they did not appeal within the given timeframe.	Information Provided
30.	Incarcerated individual relayed concerns regarding an infraction and a behavior observation entry (BOE) for the same incident.	The OCO reviewed the individual's disciplinary and BOE history and could not identify any BOE issued for the same incident that the person was infracted for. For this reason, there was insufficient evidence to substantiate the individual's concern.	Insufficient Evidence to Substantiate
31.	Person reports that DOC has not provided evaluation and treatment for several medical concerns. The person requested to see an outside specialist.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff contacted DOC Health Services and were informed that the patient had been evaluated for the reported concerns and that he had an outside consult pending approval.	Insufficient Evidence to Substantiate
32.	Incarcerated individual relayed concerns regarding an officer retaliating against the LGBTQ community.	The OCO reviewed the related grievance responses and found that DOC thoroughly investigated this concern and there was no evidence to support a finding that any staff violated policy or engaged in misconduct. The OCO informed the individual that in order to substantiate a claim of 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, which was not evident in this situation.	Insufficient Evidence to Substantiate
33.	Incarcerated individual shared concerns regarding DOC wrongfully infracting them, removing them from a reentry setting, and holding them past their release date.	The OCO was unable to substantiate the concern due to insufficient evidence. This office found that this individual acquired infractions within the community and did not to appeal the infractions. Early release is a practice utilized by DOC to award individuals that have maintained infraction-free behavior and utilized programming as well as other avenues of rehabilitative measures.	Insufficient Evidence to Substantiate
34.	Incarcerated individual shared concerns regarding DOC staff failing to properly identify themselves by obstructing their ID cards.	The OCO was unable to substantiate the concern due to insufficient evidence. There were no other complaints made regarding this concern and the resolution request filed on this issue lacked enough evidence to investigate. The OCO shared how to detail the concerns in a way that has evidence to investigate further.	Insufficient Evidence to Substantiate
35.	Incarcerated individual relayed	The OCO reviewed the BOE and found no violation of DOC	No Violation of

	concerns regarding a behavior observation entry (BOE).	policy 300.010 as the individual displayed a negative behavior resulting in the negative BOE.	Policy
36.	Incarcerated individual relayed concerns regarding placement in solitary confinement.	The OCO reviewed the individual's segregation housing placement and found no violation of DOC 320.255 Restrictive Housing as the individual's placement is per policy. The OCO informed the individual that they will remain in segregation until the investigation is complete, the outcome of the infraction hearing occurs, and a new custody facility plan (CFP) is conducted.	No Violation of Policy
37.	Incarcerated individual relayed concerns regarding a denial of a deathbed visit.	The OCO reviewed the level 1, 2 and 3 grievance response. The OCO found that DOC thoroughly investigated this concern and DOC 420.110 Escorted Leaves and Furloughs was properly followed as DOC could not confirm that the family member was terminally ill. Without the ability to verify the terminal illness as required in DOC 420.110, the visit could not be approved. Once verification of the illness was received, DOC immediately initiated DOC form 05-793 funeral trip/deathbed visit which was approved but unfortunately the family member passed before the visit could occur.	No Violation of Policy
38.	Person reported concerns about his Health Status Report (HSR) for a lower bunk expiring and said that climbing the ladder to get into an upper bunk causes him pain.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the lower bunk HSR criteria, which describes specific medical conditions that qualify an individual for a lower bunk HSR. This office reviewed this individual's resolutions request investigation from DOC HQ, which stated that he was clinically reviewed, and it was determined that he does not meet these criteria.	No Violation of Policy
39.	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
Cedar Creek Corrections Center			
40.	Incarcerated individual shared concerns regarding not receiving proper mental healthcare.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO was able to confirm that DOC scheduled the individual for mental health care and have seen them upon request.	DOC Resolved
41.	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
42.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC 460.000 Disciplinary Process for Prisons as the individual's behavior meets the infraction elements.	No Violation of Policy
Clallam Bay Corrections Center			
43.	Incarcerated person reports he would like to be interviewed for the Solitary Confinement Project.	The OCO conducted an interview with this individual regarding their experience living in solitary confinement. This information was used in the OCO Solitary Confinement Report Part 2, released September 2024.	Assistance Provided
44.	Incarcerated person reports he would like to be interviewed for the Solitary Confinement Project.	The OCO conducted an interview with this individual regarding their experience living in solitary confinement. This information was used in the OCO Solitary Confinement Report Part 2, released September 2024.	Assistance Provided
45.	External person reported concerns about an	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed the incarcerated	DOC Resolved

	incarcerated person's placement in segregation due to a pending investigation and infractions.	person's file and found that DOC did hold the person in segregation pending an investigation. The person was released from segregation and promoted a custody level after the findings showed the person had no involvement in the concern being investigated by DOC. The OCO verified the person is out of segregation and the infractions are not in their file.	
46.	A loved one reports that an incarcerated individual is getting his medication late every month.	The OCO reviewed the individual's resolution requests and spoke with health services about this concern. This office learned that injection dates can vary because some months are shorter than others, and there must be 30 days between each dose. DOC health services confirmed that the individual received his injection for August, when the initial outreach was conducted.	DOC Resolved
47.	Person reported concern about staff giving him food that he has a documented allergy for.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and reached out to DOC staff, who stated that this individual met with the state dietician, who issued a new Health Status Report (HSR) for a special diet. DOC staff said that this individual has not reported any complaints about food since.	DOC Resolved
48.	A loved one reports she is concerned for her son's safety because he has been attacked more than once at two separate facilities. She is requesting that DOC place him in a safe harbor unit and change his custody level.	The OCO contacted DOC about this concern and the DOC is unwilling to change their classification decision. The OCO provided information about how to appeal a custody decision by completing DOC 07-037 Classification Appeal and submitting it to the Assistant Secretary for Prisons/designee.	Information Provided
49.	Incarcerated individual relayed concerns regarding a loss of commissary including hygiene products and being allergic to the hygiene products issued to indigent individuals.	The OCO reviewed the individual's infraction history and confirmed that they were given a loss of store sanction and are only allowed access to indigent hygiene. The OCO informed the individual that they will need to kite their provider if they believe they are allergic to the indigent hygiene items.	Information Provided
50.	Incarcerated individual shared concerns regarding DOC not providing them with an ADA accommodating job.	The OCO provided information regarding how to utilize the internal administrative processes provided by DOC. This office also provided further information regarding the resolution program within DOC.	Information Provided
51.	Incarcerated individual shared concerns regarding DOC damaging their property during its transfer and refusing to reimburse them.	The OCO was able to confirm that this individual filed a tort claim regarding this issue and it was found to be unsubstantiated. This office provided this information to the individual and shared with them how to get in further contact with the Department of Enterprise Services risk management to inquire about next steps.	Information Provided
52.	Incarcerated individual shared concerns regarding DOC potentially jeopardizing their safety by transferring them to a different facility.	The OCO provided information regarding reporting safety concerns and ensuring their personal safety. This office spoke with DOC staff who reported that this individual stated they feel safe in their current unit.	Information Provided
53.	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 "some evidence" standard utilized by DOC to	No Violation of Policy

