OFFICE OF THE
CORRECTIONS
OMBUDS

Monthly Outcome Report
October 2023

Unexpected Fatality Reviews: 5

Case Investigations: 208

Assistance Provided: 24
Information Provided: 111
DOC Resolved: 26
Insufficient Evidence to Substantiate: 13
No Violation of Policy: 34
Substantiated: 0

Intake Investigations: 99

Administrative Remedies Not Pursued: 66
Declined: 14
Lacked Jurisdiction: 7
Person Declined OCO Involvement: 7
Person Left DOC Custody Prior to OCO Action: 5

Resolved Investigations: **312**

Assistance or Information Provided in
65%
of Case Investigations

OCO Casework Highlights

October 2023

Assistance Provided

Reported Concerns: Person reported that he requested his medications to be renewed and to see his provider several times without receiving an appointment. The patient reports it took several months to get his medication orders fixed.

OCO Actions: OCO staff reviewed patient records and substantiated the gaps in access to the medication in the patient's treatment plan. OCO verified the patient had active orders for the medication.

Negotiated Outcomes: OCO staff also elevated this concern to the Health Services administrators and the Director of Pharmacy. The OCO will be providing recommendations for the related policies and protocols that are currently under review with the DOC.

Assistance Provided

Reported Concerns: Several incarcerated individuals reported concerns regarding the behavior incentive program at OCC. The individuals stated that newly transferred people are placed in a specific unit and DOC confiscates their TV while living in this unit. The individuals are required to earn the personal TV back with good behavior.

OCO Actions: The OCO spoke with facility leadership and confirmed incarcerated individuals were having their personal TVs confiscated as part of the incentive program. The OCO verified that this practice does not occur at other camps and recommended that the individuals be allowed their personal TVs.

Negotiated Outcomes: The DOC agreed and is implementing a process to allow everyone in the unit to have their personal TVs.

Assistance Provided

Reported Concerns: Person reported that an officer took a religious item that the religious coordinator told him he was allowed to have and wear. Person said this has occurred before.

OCO Actions: The OCO reviewed the resolution request and contacted the religious coordinator at the facility, who confirmed that they had approved the religious item per a directive from DOC HQ that the gender designation had been removed on previously gendered religious items. They also confirmed that the correctional officer confiscated the item and would not return it to the individual or to the religious coordinator. The OCO contacted the Correctional Manager for Family, Religious, Volunteer, and Cultural Programs, who confirmed that this individual is allowed to have this religious item but can only wear it during religious services.

Negotiated Outcomes: Upon the OCO's request, the Correctional Manager ensured that the item was returned to the individual. Following OCO's outreach, DOC HQ released a memo stating that religious items would no longer have a gender designation and that items such as head coverings, earrings, and ceremonial dress are now available to incarcerated individuals of any gender.

Assistance Provided

Reported Concerns: Incarcerated individual reported concern regarding potential maximum custody placement. The person reported that they were experiencing distress and had concern for their mental wellbeing.
OCO Actions: The OCO immediately contacted DOC staff to ensure mental health staff were aware of the concern.
Negotiated Outcomes: Due to OCO outreach, the individual was able to speak with mental health staff the same day. The OCO also shared information with the individual regarding the custody facility plan (CFP) process and how to be an active part of it. The OCO recommended that he appeal the classification decision by completing DOC 07-037 Classification Appeal within 72 hours of receiving the decision.

Unexpected Fatality Reviews

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

UFR-23-005: The Unexpected Fatality Review Committee reviewed the unexpected death of a 55-year-old person in May 2023. The Unexpected Fatality Review Committee Report dated September 14, 2023, and the Unexpected Fatality Review Correction Action Plan (CAP) dated September 24, 2023, are publicly available documents.

UFR-23-006: The Unexpected Fatality Review Committee reviewed the unexpected death of a 34-year-old person in May 2023. The Unexpected Fatality Review Committee Report dated September 22, 2023, and the Unexpected Fatality Review Correction Action Plan (CAP) dated October 2, 2023, are publicly available documents.

