STATE OF WASHINGTON

OFFICE OF CORRECTIONS OMBUDS

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July 12, 2019

Steve Sinclair, Secretary
Department of Corrections (DOC)

Office of Corrections Ombuds (OCO) Investigative Report

Attached is the official report regarding the OCO investigation into the missing property of an incarcerated person at Larch Corrections Center. This report is submitted in conjunction with a related investigation into the loss of property from WSP. We appreciate the opportunity to work collaboratively with DOC to amend current policies and practices to better ensure that all incarcerated persons' rights are protected while they are within state confinement.

OCO has received several complaints pertaining to lost property between facility transfers as well as unit to unit transfers. In this case, an incarcerated person transferred between multiple facilities due to a fight and his full set of dentures were lost. Despite notifying staff and filing a tort claim that even resulted in the recommendation that his dentures be replaced, he released seven months after the fight without dentures. The investigation revealed gaps in documentation, communication, and continuity of care.

Any member of the public who wishes to report a concern to OCO is welcome to contact the office at (360) 664-4749 or at the address above. All concerns are logged into the OCO database and used as part of its overall reporting to policymakers and analysis of issues within DOC.

Sincerely,

Joanna Carns

Joanna Carns
Director

cc: Governor Inslee

OCO INVESTIGATION
PREPARED BY CHRISTY KUNA, ASSISTANT OMBUDS – WESTERN DIVISION

Summary of Complaint/Concern

On March 1, 2019, OCO received a complaint that alleged the following:

- An incarcerated person was involved in a fight in September 2018 at Larch Corrections Center (LCC). He had a full set of dentures due to the removal of 18 teeth in 2017. After the fight, he was first transferred to the LCC segregation unit, then to Washington Corrections Center, and finally to Coyote Ridge Corrections Center (CRCC). His dentures were reportedly in his property locker at the time of the fight, but they were not included in his property pack out nor were they ever located. The person attempted to notify staff that his dentures were missing and was told to file a tort claim, which he did. The tort claim investigation came back in December 2018 with a directive to replace the dentures, which did not happen. The person released in April without dentures, after having been without them for seven months.

OCO Statutory Authority

- Per RCW 43.06C.005, OCO was created to assist in strengthening procedures and practices that lessen the possibility of actions occurring within DOC that may adversely impact the health, safety, welfare, and rehabilitation of incarcerated persons, and that will effectively reduce the exposure of DOC to litigation.

- Per RCW 43.06C.040, OCO has the authority to receive, investigate, and resolve complaints related to incarcerated persons' health, safety, welfare, and rights.

OCO Investigative Actions

- As part of this investigation, OCO reviewed DOC policy in regard to the "Offender Grievance Program," "Personal Property of Offenders" and "Transportation of Offender Property;" related grievances, tort claim and supporting documents; and contacted various DOC staff.

OCO Findings

- OCO confirmed the incarcerated person's segregation placement as well as facility transfers as alleged. OCO also confirmed that at no time were the dentures noted on the person's property inventory, nor was there a designated spot to do so. OCO further identified that no prosthetics of any sort are on the property matrix, despite the high financial cost of loss/replacement.

- OCO reviewed the tort claim investigation conducted by LCC staff in December 2018. The recommendation was as follows:

- "It is recommended that [redacted] receive no moneys. It is also recommended that DOC initiate the process to procure a replacement set of dentures. During the investigation it was found that DOC provided the lost set of dentures to [redacted] at no expense to him on January 12, 2018 at Larch Corrections Center. It couldn't be verified that the dentures were secured in his locker as he claims nor could verified [sic] that the dentures were lost by staff during the pack-out or shipping process. The ability to determine what happened to the dentures was hampered by the dentures never being added to his property matrix. The staff who completed the pack-out didn't know they should be looking for a set of dentures and on the night of September 5, 2018 when [redacted] signed for the pack-out he failed to point out that the dentures were missing. LCC dental staff has contacted the dentist in CRCC so they can start the process of remaking a set of dentures."

- Upon following up with health services staff at CRCC in April 2019, OCO learned that the Health Services Manager was unaware of the issue and although the dental staff were aware, they were reportedly "waiting on the results of the tort claim and to see if there was proof that DOC staff had lost them."

- It was unclear what accountability, tracking, or communication process existed to ensure that the dentures were replaced.

- OCO followed up with the dental staff at DOC Headquarters to see whether the incarcerated person's dentures could still be replaced. DOC staff declined to replace the dentures as the incarcerated person had been released at the beginning of April.

Outcomes

- None. DOC staff declined to replace the dentures. Prior to this report, there was no indication of greater corrective action or analysis.

Recommendations

- DOC should consider adding prosthetics, including dentures, on incarcerated persons' property matrices so that staff are aware of the need to search for and include such prosthetics in property pack outs.

- DOC should conduct a review to determine what gaps in communication resulted in the lack of replacement dentures issued to the incarcerated person after the tort claim investigation recommended replacement, including who ultimately was accountable to perform such action.

- DOC should ensure better continuity of care post-release. Although DOC staff confirmed that the person had access to Medicaid post release, navigating community reentry was surely made more difficult in having to also obtain dentures that should have been replaced while he was still incarcerated.

- DOC should ensure a continuous improvement process exists so that when issues are identified, such as through a tort claim investigation, DOC line staff can submit them for evaluation and action.