		substantiate infractions.	
54.	Incarcerated individual relayed concerns regarding and infraction.	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 to substantiate an infraction.	No Violation of Policy
Coyote Ridge Corrections Center			
55.	Incarcerated person reports he would like to be interviewed for the Solitary Confinement Project.	The OCO conducted an interview with this individual regarding their experience living in solitary confinement. This information was used in the OCO Solitary Confinement Report Part 2, released September 2024.	Assistance Provided
56.	Incarcerated person reported concerns about an emergency medical ailment.	The OCO provided assistance. Over the OCO hotline, the OCO instructed the individual to communicate with medical staff immediately and shared how to access them. The OCO followed up with DOC staff and confirmed the individual received care after the communication with the OCO.	Assistance Provided
57.	Person reported that he has not been able to see an optometrist and that his appointment was cancelled because he was transferred to a different facility.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO confirmed with DOC staff that this individual saw an optometrist and received necessary care.	DOC Resolved
58.	Person reported that his glasses were broken when he was assaulted and wants DOC to pay for replacing his glasses.	The OCO provided information about the Care Review Committee process in determining if DOC will pay for his glasses, and provided information about appealing the Care Review Committee decision if they will not pay for his glasses. The OCO reviewed DOC records and reached out to DOC staff, who confirmed that this individual has an appointment with his provider to get new glasses. DOC staff confirmed that this individual will not have to pay for the appointment with his provider.	Information Provided
59.	Person reports that DOC staff improperly treated him, resulting in injury. The person requested that he receive treatment for the injury by a medical provider and corrective action against the staff member who hurt him.	OCO staff provided information about the clinical review performed regarding this incident. OCO staff verified that the person was scheduled for follow up with the correct medical provider. OCO does not have authority to determine disciplinary actions for DOC staff.	Information Provided
60.	Person reports facing delays in receiving physical therapy and follow up care for multiple medical issues. The person states that his condition was exacerbated by the long delays in appointment scheduling. The patient believes he should have been scheduled in the community but never went out to an appointment.	The OCO provided information to the person regarding why DOC did not send him to a community provider for care that could not be provided within the facility. OCO staff reviewed the patient's record and monitored his appointment status on the appointment tracker. OCO staff contacted DOC Health Services staff and were informed that the requested care was in progress.	Information Provided
61.	Incarcerated individual relayed concerns regarding a neutral behavior observation entry	The OCO reviewed the BOE materials for the neutral BOE and found the BOE does have negative language which violates DOC policy 300.010 Behavior Observations, Section (I)(D)(3)	Information Provided

	(BOE) being used with negative language.	which states neutral BOEs should be for behavior that is not necessarily positive or negative. The OCO spoke to DOC facility leadership about this concern and requested DOC staff be reminded of this and confirmed with DOC that a memo was sent out to all staff reminding them of the behavioral observation report process including notifying incarcerated individuals of all BOEs regardless of whether they are positive, negative or neutral.	
62.	External person reported that DOC medical staff did not treat their loved one for a medical emergency.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff reviewed the patient's medical records and confirmed an assessment was completed at the time of incident and the patient was treated per the medical provider's orders.	Insufficient Evidence to Substantiate
63.	Incarcerated individual shared concerns regarding DOC staff blocking their ability to submit an order for a musical instrument despite other orders being processed.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO was able to confirm that staff did not purposely block their ability to submit and process the order, but there was an administrative error on behalf of both the individual and DOC. This office also provided information regarding how to properly obtain a musical instrument or other related equipment.	Insufficient Evidence to Substantiate
64.	Incarcerated person reported safety concerns and concerns related to infractions they received.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the incarcerated person's Custody Facility Plans (CFPs) as well as the reported infractions. Based on DOC's use of the "some" evidence standard, the infractions were issued and upheld by DOC protocol. The person was held in segregation while DOC finalized their CFP and has transferred to a less restrictive custody level in compliance with DOC 300.380 Classification and Custody Facility Plan Review.	No Violation of Policy
GRE/CPA			
65.	Patient reports concerns about access to GRE and release from American Behavioral Health Systems (ABHS).	DOC staff resolved this concern prior to the OCO taking action on this complaint. The individual was discharged from ABHS and released on GRE.	DOC Resolved
Mission Creek Corrections Center for Women			
66.	An incarcerated individual reports that she was transferred to another facility to do the therapeutic community (TC) program and she wanted to stay where she was and participate in the intensive day treatment program (IDT). She reports that she spent over a year reaching out to the substance abuse treatment unit (SARU) and was told that a referral was made, but was never placed in IDT.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. DOC policy 580.000 IV (B) says treatment program service levels may be adjusted by SARU clinical managers based on availability of resources, length of time in confinement, and/or other clinical variables.	No Violation of Policy
Monroe Correctional Complex			
67.	Incarcerated person reports he	The OCO conducted an interview with this individual	Assistance

	would like to be interviewed for the Solitary Confinement Project.	regarding their experience living in solitary confinement. This information was used in the OCO Solitary Confinement Report Part 2, released September 2024.	Provided
68.	Individual reported he was given two minor infractions and both infractions were overturned but he was fired from his job because of the infractions and now is being infracted with a major for losing the job. Says currently the only thing he is being infracted for is losing his job which he lost because of the minor infractions which have since been overturned. Also feels like the sanctions are harsh because the minor infractions were removed.	The OCO reviewed the serious infraction and appeal. This office verified that the serious infraction was dismissed during appeal. After the infraction was dismissed the individual still had multiple sanctions. The OCO contacted facility leadership with concerns about the sanctions; the facility then shared with the OCO that they were resolving the sanctions.	Assistance Provided
69.	Incarcerated individual shared concerns regarding DOC still failing to give them a cooling towel they were approved for.	The OCO provided assistance. Upon hearing that this concern was not resolved from the previous case, this office reached out to DOC staff and ensured they were given the towel. After OCO outreach, the individual received the cooling towel the same day.	Assistance Provided
70.	Incarcerated person reports they would like to be interviewed for the Solitary Confinement Project.	The OCO conducted an interview with this individual regarding their experience living in solitary confinement. This information was used in the OCO Solitary Confinement Report Part 2, released September 2024.	Assistance Provided
71.	Incarcerated person reports he would like to be interviewed for the Solitary Confinement Project.	The OCO conducted an interview with this individual regarding their experience living in solitary confinement. This information was used in the OCO Solitary Confinement Report Part 2, released September 2024.	Assistance Provided
72.	Incarcerated person reports he would like to be interviewed for the Solitary Confinement Project.	The OCO conducted an interview with this individual regarding their experience living in solitary confinement. This information was used in the OCO Solitary Confinement Report Part 2, released September 2024.	Assistance Provided
73.	Incarcerated individual reports DOC is not following policy related to the transgender housing protocol, she is currently housed in solitary confinement and is also concerned about access to medical care, alternative clothing, and property. The person requested their trans housing protocol be completed and they be released from IMU since they were placed there for safety after reporting abuse.	The OCO provided assistance by elevating the concerns to facility leadership regarding access to property and alternative clothing while in solitary. The OCO also elevated the housing protocol concerns. After OCO outreach, the person's housing protocol was completed and the person is no longer in IMU. The OCO consulted with health services to confirm access to medical care regardless of placement.	Assistance Provided
74.	Incarcerated person reports they would like to be	The OCO conducted an interview with this individual regarding their experience living in solitary confinement. This	Assistance Provided

	interviewed for the Solitary Confinement Project.	information was used in the OCO Solitary Confinement Report Part 2, released September 2024.	
75.	Incarcerated person reports they would like to be interviewed for the Solitary Confinement Project.	The OCO conducted an interview with this individual regarding their experience living in solitary confinement. This information was used in the OCO Solitary Confinement Report Part 2, released September 2024.	Assistance Provided
76.	Incarcerated individual shared a concern regarding DOC not reviewing their medical concern despite putting in an emergency medical grievance.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO was able to confirm that DOC staff have seen the individual and have continued to provide requested care.	DOC Resolved
77.	An incarcerated individual reports that DOC is refusing to honor his ADA accommodations for cell grab bars.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO contacted DOC about this concern and confirmed that the in-cell grab bars were installed in his cell.	DOC Resolved
78.	Incarcerated individual shared concerns regarding DOC staff not providing adequate mental healthcare as well as not infracting an individual who is purposefully harassing them.	The OCO provided information regarding how to file PREA concerns when they deem an issue appropriate. This office confirmed that this individual filed an emergency resolution request regarding the issue of harassment, and while it was deemed non-emergent, it was reviewed for a PREA and deemed not to rise to the level of concern for PREA. DOC staff did ensure that they took and will continue to take steps ensuring that this issue does not happen again and will continue looking to prevent misconduct. This office was also able to confirm that this individual has been given continuous adequate mental healthcare when needed or requested.	Information Provided
79.	Incarcerated individual shared concerns regarding not receiving proper dental care.	The OCO provided information regarding how to properly utilize the internal administrative processes outlined by DOC. The OCO was able to verify they did receive dental care. This office also provided information regarding how to contact medical staff to see about receiving treatment.	Information Provided
80.	External person reported their loved one is not able to access mental health care where he is currently housed.	The OCO provided information to the person regarding how to contact mental health at his new facility.	Information Provided
81.	Person reports concerns about ADA job access.	The individual was moved to county jail prior to OCO involvement and this office provided information about a pathway for follow up if the issue is still occurring once the individual is returned to a DOC prison facility.	Information Provided
82.	Incarcerated individual relayed concerns regarding a loss of commissary including hygiene products.	The OCO reviewed the related grievance and infraction history and confirmed that due to a loss of store sanction, the individual is only allowed to access indigent hygiene. The OCO informed the individual that if they have medical-related concerns about the indigent hygiene products, they will need to kite their provider.	Information Provided
83.	Patient reported concerns about access to medications.	The individual was moved to county jail prior to OCO involvement and this office provided information about how to follow up with DOC and OCO if issues continue once the individual is returned to a DOC prison facility.	Information Provided
84.	Person reports that he does not believe that his medical	OCO staff provided information to the patient regarding the status of his ADA request. OCO staff also provided information	Information Provided