UFR-23-007: The Unexpected Fatality Review Committee reviewed the unexpected death of a 23-year-old person in June 2023. The Unexpected Fatality Review Committee Report dated October 9, 2023 is a publicly available document.

UFR-23-008: The Unexpected Fatality Review Committee reviewed the unexpected death of a 35-year-old person in June 2023. The Unexpected Fatality Review Committee Report dated October 10, 2023 is a publicly available document.

UFR-23-009: The Unexpected Fatality Review Committee reviewed the unexpected death of a 29-year-old person in June 2023. The Unexpected Fatality Review Committee Report dated October 13, 2023 is a publicly available document.

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

Monthly Outcome Report: October 2023

	Complaint Summary	Outcome Summary	Case Closure Reason
UNEXPECTED FATALITY REVIEWS			
Monroe Correctional Complex			
1.	The OCO opened an investigation into an unexpected fatality.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-23-005 was delivered to the Governor and state legislators last month. It is also publicly available on the DOC website.	Unexpected Fatality Review
Progress House Reentry Center			
2.	The OCO opened an investigation into an unexpected fatality.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-23-006 was delivered to the Governor and state legislators last month. It is also publicly available on the DOC website.	Unexpected Fatality Review
Washington State Penitentiary			
3.	External person inquired about the OCO's awareness and plan of action surrounding the recent suicides at a facility. Person also expressed concerns about the facility's response to the recent events.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-23-008 was	Unexpected Fatality Review

		delivered to the Governor and state legislators this month. It is also publicly available on the DOC website.	
4.	External person inquired about the OCO's awareness and plan of action surrounding the recent suicides at a facility. Person also expressed concerns about the facility's response to the recent events.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-23-009 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website.	Unexpected Fatality Review
5.	External person inquired about the OCO's awareness and plan of action surrounding the recent suicides at a facility. Person also expressed concerns about the facility's response to the recent events.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-23-007 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website.	Unexpected Fatality Review

CASE INVESTIGATIONS

Airway Heights Corrections Center

6.	Person reported that a corrections officer took his religious items box and that he has not been able to get the box returned to him. Person stated that the religious coordinator is supposed to be involved but has not been. Person expressed that he is afraid that the box was thrown out.	The OCO provided assistance. The OCO contacted the religious coordinator and informed him of the situation. After OCO outreach, the religious coordinator met with this individual and confirmed that the box had not been thrown away and returned the box to the individual. The religious coordinator also stated that they went through the box and added some items that he was allowed to have. The OCO reviewed DOC records and confirmed that the religious items, including the newly added ones, are listed on his religious property matrix.	Assistance Provided

7.	External person reported their loved one has not received necessary durable medical equipment (DME) since arriving to DOC.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff reviewed the patient's electronic record and found the patient had been issued the equipment prior to OCO involvement.	DOC Resolved
8.	Incarcerated person reported legal mail from the courts was tested by mail staff at DOC and came back as positive for drugs and they received an infraction. Person states there is no way the papers could have tested positive unless the courts are sending drugs into prison.	DOC staff resolved this concern prior to the OCO taking action on this complaint.	DOC Resolved
9.	Incarcerated individual reported concern regarding a public records request they filed with DOC. The individual requests OCO assistance in ensuring he can access the full request he filed with DOC.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The individual called the OCO hotline and shared that the issue was resolved and the case could be closed.	DOC Resolved
10.	Person reported his optical appointment was cancelled and has not been rescheduled for several weeks.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff reviewed the patient's future appointments and found his appointment had been rescheduled. The patient was provided with the reason his last appointment was cancelled.	DOC Resolved
11.	Incarcerated individual expressed concerns about extended placement in segregation.	The OCO reached out to DOC and confirmed that the individual was scheduled to be released from segregation later that day.	DOC Resolved
12.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction and confirmed it was dismissed on appeal per the DOC memo regarding changing to the presumptive positive testing.	DOC Resolved
13.	Person reported concerns with his current cellmate, and that he feels threatened by him. Person stated that he fears being attacked by his cellmate, which has affected his sleep and caused stress. Person said he has filled out the courtesy move form and talked with the Custody Unit Supervisor (CUS) and Sergeant, but nothing has happened.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reached out to the CUS, who confirmed that this individual has been moved to a different cell and has reported that things are going well with his new cellmate. The OCO reviewed DOC records and verified that he had been moved.	DOC Resolved
14.	Person stated they were approved for hearing aids but had not yet received them. They were told they would have an appointment but the	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff verified an appointment was scheduled for the patient with the necessary provider.	DOC Resolved