	provider is correctly updating his medical records. The patient also requested specific ADA accommodations for his condition.	to the patient regarding the steps needed to ensure his medical record had been updated and to be able to notify his current medical team of any missing information.	
85.	Incarcerated individual shared concerns regarding being subjected to extended wait times when trying to receive dental treatment.	The OCO was able to confirm that this individual has been receiving requested care. DOC medical has extended wait times depending on the type of care the individual requires, this is an issue that many individuals face both within DOC and in the community.	Information Provided
86.	Person reported that he was denied accommodations for his medical condition. The person also stated that DOC staff failed to assign a log ID number to his medical resolution requests regarding this issue.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff contacted DOC Health Services staff and verified the patient had been evaluated by his medical provider for all of the requested accommodations. Per DOC 600.000 Health Services Management, clinical decisions are the sole province of the responsible health care practitioner and are not countermanded by non-clinicians. OCO also verified the person had one accommodation request going to the Care Review Committee to determine if it is a medical necessity. OCO staff reviewed the person's resolution requests and noted that they were all assigned individual log IDs and that no log IDs were changed after they were assigned. Emergency resolution requests are not assigned a log ID until they are processed by the resolution department after the issue is addressed by medical staff.	Insufficient Evidence to Substantiate
87.	Incarcerated individual relayed concerns regarding two infractions and a desire for them to be in the same infraction group number (IGN).	The OCO reviewed the infraction materials for both infractions and found that because the two incidents happened on two different days, they would not be part of the same IGN.	No Violation of Policy
88.	Incarcerated individual relayed concerns regarding the denial of an extended family visit (EFV).	The OCO reviewed the visitation denial and appeal and found no violation of DOC 590.100 Extended Family Visiting as there were multiple valid reasons for the EFV denial.	No Violation of Policy
89.	Incarcerated individual relayed concerns regarding a recent 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
90.	Incarcerated individual relayed concerns regarding an infraction for refusing to program due to a health condition.	The OCO reviewed the infraction materials and found that it was confirmed with medical that the individual does not have any active HSRs that would preclude them from being able to do the assigned job, thus by refusing the job, there is no violation of DOC policy 460.000 by the infraction being written.	No Violation of Policy
91.	Incarcerated individual relayed concerns regarding an infraction case for a refusal of a urinary analysis (UA) they previously had OCO look at as they state they now have an HSR and their provider sent a note that it should be overturned.	The OCO confirmed with DOC that the individual did not have an HSR at the time of the infraction and did not request an HSR until after the infraction occurred. As a result, there is no violation of DOC policy 460.000 in the issuance of the infraction.	No Violation of Policy

92.	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
93.	Incarcerated individual relayed concerns regarding a recent 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
94.	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 "some evidence" standard utilized by DOC.	No Violation of Policy
Olympic Corrections Center			
95.	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
96.	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
Other			
97.	Incarcerated individual relayed concerns regarding being taken off of a particular prescription.	The OCO reviewed the individual's medical records and spoke with DOC staff to confirm that DOC has resolved this issue as the individual is now on the requested medication.	DOC Resolved
98.	Loved one expressed concerns about a death that occurred in a county jail.	The OCO provided the loved one with information about how to file a complaint regarding an unexpected fatality review with the Department of Health as the OCO does not have jurisdiction over concerns that occur in a jail facility per WAC 138-10-040(3)(a).	Information Provided
Stafford Creek Corrections Center			
99.	Incarcerated individual shared concerns regarding DOC being unwilling to provide them with necessary medical boots.	The OCO provided assistance. The OCO found that the individual filed a resolution request (RR) about this issue, following this, DOC staff approved for them to receive the shoes. There was a delay in scheduling the appointment and following OCO inquiry, DOC staff scheduled the appointment for them to be fitted for, and receive, their shoes.	Assistance Provided
100.	Incarcerated person reports he would like to be interviewed for the Solitary Confinement Project.	The OCO conducted an interview with this individual regarding their experience living in solitary confinement. This information was used in the OCO Solitary Confinement Report Part 2, released September 2024.	Assistance Provided
101.	An incarcerated individual expressed concerns about their food allergies and DOC kitchen staff taking him off his special diets, despite having an HSR for his food allergies.	The OCO reviewed the individual's resolution requests and current health status reports (HSR) to verify food allergies. This office also contacted health services and asked if the individual could meet with a dietician to address his dietary needs. DOC confirmed that the individual will be referred to the dietician by his provider.	Assistance Provided
102.	Patient reports delayed gender affirming appointments due to insurance and other paperwork errors. The individual also requested a policy change regarding transgender individuals having access to Health Status Reports	The OCO elevated this concern through health services leadership and confirmed the paperwork was corrected and the consults scheduled. Currently, DOC policy and protocols do not allow for wigs to be issued as HSRs and this recommendation was documented in OCO's case management system in case the opportunity for policy changes arise. This office provided the individual information about how incarcerated individuals can contribute to policy	Assistance Provided

	(HSRs) for wigs as part of gender affirming care.	changes and recommendations.	
103.	Incarcerated individual shared concerns regarding DOC not repairing their wheelchair and infracting the individual after the individual found means to repair it themselves.	DOC staff resolved this concern prior to the OCO taking action on this complaint. Our office was able to confirm that DOC staff dismissed the infraction after the hearing and also fixed their wheelchair.	DOC Resolved
104.	External person reports their loved one has not been given a medication that was recommended by a specialist.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff contacted DOC Health Services staff and were informed that the medication had to be approved through the Nonformulary Review process to be ordered for the patient. OCO staff also verified the person had a follow-up appointment scheduled with the specialist in the future.	DOC Resolved
105.	Incarcerated individual shared concerns regarding DOC wrongfully denying their mail.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The incarcerated individual called the OCO during hotline hours and informed this office that DOC had resolved the issue.	DOC Resolved
106.	Incarcerated individual shared concerns regarding DOC not allowing them to start a religious program.	The OCO provided information about next steps the individual can take to submit a proposal. DOC denied the program proposal due to the proposal containing discriminatory language. The OCO reviewed the program proposal and determined that the program proposal did include discriminatory language. Per DOC policy 100.500 “DOC prohibits discrimination... [against] individuals under the Department's jurisdiction on the basis of genetic information, religion/creed, age, gender, gender expression, etc.” The individual will want to refine the proposal language and they can re-submit it after those edits.	Information Provided
107.	Incarcerated individual reports concerns about banking and not receiving their IRS stimulus impact check.	The OCO provided information regarding how to properly recoup their money from the IRS and what forms to utilize for that process.	Information Provided
108.	Incarcerated individual shared concerns regarding their children not being able to visit in person.	The OCO spoke with DOC staff regarding this issue and were provided with resources that this individual could utilize. This office provided this information to the individual which included hiring professionals that could escort the children in or finding other approved adults they may know.	Information Provided
109.	Incarcerated individual shared concerns regarding DOC holding them past their early release date (ERD) due to there being no options to release despite having release options.	The OCO provided information regarding why they have been held past their ERD. This office also shared information regarding other options to release to and how individuals can only release to their home county or neighboring county.	Information Provided
110.	Incarcerated person reports concerns regarding force DOC used on them during an altercation.	The OCO reviewed the documentation and evidence related to the force used and found the DOC staff's action to be in compliance with DOC's restricted policy governing uses of force. The OCO verified that the individual was not infracted for the incident and was returned to general population after being placed into segregation. The person was not held in segregation longer than the DOC policy outlines. The OCO	Information Provided