	patient is requesting the appointment be made sooner.	The OCO cannot make appointment happen sooner as appointments are scheduled by availability. DOC has hired an audiologist for that facility to shorten the time a hearing aid consult takes to complete. There are limited providers in that area for that specialty.	
15.	Person reported that he has been trying to get a job in the unit for months, and that many people who have not been on the referral list as long as him have gotten jobs before him. Person said that DOC staff have said that he will not get hired because he files grievances. Person also described other ways that he has been targeted in the unit for his race.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed this individual's resolutions request investigations and found that he withdrew his resolutions request after being hired for a job in the unit. The OCO could not substantiate that DOC staff said he will not get hired because he files grievances.	DOC Resolved
16.	Person reported having a Prison Rape Elimination Act (PREA) allegation filed against them and has not heard anything from DOC about it.	The OCO provided information. The OCO reviewed DOC records and found that this PREA allegation was closed as unsubstantiated, and that this individual was moved to a different cell.	Information Provided
17.	Person reported that two books were rejected and are being held by the mailroom. Person said that it is too late to return them. Person said that the OCO informed him of upcoming changes to the WAC regarding mail rejections and requested that the OCO help him keep the books at the facility until the policy changes.	The OCO provided information and shared that the facility will not hold the books until the policy changes. The OCO encourages this individual to work with the mailroom to send the books out via property disposition, or DOC will dispose of the books. Once the policy changes, he can try to order these books again.	Information Provided
18.	Incarcerated individual reports concerns about not being able to transfer to camp. The individual requests assistance in transferring to a camp setting.	The OCO provided information regarding transfers to DOC camps. The OCO shared that individuals need to be at least five years from their release date to be eligible for a camp setting. Due to the sentence he is currently serving he is ineligible for camp until he is closer to release.	Information Provided
19.	Incarcerated individual reported a concern regarding DOC staff opening a box of his property that was shipped to the facility where he is currently located.	The OCO provided information about how to file a tort claim. The OCO reviewed the DOC investigation and found that the box was searched upon arrival which is why the box was opened. The OCO verified that the items confiscated were removed in compliance with DOC 440.000 Personal Property for Incarcerated Individuals. The OCO shared that if the individual would like to be	Information Provided

		considered for compensation for the shipping costs of the box or the items confiscated, he may file a tort claim with the Department of Enterprise Services (DES) Office of Risk Management (ORM). This office explained the steps to file a tort claim.	
20.	The individual reports that he was moved out of his unit pending an investigation but was not infracted. The individual says he was then moved to a different unit but was not given his job or television privileges back. The individual says he was moved to the bottom of the job list and does not understand why he was moved to a new unit and he feels this is racial discrimination.	The OCO provided information. This office verified that the individual was infracted and reviewed the infractions he received, and found they were completed per DOC 460.000 Disciplinary Process for Prisons. The OCO found that the individual did lose his job, as the DOC has the authority to remove individuals from their positions if they are infracted and/or cannot meet the attendance requirements of the job. This office found that the individual was hired for another position and will have additional referrals open once the three month Return on Training Investment (RTI) period of his previous position concludes.	Information Provided
21.	The individual reports that he was forced to serve a sanction on an infraction after it had expired. He reports that he filed a resolution request which was not accepted, as he was told that it was an appealable issue. He reports he was trying to grieve the sanction being expired and not removed and was not trying to appeal the infraction.	The OCO provided information. This office informed the individual that he may kite the hearings officer about this and if any similar issues arise in the future.	Information Provided
22.	Incarcerated individual reported safety concerns at the facility where he is housed.	The OCO provided information about how to report safety concerns to the DOC. The OCO spoke with DOC staff regarding the individual's housing assignment and they shared that the individual was moved for safety reasons and that the individual did not report further concerns to them regarding his placement. The OCO shared with the individual how to report verifiable concerns to DOC staff.	Information Provided
23.	Person reported that he has a health issue that prevents him from being able to write kites or letters. Person said he has not been able to get a Health Status Report to help with his ability to write. Person also said that	The OCO provided information. The OCO reached out to the ADA coordinator, medical staff, and this individual's counselor, who all confirmed that this individual has spoken with medical, custody, and ADA staff about this issue. They stated that this individual can	Information Provided