		provided this information to the person and shared information about how to navigate issues with their assigned cellmate.	
111.	Person reports that he has not been seen by a specialist for his chronic injury. The person requested treatment by a specialist outside of the DOC. The patient also requested a medical mattress and a larger cell.	The OCO provided information to the patient regarding his request for a medical mattress and larger cell. OCO staff reviewed the patient's consultation and noted he is already scheduled to see the specialist. OCO contacted DOC Health Services staff and were informed of the diagnostics that had been performed leading up to the specialist appointment.	Information Provided
112.	Patient report that he was ordered regular diagnostic testing that has not been carried out. The person requests that his treatment plan be discussed with him.	The OCO provided information to the patient regarding the steps to get updates on his care plan. OCO staff contacted DOC Health Services staff and were informed the diagnostics were still taking place and that the patient's care is being handled by the Facility Medical Director. The OCO encourages patients to contact their facility's Patient Care Navigator or Care Management Nurse for questions about their chronic care treatment plans.	Information Provided
113.	Person requested to be added to the callout for OCO's LGBTQ+ meeting at Stafford Creek Corrections Center (SCCC).	The OCO did not receive notification in time to add the individual to the callout and provided information about the next meeting that is being scheduled.	Information Provided
114.	Incarcerated individual relayed concerns regarding a neutral behavior observation entry (BOE) being used with negative language.	The OCO reviewed the BOE materials for the neutral BOE and found the BOE does have negative language which violates DOC policy 300.010(I)(D)(3) which states neutral BOEs should be for behavior that is not necessarily positive or negative. The OCO spoke to DOC facility leadership about this concern and requested DOC staff be reminded of this and confirmed with DOC that a memo was sent out to all staff reminding them of the behavioral observation report process including notifying incarcerated individuals of all BOEs regardless of whether they are positive, negative or neutral.	Information Provided
115.	Incarcerated individual shared concerns regarding DOC staff infracting them and lying about an incident.	The OCO was unable to substantiate the concern due to insufficient evidence. This office was not able to confirm that this individual was infracted related to any recent issue.	Insufficient Evidence to Substantiate
116.	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
Washington Corrections Center			
117.	Person reports concerns about their placement and wants to be considered for Residential Treatment Unit (RTU) for more access to mental health care.	The OCO elevated the concerns through health services leadership and discussed RTU consideration with clinical mental health leadership. The patient was placed in a therapeutic community and approved for a 6-month single cell to assist with the patient's symptoms related to overstimulation from general population setting. The OCO provided the patient with self-advocacy information and pathway for reconsideration. At this time, the patient was not approved for RTU level care.	Assistance Provided
118.	Multiple individuals shared	The OCO brought this concern to the facility leadership for	Assistance

	concerns in-person with the OCO regarding mistreatment by a staff member. This mistreatment entailed the staff member failing to provide adequate help, belittling individuals, not speaking at all to certain people, and most notably consistently being standoffish with individuals in the unit.	review. The facility leadership acknowledged that this was not new information and reported that they will work to resolve the situation.	Provided
119.	Patient reports concerns that DOC said they will no longer pay for his prescription.	The OCO elevated this concern through health services leadership and found the prescription had not been discontinued and is available. Providers met with the patient to confirm prescription details. The patient called and said the issue was resolved with the provider and thanked OCO for our assistance.	Assistance Provided
120.	Person reports that he could not move forward with his treatment while housed in receiving. The person states his resolution request was not handled as a medical request and that he had not had a medical appointment since arriving. The person requested to be transferred to receive medical care.	The OCO provided assistance by contacting DOC resolutions staff and requesting the resolution be reopened. DOC agreed to overturn the resolution decision. The patient was transferred through the regular classification process. OCO staff reviewed the patient appointments and noted that several appointments had been scheduled since the person arrived at their new facility.	Assistance Provided
121.	Person reported pain from an old wound and is seeking care and pain management.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and reached out to DOC staff, who confirmed that this individual has received care and pain management and was counseled on options for care going forward.	DOC Resolved
122.	An incarcerated individual reports that he has been experiencing issues with accessing medical and dental services.	The OCO contacted health services about this individual's concerns and staff verified this person is on the dental waiting list. DOC also confirmed multiple appointments this individual has had with mental health and reported medical kites to the nurse have been addressed.	DOC Resolved
123.	Incarcerated individual shared concerns regarding DOC staff not treating them for dental concerns despite filing numerous emergency resolution request (RR) regarding their issue.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO confirmed the individual was scheduled for an appointment and was seen by the dental provider.	DOC Resolved
124.	Person reported concern about not getting access to Medication Assisted Therapy (MAT) prior to release and reports this is the only facility that does not prescribe that medication prior to release.	The OCO provided information about the limitations to MAT access at his current facility. The OCO reviewed DOC records and found that this individual has met with his provider and was counseled about community treatment options.	Information Provided

125.	Incarcerated individual shared concerns regarding DOC's unwillingness to send a sample to the lab before making a presumptive guilty decision.	This person was released prior to the OCO taking action on the complaint. This office was able to confirm that there was no infraction on this individual's central file regarding this issue.	Information Provided
126.	Incarcerated individual shared concerns regarding not being provided pain medication.	The OCO provided information regarding how to utilize the internal administrative process provided by DOC. This office also provided pertinent information regarding the resolution program and further information regarding how to obtain medical care.	Information Provided
127.	Person reports receiving delayed care for an injury and is concerned that multiple consults are preventing him from getting surgery.	The OCO provided information to the person regarding the process to get approved for surgery. OCO staff reviewed the patient's records and found that the current consultations are in place to get the person fully evaluated and approved for surgery.	Information Provided
128.	Incarcerated individual shared concerns regarding DOC failing to provide adequate pain management.	The OCO spoke with DOC staff regarding this issue and DOC reported that this individual is receiving adequate care. Our office also discovered that the individual was denied a specific medication per the Care Review Committee (CRC); which is a committee of outside providers that has the authority to approve out of policy treatments or medications. The OCO provided information about how to appeal the CRC decision.	Information Provided
129.	Incarcerated individual relayed concerns regarding not getting access to the medication assisted treatment (MAT) program.	The OCO reviewed all medical records related to the individual's participation in the MAT program and confirmed that the individual was given a prescription and had access.	Information Provided
130.	Patient reports concerns about prescription being given at night versus morning.	The OCO elevated this concern to health services leadership for review of medication timing. The prescription is "Keep On Person" (KOP) and is still prescribed. The OCO provided this information to the patient along with pathways to follow up if needed.	Information Provided
131.	Incarcerated individual shared concerns regarding not hearing anything about their graduated reentry (GRE) request.	The OCO found that this individual was provided with a response regarding their GRE denial. This office provided information regarding the GRE program and reasons for denial.	Information Provided
132.	Incarcerated individual relayed concerns regarding a behavior observation entry (BOE) they believe is retaliation from DOC staff.	The OCO reviewed the related PREA and grievances the individual filed regarding the staff conduct concern. Because the BOE was written before the PREA was reported, there is insufficient evidence of retaliation. Additionally, because the grievances were closed at level 0 as not accepted and the PREA was unfounded, there is insufficient evidence of retaliation.	Insufficient Evidence to Substantiate
133.	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
Washington Corrections Center for Women			
134.	Patient reports concerns about delayed scheduling of gender affirming surgery and a missed consult appointment.	The OCO provided assistance by elevating the concerns through health services leadership. The OCO confirmed the telehealth appointment was rescheduled and was added to the office's appointment tracker to confirm it occurred. The	Assistance Provided

		OCO continued to communicate with the facility health services and scheduling staff about the timeline of surgery appointment, considering the individual's approaching release date. The OCO confirmed the gender affirming surgery was scheduled and occurred.	
135.	While conducting open hours at the facility, an incarcerated individual expressed concerns about a previous OCO case.	The OCO confirmed that there was a previous OCO case for the individual and sent the individual a closed case review form (CCR) for the individual to explain why they disagree with the closing of the case and/or provide more information.	Assistance Provided
136.	Incarcerated individual shared concerns regarding DOC failing to provide them with glasses and refusing to test their vision.	The OCO was unable to confirm that the individual filed a resolution request regarding this issue. This office provided information regarding how to utilize the internal administrative processes provided by DOC.	Information Provided
137.	Incarcerated individual shared concerns regarding DOC gender discrimination.	The OCO was unable to confirm that the individual filed a resolution request regarding this issue. This office provided information regarding how to utilize the internal administrative processes provided by DOC.	Information Provided
138.	Incarcerated individual shared concerns regarding DOC failing to provide adequate dental care.	The OCO was unable to confirm that the individual filed a resolution request regarding this issue. This office provided information regarding how to utilize the internal administrative processes provided by DOC.	Information Provided
139.	Person reports being moved to a different unit and recognizing she had a need for a Health Status Report. The person states she was denied a Health Status Report and has not been seen by her provider since requesting one.	The OCO provided self-advocacy information to the patient including how to request a chronic care follow-up appointment and the criteria required for the Health Status Report to be allowed.	Information Provided
140.	Incarcerated individual shared concerns regarding DOC refusing to provide them with accommodating medical care despite having provided it in past.	This office provided information regarding current treatment options available to them and their request being sent to the Care Review Committee (CRC) and next steps. This office shared they can appeal the CRC denial, if their request is denied.	Information Provided
141.	Incarcerated individual relayed concerns regarding placement in the close observation area (COA).	The OCO discussed this concern with DOC staff and reviewed the placement in COA. After DOC implemented a pathway for the individual to release from COA, the OCO confirmed that the individual did successfully release from the COA.	Information Provided
142.	An incarcerated person reports that she has been on the wait list for cavity filings and a nightguard for over a year. She says two of her top teeth have chipped away and DOC is denying her access to the patient-paid healthcare plan.	The OCO confirmed with health services that the individual had two appointments for dental work last month and has more appointments scheduled. The OCO provided information about how to access patient-paid healthcare with DOC form 13-460 (Patient Request for Outside Health Services) and submitting it to the facility's business office.	Information Provided
Washington State Penitentiary			
143.	External person reported concerns about their	After OCO outreach, DOC completed the new custody facility plan (CFP) and transgender housing protocol, and the person	Assistance Provided

	transgender loved one being placed in solitary for safety.	was transferred.	
144.	Incarcerated person reports he would like to be interviewed for the Solitary Confinement Project.	The OCO conducted an interview with this individual regarding their experience living in solitary confinement. This information was used in the OCO Solitary Confinement Report Part 2, released September 2024.	Assistance Provided
145.	Incarcerated person reports he would like to be interviewed for the Solitary Confinement Project.	The OCO attempted to interview this individual, however they had moved to a different facility after the OCO scheduled the interview. The OCO sent the individual the interview questions to fill out and send back to the office. The OCO did not receive a response.	Assistance Provided
146.	Incarcerated person reports he would like to be interviewed for the Solitary Confinement Project.	The OCO conducted an interview with this individual regarding their experience living in solitary confinement. This information was used in the OCO Solitary Confinement Report Part 2, released September 2024.	Assistance Provided
147.	Incarcerated person reports he would like to be interviewed for the Solitary Confinement Project.	The OCO conducted an interview with this individual regarding their experience living in solitary confinement. This information was used in the OCO Solitary Confinement Report Part 2, released September 2024.	Assistance Provided
148.	Person reports they are on food strike and requested facility transfer.	The OCO provided assistance by elevating the concerns to health services leadership and confirming follow up with the patient. Person called the OCO to say he is no longer on hunger strike and the OCO can close the case.	Assistance Provided
149.	Incarcerated person reports he would like to be interviewed for the Solitary Confinement Project.	The OCO attempted to interview this individual, however they had moved to a different facility after the OCO scheduled the interview. The OCO sent the individual the interview questions to fill out and send back to the office. The OCO did not receive a response.	Assistance Provided
150.	Incarcerated individual shared concerns regarding DOC taking their earned time credits and miscalculating their release date.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO found that the person filed a resolution request (RR) and DOC staff corrected their requested earned time credits after classification counselor did an audit.	DOC Resolved
151.	Incarcerated individual shared concerns regarding DOC failing to provide adequate medical care.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO found that DOC scheduled the individual for treatment and the OCO ensured that the individual was seen by medical staff.	DOC Resolved
152.	A loved one reports that her brother's eye was injured and the DOC has not prioritized his healthcare requests.	The OCO reviewed the individual's resolution requests about his medical appointments and contacted health services regarding his medical kites. This office followed up with health services about this concern, and DOC staff confirmed they were able to get him an ophthalmology appointment. The OCO will continue to monitor the progress of this individual's eye appointments and encouraged him to contact this office if he does not receive his medical appointment.	Information Provided
153.	Incarcerated individual shared concerns regarding DOC property withholding their playing cards despite DOC allowing them to have them in the past.	The OCO spoke with DOC staff regarding this issue. This office was informed that there was a miscommunication between DOC and the mailroom regarding these playing cards being allowed in. DOC deemed these cards to have monetary value and thus they are withheld for security purposes. This office provided this information to the incarcerated individual.	Information Provided

154.	Individual reports they were moved to Restrictive Housing on Administrative Segregation for Security Threat Group activity and placed on a program and the out-of-state transfer list. They can only reach level 2 on this program, and they should be able to program to level 3. They want to know if there is any way to determine whether classification packets are being sent to other states and if they can request specific states. They are also on a security enhancement plan that restricts them from their tablet, and the security enhancement plan keeps getting extended—it is now past 75 days.	The DOC maintains that due to evidence of involvement in a Security Threat Group, the individual is no longer suitable for the general population in the Washington state prison system. The DOC is operating within DOC 330.600 Prisons Compact. The policy does not allow individuals to request a state. Their tablet has been returned at this time, and the SEP has been removed.	Information Provided
155.	Person reports they are not being afforded the opportunity to work certain jobs based on their medical conditions. The person stated they were given vague information when they asked why they were not considered for other jobs.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff reviewed the person's record and provided information to the person regarding their job screening.	Insufficient Evidence to Substantiate
156.	Person reports concerns regarding the scheduling of an offsite procedure. The person stated that DOC staff told him the DOC was probably delaying scheduling because he had a release date approaching.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff reviewed the patient's consult and found that he was already scheduled for the requested procedure. DOC schedulers are given next available dates by the community clinic and are not able to request an earlier appointment without there being a significant change to a patient's condition. The OCO encourages patients to kite the facility's Patient Care Navigator or health services managers for questions about scheduling with outside clinics.	Insufficient Evidence to Substantiate
157.	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
158.	Incarcerated individual relayed concerns regarding a DOSA revoke.	The OCO reviewed the field discipline documents and found no violation of DOC policy as there is evidence to show the individual committed the violation.	No Violation of Policy
159.	External person reported concerns about an incarcerated person's placement in segregation. The incarcerated person contacted the OCO and asked for a review their placement in segregation.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the person's Custody Facility Plan (CFP) and verified that it is current and complies with DOC 300.380 Classification and Custody Facility Plan Review. The OCO verified the DOC is looking at options with the person to be housed outside of segregation.	No Violation of Policy