	DOC staff will not help him get a new typewriter.	request a medical appointment or ask for an ADA accommodation.	
24.	Incarcerated individual expressed concerns about changes in DOC policy that limit the amount of beads an individual may have.	The OCO provided the individual with information that the changes made to DOC 540.105 are currently being revised.	Information Provided
25.	Loved one expressed concerns about changes to DOC policy that impacts the amount of beads an incarcerated individual can have.	The OCO provided information to the individual that confirmed the changes made to DOC 540.105 are currently being revised.	Information Provided
26.	Person reported that the DOC Public Records Office incorrectly summarized his public records request, and asked if the OCO has jurisdiction over DOC Public Records.	The OCO provided information. The OCO may investigate a concern regarding DOC Public Records and encouraged this individual to appeal the response to his public records request. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Information Provided
27.	An incarcerated person reports that he is concerned he will be infracted for the behavior/actions of his cellmate. He states he has not yet been infracted.	The OCO provided information regarding the infraction, and appeals process.	Information Provided
28.	Incarcerated person reported they have been told their current dental diagnoses do not meet the criteria for DOC Dental plan to cover a partial, but he wants a partial.	The OCO provided information regarding the limitations of the DOC Healthplan/dental plan and verified that the person is able to eat. This office explained that the issue does not yet reach the level of medical necessity despite it being an issue for the person as they are visibly missing teeth.	Information Provided
29.	Incarcerated individual reported he was transferred to a new facility and has not received his chain bag. The individual reports this is an issue that other people have experienced and wants individuals to be able to receive their chain bags in a timely manner.	The OCO provided information. The OCO reached out to DOC staff at the facility to ensure that individuals received their chain bags. DOC staff explained that there was no issue with the chain bag process and that this was an isolated incident. The OCO confirmed the individual received their chain bag after filing a resolution request.	Information Provided
30.	Incarcerated individual reported their property did not arrive after transfer to a minimum security facility. The individual requests OCO assistance in obtaining their lost items.	The OCO provided information about the lost items and how to file a tort claim to be compensated for lost property. The OCO spoke with DOC property staff and confirmed the individual's property was lost. The OCO explained how to file a tort claim with	Information Provided