160.	Incarcerated individual relayed concerns regarding a recent 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
161.	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
162.	Incarcerated individual relayed concerns regarding a DOSA revoke.	The OCO reviewed the field discipline materials and found no violation of DOC policy as there is evidence the individual committed the violations.	No Violation of Policy
163.	Incarcerated person reported concern about their maximum custody level and DOC housing them in segregation.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the persons Custody Facility Plan and DOCs reasons for continuing to house them in segregation. These DOC decisions comply with DOC 300.380 Classification and Custody Facility Plan Review. DOC is looking for other options to house this person in a lower custody and the person is working with the Washington Way resource team.	No Violation of Policy
Intake Investigations			
Airway Heights Corrections Center			
164.	Loved one expressed concerns about an incarcerated individual being placed under investigation for a fight.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
165.	Loved one relayed concerns about an infraction.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
166.	External person reported concerns about an incarcerated person being housed in segregation and having safety concerns in general population.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance. The OCO reviewed the persons file and found they are no longer in segregation and have not reported safety concerns in their recent unit placement.	Person Declined OCO Assistance
167.	Loved one relayed concerns about an incarcerated individual being punished for disclosing their drug usage.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
168.	External person reports concerns about an incarcerated person accessing their clothing for their upcoming release.	This person was released prior to the OCO taking action on the complaint. The OCO reviewed the individuals file and it appears the release clothing was obtained prior to the persons release.	Person Released from DOC Prior to OCO Action
169.	An incarcerated individual reports that he tried to request transcripts from his teacher. The teacher was rude, accused	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action

	him of having an attitude, and gave him an infraction for an incident that did not happen.		
170.	Incarcerated individual shared concerns regarding being infracted for having a disability.	This person was released prior to the OCO taking action on the complaint. The OCO reviewed and found there were no infractions related to this incident.	Person Released from DOC Prior to OCO Action
171.	Incarcerated individual shared concerns regarding DOC staff mistreating them.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about utilizing the resolution program.	Technical Assistance Provided
Clallam Bay Corrections Center			
172.	Loved one expressed concerns about an infraction.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
173.	Loved one relayed concerns about a group violence reduction strategy (GVRS) incident.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
174.	Incarcerated individual shared concerns regarding wanting DOC to continue giving them a certain medication.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about utilizing the internal administrative processes provided by DOC.	Technical Assistance Provided
Coyote Ridge Corrections Center			
175.	Loved one expressed concerns regarding an infraction.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
176.	Loved one expressed concerns about an infraction.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
177.	Loved one relayed concerns about an incarcerated individual needing assistance with release planning.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
178.	Loved one expressed concerns regarding a use of force.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO	Person Declined OCO Assistance

		informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	
179.	Loved one expressed concerns about an infraction.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
180.	Loved one relayed concerns about a staff misconduct incident.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
181.	Loved one expressed concerns about staff misconduct.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
182.	Loved one relayed concerns about a staff misconduct incident.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
183.	Incarcerated individual reports concerns about staff conduct.	This person died prior to the OCO taking action on the complaint. The incidents surrounding the person's death were reviewed as part of the Unexpected Fatality Review (UFR) process.	Person Released from DOC Prior to OCO Action
184.	An individual made a concern on behalf of another incarcerated individual regarding lack of communication about medical test results.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to file a resolution request.	Technical Assistance Provided
Monroe Correctional Complex			
185.	Loved one expressed concerns regarding an infraction.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
186.	Loved one expressed concerns regarding a transfer.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
187.	Loved one relayed concerns about a facility move.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to	Person Declined OCO Assistance

		having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	
188.	External person reported concerns about an individual being held in solitary confinement.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance. The OCO reviewed the segregation placement and found it to comply with DOC policy. The individual has since been released from segregation.	Person Declined OCO Assistance
189.	Loved one relayed concerns about a bed assignment.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
190.	Incarcerated individual shared concerns regarding DOC failing to provide them with mental health care.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about utilizing the resolution program provided by DOC.	Technical Assistance Provided
Olympic Corrections Center			
191.	Incarcerated individual reported concerns about facility infrastructure.	The OCO provided self-advocacy information about how to file a resolution request to address this issue prior to OCO involvement. The OCO has also spoken to the superintendent of the facility about this concern.	Technical Assistance Provided
Other			
192.	Incarcerated individual relayed concerns regarding being given additional probation time.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
193.	Individual relayed concerns regarding a community corrections officer's conduct.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
194.	A complaint was filed regarding staff behavior in the Florida Department of Corrections.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
195.	Individual relayed concerns regarding a community corrections officer's conduct.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
196.	Incarcerated individual relayed concerns regarding occurrences in a county jail.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
197.	Individual expressed concerns about healthcare at a jail facility.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
Reentry Center - Helen B. Ratcliff - King			
198.	Loved one relayed concerns	The OCO sent the individual an ombuds review request form	Person Declined

	about an individual needing assistance with securing a job.	to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	OCO Assistance
Stafford Creek Corrections Center			
199.	Loved one expressed concerns regarding a mail rejection.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
Washington Corrections Center			
200.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found the individual pled guilty to the violations, so there was insufficient evidence to continue the investigation process.	Declined
201.	Incarcerated individual relayed concerns regarding a desire to have an investigation conducted into the bribery of a community custody officer.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
202.	Loved one relayed concerns about an incarcerated individual's broken hand.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
203.	Loved one expressed concerns regarding an incarcerated individual's cell not having power.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
204.	Loved one expressed concerns regarding an infraction.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
205.	Loved one expressed concerns regarding an infraction.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance

206.	Loved one relayed concerns about an incarcerated individual's missing property.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
207.	Loved one expressed concerns regarding an incarcerated individual feeling threatened.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
208.	Incarcerated individual shared concerns regarding not being seen by DOC medical.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to file resolution request for medical issues.	Technical Assistance Provided
Washington Corrections Center for Women			
209.	External person reports their loved one was facing an issue accessing medication.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint.	Person Declined OCO Assistance
210.	Loved one expressed concerns regarding a mail rejection.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
211.	Incarcerated individual shared concerns regarding DOC discriminating against them because of their gender.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about utilizing the resolution program.	Technical Assistance Provided
Washington State Penitentiary			
212.	External person reports concerns regarding their loved one's access to medical care. The person also reported concerns regarding staff conduct.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance
213.	Loved one relayed concerns about a lack of air conditioning in the unit.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
214.	Loved one expressed concerns regarding an incarcerated individual's wedding ring being taken away and DOC not	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further	Person Declined OCO Assistance

	having record of their marriage.	investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	
215.	Loved one relayed concerns about a facility move.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
216.	Loved one expressed concerns regarding an infraction.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
217.	Incarcerated individual shared concerns regarding DOC not allowing them to keep legal property.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
218.	Incarcerated individual shared concerns regarding an infraction they did not deserve and being given limited time outside of their cell as a sanction.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
219.	An incarcerated individual reports that he had ordered a curio package but could not receive it because he was living in the IMU.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process. The OCO provided technical assistance regarding how to file a tort claim and utilize the appeals process for lost property.	Technical Assistance Provided

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-004

Report to the Legislature

As required by RCW 72.09.770

September 3, 2024

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

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Unexpected Fatality Review Committee Report

UFR-24-004 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 July 11, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Patricia Paterson, Chief of Nursing
- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Ryan Quirk, Director – Mental Health
- Mark Eliason, Deputy Assistant Secretary
- Dr. Rae Simpson, Director – Quality Systems
- 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
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Program Manager
- Rochelle Stephens, Men's Prisons Project Manager

DOC Risk Mitigation

- Michael Pettersen, Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Madison Vinson, Assistant Corrections Ombuds - Policy

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Sophie Miller, Medical Officer

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

Fatality Summary

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

Date of Incarceration: January 2021

Date of Death: February 2024

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

His cause of death was due to dilated cardiomyopathy. The manner of his death was natural.

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

Day of Death	Event
1113 hours	• Custody staff found the incarcerated individual unresponsive in his cell and began lifesaving measures.
1114 hours	• Facility medical staff arrived and assumed care.
1126 hours	• Community Emergency Medical Services (EMS) arrived and assumed care.
1147 hours	• EMS pronounced death.

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 committee found:

      a. The incarcerated individual received episodic problem focused medical and ongoing behavioral health care. The committee identified an opportunity for an annual wellness exam.

      b. During his intake physical exam, he reported a history of an irregular heartbeat as a child. Clinical evaluation was completed at his parent facility, and he was advised to declare a medical emergency if he experienced additional symptoms.

c. He was prescribed medication to assist in managing his mental health symptoms and increasing daily dosages. He did not receive follow-up testing to monitor medication effects. An electronic health record would have provided automatic notifications for follow-up testing. The committee identified opportunities for multidisciplinary care planning that would augment current prescribing practices, including monitoring and management of prescribed medications.

2. The committee recommended:

   a. A referral to the Unexpected Fatality Review Committee.

   b. DOC clinical leadership provide education for safe prescribing and medication monitoring guidelines.

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. Some tier checks were not in compliance with DOC Policy 420.370 Security Inspections.

      b. Facility automated external defibrillators (AED) were being replaced and standardized and staff were not trained on all available models.

      c. Custody and medical staff could improve communication and collaboration when medical emergencies arise.

   2. A Root Cause Analysis (RCA) was conducted for the findings of the CIR and determined the CIR findings did not directly correlate to the cause of death and will be remediated per DOC Policy 400.110 Critical Incident Reviews.

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

   1. Clinical care and impacts of facility transfers:

   The committee members concurred with the mortality review findings and recommendations for improvement in clinical care and collaboration.

   The committee discussed facility transfers and the potential impact the moves may have had on building trusting care relationships. DOC offered information on the transfer and housing process and the Department's commitment to housing individuals in the least restrictive, most supportive, and appropriate environment. DOC Health Services has weekly medical and mental health transfer calls and care navigators that help coordinate and follow complex incarcerated

individuals to assist with their transitions. In addition, the DOC classification process is used to assign incarcerated individuals to the least restrictive custody designation that addresses programming and other needs while providing for the safety of personnel, the community, and incarcerated individuals.

2. Emergency response:

   The UFR committee discussed DOC's medical emergency response process including readiness drills. DOC staff are basic life support (BLS) responders and provide care until community emergency response services arrive. Members offered practices from the community for consideration by DOC including visual identification for medical team lead.

   DOC provided information on the updates to the Automated External Defibrillators (AEDs). The committee agreed that AEDs are designed to be used correctly by lay people and that standardization or model specific training is not required.

   DOC has also established a collaborative workgroup between the Prisons and Health Services divisions to review and make recommendations to improve current emergency medical response processes to ensure that Department staff are equipped with information, skills and equipment needed to effectively respond to medical emergencies.

3. Tier checks:

   The committee discussed the intent and timing of tier checks. Custody tier checks were not consistently completed or documented as required per policy. The committee members recommended changing the name of tier checks to clarify purpose and function.

   DOC has also established a collaborative workgroup between the Prisons and Health Services divisions to review and make recommendations to improve current emergency medical response processes to ensure that Department staff are equipped with information, skills and equipment needed to effectively respond to medical emergencies.

Committee Findings

The incarcerated individual died as a result of dilated cardiomyopathy. The manner of his death was natural.

Committee Recommendations

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

Table 1. *UFR Committee Recommendations*
1. Until an electronic health record system is implemented, DOC should provide education and care management guidelines that augment current prescribing practices and facilitate medication monitoring.

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

1. DOC should develop a written guidelines for the tier check process that will clarify the purpose and function.
2. DOC Health Services should work toward proactively offering an annual wellness exam visit for each incarcerated individual housed in a prison facility.
3. DOC should continue to pursue an electronic health record when full legislative funding becomes available to support care delivery.

Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality

UFR-24-001

Report to the Legislature

As required by RCW 72.09.770

August 12, 2024

DOC Corrective Action, Publication Number 600-PL001

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

Unexpected Fatality Review
DOC Corrective Action Plan

DOC Corrective Action Publication Number 600-PL001

Legislative Directive

Engrossed Substitute Senate Bill 5119 (2021)

Unexpected Fatality Review Governance

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

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

"'Unexpected fatality review' means a review of any death that was not the result of a diagnosed or documented terminal illness or other debilitating or deteriorating illness or condition where the death was anticipated and includes the death of any person under the jurisdiction of the department, regardless of where the death actually occurred. A review must include an analysis of the root cause or causes of the unexpected fatality, and an associated corrective action plan for the department to address identified root causes and recommendations made by the unexpected fatality review team under this section."

Unexpected Fatality Review Committee Report

The department issued the UFR committee report #24-001 on August 2, 2024 (DOC publication 600-SR001). This document includes the required corrective action plan. The department is required to implement the corrective actions within 120 days from the corrective action plan publication.

Corrective Action Plan

CAP ID Number:	UFR-24-001-1
Finding:	The health record did not contain documentation of appropriate diagnostic curiosity or treatment planning for the abnormal physical exam findings.
Root Cause:	The evaluating nurse did not recognize clinical signs of a serious illness and treatment plan did not address abnormal physical exam findings.
Recommendations:	DOC should conduct physical assessment training for nurses and practitioners to include simulations.
Corrective Action:	DOC Health Services will conduct physical assessment training for nurses and practitioners augmented with hands-on simulations.
Expected Outcome:	Improved clinical skills for practitioners and improved care for incarcerated individuals.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-003

Report to the Legislature

As required by RCW 72.09.770

August 15, 2024

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

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Unexpected Fatality Review Committee Report

UFR-24-003 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 July 25, 2024:

DOC Health Services

- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Ryan Quirk, Director – Mental Health
- Dr. Rae Simpson, Director – Quality Systems
- Mark Eliason, Deputy Assistant Secretary
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- Lorne Spooner, Director for Correctional Services
- Page Perkinson, Correctional Operations Program Manager

DOC Community Corrections Division

- Kristine Skipworth, Administrator – East Region
- Kelly Miller, Administrator – Graduated Reentry

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

Health Care Authority (HCA)

- Dr. Heather Schultz, Associate Medical Director

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

Fatality Summary

Year of Birth: 1964 (59-years-old)

Date of Incarceration: November 2021

Date of Death: January 2024

At the time of his death, this incarcerated individual had been held for approximately thirteen (13) months in a county jail awaiting trial on new felony charges. Prior to his final arrest, he was a participant of the DOC Graduated Reentry program and was on unauthorized leave. The county jail is required to complete an independent fatality review of events for the time this incarcerated individual was housed in their facility. The DOC UFR Committee reviewed his DOC records for this report.

His cause of death was acute fentanyl intoxication. The manner of his death was accident.

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

Prior to Death	Event
20 months – 13 months prior	• He transferred from a DOC prison facility directly to inpatient substance use treatment as a participant of the Graduated Reentry (GRE) program. • After successfully completing treatment, he resided in his private residence on electronic home monitoring for one (1) week prior to taking unauthorized leave. • He did not respond to attempts to contact him and DOC staff were unable to locate him. • A DOC Secretary's warrant was issued. • He was arrested by the county sheriff's department and was housed at the county jail while awaiting trial for new charges.
Day of Death	**Event**
Day 0	• He was found deceased in his cell at community jail.

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 Mortality Review committee found no care gaps while he was incarcerated in a DOC facility.

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

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. The CIR found DOC staff followed policy and operated within DOC guidelines.

C. The committee reviewed the unexpected fatality, discussed the DOC process for screening incarcerated individuals for substance use disorder, the benefit of record sharing with community care providers, and the importance of providing Narcan kits and overdose prevention training to DOC staff and incarcerated individuals reentering the community. Additionally, the committee was not provided jail records for review but confirmed that the county jail is required by law to complete an Unexpected Fatality Review for individuals housed in one of their facilities.

Committee Findings

The incarcerated individual died as a result of acute fentanyl intoxication. The manner of his death was accidental.

Committee Recommendations

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

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

1. DOC should continue to pursue funding for an electronic health record (EHR) to replace paper files and allow interface with community care providers.