		Department of Enterprise Services (DES) Office of Risk Management (ORM).	
31.	Incarcerated individual expressed concerns about the language of WAC 137-28-400 which states "the time limitations expressed in these regulations are not jurisdictional and failure to adhere to any particular time limit shall not be grounds for reversal or dismissal of a disciplinary proceeding."	The OCO informed the individual that the OCO is constantly monitoring concerns regarding the disciplinary system and attends the public hearings whenever a WAC is up for review. When WAC 137-28-400 is pending review, the OCO will plan to attend the public hearing and point out the contradictory nature.	Information Provided
32.	The individual reported they failed a urine analysis (UA) for medication they were prescribed earlier in the year and subsequently received an infraction. At the time of the UA, medical could not verify that he was prescribed this medication.	The OCO provided information regarding how to appeal an infraction while speaking to this individual on the hotline. This person followed the appeal process, and the DOC overturned their infraction.	Information Provided
33.	Incarcerated individual reported concerns about how DOC responds to concerns about their staffs conduct. The individual explained he has seen other incarcerated individuals experience retaliation after reporting concerns about facility leadership.	The OCO provided information about how to report incidents of staff misconduct. The OCO explained incarcerated individuals can file a resolution request about staff and they can also report the concern to the OCO after receiving a level 2 resolution request response. The OCO will review staff conduct concerns, in an effort to resolve conflict at the lowest level possible. The OCO also shared information about a survey conducted, as the concern was directly related.	Information Provided
34.	Person reported he was removed from his job for mental health reasons and was told he could try to get another job with Correctional Industries (CI) after six months. This person is requesting he be allowed to get another CI job before that time since he was removed for a reason outside of his control.	The OCO provided information to the person regarding the Work Programs policy. During the investigation the person became ineligible for work in Correctional Industries. Per DOC 700.000 to be eligible for Class I, II, and IV work programs, workers must meet requirements including: A minimum of 6 months since disposition of a guilty finding for any other serious violation, a minimum of 12 months since disposition of a guilty finding for any Category A violation or drug-related violation.	Information Provided
35.	A loved one reported that an incarcerated individual has been in solitary confinement for a month. She stated that this individual received an infraction and was	The OCO provided information. The OCO reached out to DOC Headquarters, who confirmed that this individual has not been assigned to max custody, and has been transferred to a medium custody facility	Information Provided

	supposed to engage in programming, but was also told he could be in solitary confinement for six months.	pending his infraction hearing. The OCO could not find a violation of DOC 320.000 Administrative Segregation.	
36.	Person reported that the DOC dentist damaged his teeth during a dental procedure. The patient had severe sensitivity after the procedure and was not offered pain medication. The patient is requesting that the dentist not be able to practice anymore and to be transferred to a different facility.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff reviewed the patient dental records and was unable to substantiate that the dentist caused the damage that led to sensitivity. OCO also verified the patient signed a consent to the procedure that detailed possible risks of the treatment received. OCO cannot impact the patient's requested resolutions. OCO staff also verified the source of the sensitivity was treated by DOC dental staff.	Insufficient Evidence to Substantiate
37.	Incarcerated individual expressed concerns regarding two infractions in which they state their transgender rights were violated.	The OCO reviewed the infraction and appeal packet for each of the two infractions and did not find any evidence that shows there was a violation of the individual's rights, rather, the individual's behavior met the infraction elements.	Insufficient Evidence to Substantiate
38.	Person reported that he waited an excessive amount of time to be seen by his new provider after arriving at a new facility.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff reviewed records and found the person was seen multiple times by different medical staff. OCO staff confirmed chronic care management had been initiated for this patient and he was able to be seen in a timeframe that is typical for that facility. The patient's medical codes did not indicate more frequent appointments in mental health or medical disciplines.	Insufficient Evidence to Substantiate
39.	Person reported that he purchased public records, and that the mailroom gave him copies and retained the original. Person said that the copies were made poorly and were ineligible. Person filed a Resolution Request and it was found Unsubstantiated and person says his claim is legitimate and should be found Substantiated.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed this individual’s resolution request and found that this individual had the original records mailed out, and so DOC HQ staff were unable to confirm whether the copies were made poorly or if it was the original document. The OCO could not find a violation of DOC 450.100 Mail for Individuals in Prison.	No Violation of Policy
40.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction narrative and found no violation of DOC policy 460.000 as the individual's actions met DOC's "some evidence" standard utilized to uphold infractions.	No Violation of Policy