Unexpected Fatality Review DOC Corrective Action Plan

Unexpected Fatality UFR-24-008

Report to the Legislature

As required by RCW 72.09.770

September 1, 2024

DOC Corrective Action, Publication Number 600-PL001

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

Unexpected Fatality Review
DOC Corrective Action Plan

DOC Corrective Action Publication Number 600-PL001

Legislative Directive

Engrossed Substitute Senate Bill 5119 (2021)

Unexpected Fatality Review Governance

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

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

"Unexpected fatality review" means a review of any death that was not the result of a diagnosed or documented terminal illness or other debilitating or deteriorating illness or condition where the death was anticipated and includes the death of any person under the jurisdiction of the department, regardless of where the death actually occurred. A review must include an analysis of the root cause or causes of the unexpected fatality, and an associated corrective action plan for the department to address identified root causes and recommendations made by the unexpected fatality review team under this section."

Unexpected Fatality Review Committee Report

The department issued the UFR committee report 24-008 on August 22, 2024. (DOC publication 600-SR001). This document includes the required corrective action plan. The department is required to implement the corrective actions within 120 days from the corrective action plan publication.

Corrective Action Plan

CAP ID Number:	UFR-24-008-1
Finding:	A licensed practical nurse (LPN) performed a restrictive housing assessment that was not reviewed by the delegating registered nurse (RN) and did not contain vital signs.
Root Cause:	It has become accepted not to perform vital signs during restrictive housing assessment and for RNs not to review and co-sign when assessment is performed by an LPN.
Recommendations:	DOC should provide direction regarding restrictive housing assessments.
Corrective Action:	DOC clinical leadership will provide clear direction regarding restrictive housing assessments requiring vital signs, a plan of care and oversight by an RN.
Expected Outcome:	Improved care for incarcerated individuals in restrictive housing.

CAP ID Number:	UFR-24-008-2
Finding:	The incarcerated individual declined several doses of his medication for opioid use disorder (MOUD) medication.
Root Cause:	There is no requirement to assess an incarcerated individual who is declining medication while in restrictive housing.
Recommendations:	DOC should update nursing protocol to direct a scheduled nurse visit when there is a missed dose of MOUD medication.
Corrective Action:	DOC clinical leadership will update protocol to direct a scheduled nurse visit when an incarcerated individual misses a dose of critical medication.
Expected Outcome:	Improved care for incarcerated individuals.

CAP ID Number:	UFR-24-008-3a
Finding:	Clinical staff to include nurses and physician assistant misinterpreted the early signs of sepsis as withdrawal, falling prey to selection bias and failing to recognize use of unsterile needles as a risk factor and widen the differential diagnosis to include bacterial endocarditis.
Root Cause:	Clinical staff did not utilize appropriate diagnostic curiosity or recognize the increased infection risk for an incarcerated individual using home-made syringes.
Recommendations:	DOC health services should propagate a culture of heightened diagnostic curiosity and effective clinical decision making when faced with patients whose vital signs, labs, or symptoms are not completely explained by the working diagnostic hypothesis; further, a culture of shared responsibility where teams

	actively discuss patients is highly recommended.
Corrective Action:	DOC Health Services will provide education to support clinical decision-making for incarcerated individuals with symptoms of sepsis.
Expected Outcome:	Improved care for incarcerated individuals.

CAP ID Number:	UFR-24-008-3b
Finding:	Clinical staff to include nurses and physician assistant misinterpreted the early signs of sepsis as withdrawal, falling prey to selection bias and failing to recognize use of unsterile needles as a risk factor and widen the differential diagnosis to include bacterial endocarditis.
Root Cause:	Clinical staff did not utilize appropriate diagnostic curiosity or recognize the increased infection risk for an incarcerated individual using home-made syringes.
Recommendations:	DOC health services should propagate a culture of heightened diagnostic curiosity and effective clinical decision making when faced with patients whose vital signs, labs, or symptoms are not completely explained by the working diagnostic hypothesis; further, a culture of shared responsibility where teams actively discuss patients is highly recommended.
Corrective Action:	DOC will conduct an internal review of sepsis cases to identify opportunities for improvement.
Expected Outcome:	Improved care for incarcerated individuals.

CAP ID Number:	UFR-24-008-4
Finding:	Incarcerated individual tested positive twice on clinical toxicology screens for non-prescribed substances and there was no clinical follow-up with incarcerated individual.
Root Cause:	The MOUD protocol does not provide clear direction for clinical response to positive toxicology results.
Recommendations:	DOC should update the MOUD protocol to include recommended clinical responses when there is a positive toxicology result, provide education to staff on the changes to protocol and offer ideas for engaging incarcerated individuals diagnosed with substance use disorder in their care planning.
Corrective Action:	DOC Addiction Medicine team should update the MOUD protocol to include recommended clinical responses when there is a positive toxicology result, provide education to staff on the changes to protocol and offer ideas for engaging incarcerated individuals diagnosed with substance use disorder in their care planning.
Expected Outcome:	Improved care and care planning for incarcerated individuals diagnosed with substance use disorder.

CAP ID Number:	UFR-24-008-5
Finding:	Wellness checks for the incarcerated individual were not consistently documented per policy.
Root Cause:	There is no written process for performing and documenting of a nursing wellness check in the restricted housing unit.
Recommendations:	DOC should provide clear direction on how to perform and document a wellness check for incarcerated individuals in a restricted housing unit.
Corrective Action:	DOC Health Services leadership should provide clear direction on how to perform and document a nursing wellness check for incarcerated individuals in a restricted housing unit.
Expected Outcome:	Consistent nursing wellness checks and documentation.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-009

Report to the Legislature

As required by RCW 72.09.770

August 30, 2024

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
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Unexpected Fatality Review Committee Report

UFR-24-009 Report to the Legislature–600-SR001

Legislative Directive and Governance

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- Dr. Ryan Quirk, Director – Mental Health
- Dr. Rae Simpson, Director – Quality Systems
- Mark Eliason, Deputy Assistant Secretary
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

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- EV Webb, Assistant Corrections Ombuds – Investigations
- Madison Vinson, Assistant Corrections Ombuds - Policy

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

Health Care Authority (HCA)

- Dr. Heather Schultz, Associate Medical Director

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

Fatality Summary

Date of Birth: 1985 (39-years-old)

Date of Incarceration: March 2023

Date of Death: May 2024

At the time of this death, the incarcerated individual was participating in the DOC Graduated Reentry (GRE) program and living in a community transition house.

The death was due to sudden cardiac death with underlying end stage liver disease including cirrhosis. The manner of death was natural.

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

Days Prior to Death	Event
90 days prior	• The incarcerated individual directly transferred from a prison facility to community inpatient substance use treatment as a requirement of GRE participation.
24 days – 18 days prior	• After successfully completing treatment, they transferred to their DOC approved residence. • Had two in person meetings with their DOC case manager and two (2) negative drug screens during this timeframe.
Day of Death	**Event**
Day 0	• Another resident found them deceased in the transitional house in the afternoon. • The house manager did not notify DOC of the death in a timely manner.

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 Mortality Review committee found:

    a. The incarcerated individual did not report any concerning symptoms and stated they had been sober for three (3) years.

    b. Intake laboratory testing showed a mildly elevated bilirubin level. All other results were within normal limits. There was no documented care plan to follow-up on the elevated result.

    c. Committee members concurred there was a low index of suspicion for serious illness based on exam findings and reported symptoms.

2. The Mortality Review committee recommended:

    a. A referral to the Unexpected Fatality Committee for review.

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 GRE staff inconsistently followed DOC policy and procedures regarding documentation and recordkeeping.

    2. The findings were administrative in nature and did not correlate to the cause of death. Findings will be remediated per DOC Policy 400.110 Critical Incidents Reviews.

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

    1. The DOC process for follow-up on abnormal test results; and

    2. Transitional housing staff reporting emergencies to DOC.

Committee Findings

The incarcerated individual died as a result of sudden cardiac death with underlying end stage liver disease including cirrhosis. The manner of their 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:

1. DOC should provide education to staff on the importance documenting a care plan for follow-up of abnormal lab results.