41.	The individual reported that they are trying to get married to another incarcerated individual within the DOC. The individual reports that the DOC is not letting them move forward with the marriage process.	The OCO was unable to substantiate a violation of policy by the DOC. The OCO verified that the DOC was allowing the marriage application per DOC 590.200 Marriages and State Registered Domestic Partnerships. However, it was denied as the other party rescinded their marriage application.	No Violation of Policy
42.	The individual reported that he was found releasable by the Indeterminate Sentence Review Board (ISRB) but has had multiple addresses denied. The individual says he is open to different options and wants a pathway to release.	The OCO was unable to substantiate a violation of policy by the DOC. Per DOC 350.200, Transition and Release, Release plans for individuals under Board jurisdiction will be routed to the Board for final approval per DOC 320.100, Indeterminate Sentence Review Board. Per policy, the Board retains the sole authority to approve/deny the release plan. The OCO verified that the individual currently has an Offender Release Plan (ORP) in review.	No Violation of Policy
43.	The individual reported that he was denied Graduated Reentry (GRE) and work release and says that the DOC has not provided him with a reason for the denial.	The OCO was unable to substantiate a violation of policy by the DOC. Per DOC 390.590, Graduated Reentry, and DOC 300.500, Reentry Center Screening, the Headquarters Community Screening Committee (HCSC) will make the final decision when there are existing or suspected community concerns. The HCSC recommended denial for the individual. The OCO verified that the individual has an upcoming Planned Release Date (PRD).	No Violation of Policy
44.	Person reported concerns with his property and said a corrections officer took all of his commissary food items in his locker while he was at work. Person said that he got some, but not all of his items back, and wanted to be reimbursed for the missing food items. Person also expressed concern with how the resolutions investigation was conducted.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the resolutions investigation, which stated that the food items listed as missing were purchased over a six-month period and are reasonably expected to be consumed. They also stated that the officer conducted a search because this individual was using an adjacent locker to store overflow food items, and that the only items that were not returned were provided through the kitchen and considered nuisance contraband if not consumed within the timeframes outlined in the AHCC Minimum Security Unit handbook. The OCO could not find a violation of DOC 440.000 Person Property in Prisons or the Resolution Program Manual.	No Violation of Policy

45.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction and found the individual's behaviors met the "some evidence" standard utilized by DOC.	No Violation of Policy
Cedar Creek Corrections Center			
46.	The individual reported that he was approved to go to work release and should have gone last month, but he has not heard anything. The individual reported that he asked DOC staff, but they did not have an answer regarding when he would go to work release.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO verified that the individual transferred to work release shortly after this concern was reported.	DOC Resolved
47.	Person said that he is releasing soon, and DOC is not giving him access to resources. Person said he has no housing and will release homeless and wants support. Person reported that DOC staff told him he will not get release money.	The OCO provided information about DOC policy and RCW 72.02.100. The OCO reviewed DOC records and found that DOC did complete release planning with this individual and that he turned down a housing option and released on his maximum date. The OCO could not find record showing that he did not receive release money. DOC 210.025 Release Money/Transportation Funds states, "Individuals releasing to the community from a Prison or Reentry Center will be provided release money in the amount authorized per RCW 72.02.100."	Information Provided
48.	Incarcerated person expressed frustration with lack of options in job assignment.	The OCO provided information regarding how to request job change, appeal decisions made at their Custody Facility Plan Meeting.	Information Provided
49.	Incarcerated person reported a complaint regarding DOC staff behavior. Person asked for staff member to be fired and to be compensated financially due to behavior.	The OCO provided information regarding how to file a tort claim and verified that DOC has received the staff behavior complaint.	Information Provided
50.	Incarcerated individual expressed concerns about an infraction they received.	The OCO requested video of the incident that led to the infraction, but DOC stated no video evidence was retained. Video evidence is only retained for a 30 day period, and by the time the individual had contacted the OCO, the 30 day retention period had expired and the video was no longer available. Thus, the OCO was unable to view the video footage of the event and unable to substantiate the individual's account of the incident.	Insufficient Evidence to Substantiate
51.	Incarcerated individual expressed concerns about an infraction they received.	The OCO requested video of the incident that led to the infraction, but DOC stated no video evidence was retained. Video evidence is only	Insufficient Evidence to Substantiate

		retained for a 30 day period, and by the time the individual had contacted the OCO, the 30 day retention period had expired and the video was no longer available. Thus, the OCO was unable to view the video footage of the event and unable to substantiate the individual's account of the incident.	
Clallam Bay Corrections Center			
52.	Incarcerated individual expressed concerns about a delay in being served an infraction.	The OCO contacted DOC and confirmed the delay was due to the infracting staff's leave of absence. As the individual had not yet been served the infraction, the delay was not a violation of DOC policy 460.000 as the individual still had the hearing within a timely manner after being served.	Information Provided
53.	Incarcerated individual relayed concerns regarding their eligibility under the new DOC memo to have several infractions dismissed.	The OCO informed the individual that DOC has not yet published an official policy regarding the process changes to the presumptive drug testing. However, based on the September 6, 2023 DOC memo, headquarters has compiled a list of all individuals who are eligible to have their infractions overturned from the past two years and is sending letters to those who have had changes made to their records as a result.	Information Provided
54.	Incarcerated individual relayed concerns regarding changes in DOC policy regarding beading equipment.	The OCO provided the individual with information that confirmed the changes made to DOC Policy 540.105 are currently being revised.	Information Provided
55.	Patient expressed concerns about staff conduct at an offsite medical appointment and upon returning to the facility.	The OCO reviewed related incident reports, medical records, and contacted health services leadership. This office discussed the incident as well as the patient's current access to medical care with DOC health services leadership at the facility and DOC headquarters. After scheduling a phone call with the patient and gathering more information, a separate case was opened to address the pain medication grievance delay. The OCO is in continued conversations with leadership about medical emergency response and flagged this case for further consideration. The OCO provided information to the patient via phone and letter, including patient’s rights to file with the Department of	Information Provided

		Enterprise Services (DES) Office of Risk Management.	
56.	Incarcerated individual expressed concerns about the inability to be housed with/near a loved one and the issuance of a keep separate.	The OCO contacted DOC and confirmed that due to validated safety and security concerns, the keep separate is appropriate at this time.	Information Provided
57.	Incarcerated individual reported safety concerns about their facility placement. The individual does not want to be in solitary confinement due to his safety concerns.	The OCO provided information regarding the individual's housing assignment. The OCO reviewed the individual's recent housing assignments and found safer housing options were refused. The OCO shared information with the individual about how to report safety concerns to the DOC staff and how to participate in his Custody Facility Planning.	Information Provided
58.	Person reported that he was sent pieces of art that were rejected as sexually explicit material.	The OCO provided information. The OCO reviewed the rejection and found that the rejected images were classical pieces of art. The OCO reached out to DOC Headquarters, who said that the Sergeant agreed that these images should not have been rejected, but that this individual did not appeal the rejection. The OCO encourages the individual to appeal the rejection.	Information Provided
59.	Individual reported he is being held in solitary confinement on the out-of-state transfer list based on erroneous information.	The OCO reviewed the out-of-state transfer decision for this individual and spoke with the DOC Classifications. The DOC maintains that this individual is not safe at any of the facilities statewide. The DOC is within policy 330.600	No Violation of Policy
Coyote Ridge Corrections Center			
60.	Person reported that a correctional officer has taken a religious item that the religious coordinator told him he is allowed to have and wear. Person said this is not the first time this correctional officer has taken this religious item.	The OCO provided assistance. The OCO reviewed the resolution request and reached out to the religious coordinators at the facility, who confirmed that they had approved the religious item per a directive from DOC HQ that the gender designation had been removed on previously gendered religious items. They also confirmed that the correctional officer confiscated the item and would not return it to the individual or to the religious coordinators. The OCO reached out to the Correctional Manager for Family, Religious, Volunteer, and Cultural Programs, who confirmed that this individual is allowed to have this religious item but can only wear it during religious services. Upon the OCO's request, the Correctional Manager ensured	Assistance Provided

		that the item was returned to the individual. After the OCO's outreach, DOC Headquarters released a memo stating that they have ended the gender designation on all religious items, and that items such as head coverings, earrings, and ceremonial dress are now available to incarcerated individuals of any gender.	
61.	The individual reported concerns regarding being housed with STG members despite not being in an STG. The individual reports safety concerns in his current housing.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO verified that the individual has since transferred to another facility for programming.	DOC Resolved
62.	Person reported that someone else is using his PIN number to place phone calls, which is using up the money he put on his account.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and found that staff addressed this concern and worked with the Intelligence and Investigations Unit to get his PIN changed.	DOC Resolved
63.	Person requested the OCO send him information regarding a DOC administrative investigation from a previous case. Person also requested the OCO get him information on a tort claim he filed.	The OCO provided information about filing public records requests with the DOC and the Department of Enterprise Services Risk Management office. The OCO lacks jurisdiction over the Department of Enterprise Services and cannot provide any information about his tort claim. RCW 4.92.100 states, "(1) All claims against the state, or against the state's officers, employees, or volunteers, acting in such capacity, for damages arising out of tortious conduct, must be presented to the Office of Risk Management."	Information Provided
64.	Person reported that DOC completed his Custody Facility Plan and is supposed to transfer to another facility. The patient reported that DOC is refusing to move him.	The OCO provided information to the patient regarding the reason behind the medical hold. OCO staff reviewed the patient record and noted a medical hold is in place. OCO staff verified the patient has appointments scheduled that would call for a medical hold. The patient can discuss the length of the hold with his medical provider. Per DOC 300.380 Holds placed by Health Services may only be closed by appropriate health services employees/contract staff related to the hold.	Information Provided
65.	Incarcerated individual expressed concerns about a sanction they received as a result of an infraction.	The OCO verified the sanction was within DOC Policy 460.050 and provided the individual this information.	Information Provided

66.	The individual reported that he received a letter saying he was eligible for Graduated Reentry (GRE) and would be notified of a decision, but he has not heard anything.	The OCO provided information. This office informed the individual that if he is approved for GRE, he will be notified. The OCO is not able to provide a timeline regarding when the individual would be notified.	Information Provided
67.	Person reported that he is being prevented from completing required programing. He is requesting to be released so he can complete his court ordered program in the community.	The OCO provided information to the person regarding the limitations on the authority of this office. The OCO also provided information to the person about the reason he is not able to access the requested program.	Information Provided
68.	External contact reports issue with CRCC staff. No incarcerated individual is named in the complaint.	The OCO did not have enough information to substantiate this concern.	Insufficient Evidence to Substantiate
69.	Incarcerated individual expressed concerns about the way a urinary analysis (UA) test was administered that resulted in an infraction.	The OCO reviewed the documentation that corresponded to this infraction and was unable to locate evidence to substantiate the individual's recollection of the events to verify that the test was administered improperly.	Insufficient Evidence to Substantiate
70.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction narrative as well as the corresponding evidence and found no violation of DOC Policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
71.	Person reports they have had ongoing issues with the custody facility plan reviews. The person reports he was not given any good time back from his review.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed the person's electronic records and found that the person declined to participate in the good conduct time restoration pathway. Denials of earned time may be appealed per DOC 300.380 Classification and Custody Facility Plan Review.	No Violation of Policy
72.	The individual reports concerns regarding the DOC denying multiple release addresses.	The OCO was unable to substantiate there was a violation of policy by the DOC. This office found that the DOC has been working on a release plan per DOC 350.200, Transition and Release. Per policy, if an investigation release plan is denied, the case manager will notify the individual of the denial reason and work with the individual to develop an alternative release address. The individual has had several addresses denied, however, the OCO verified that DOC staff continue to work with the individual to find a suitable address for his release.	No Violation of Policy

73.	Person reported that DOC is not allowing him to work in maintenance, and that staff said it is because of his infraction history.	The OCO was unable to substantiate a violation of policy by DOC. DOC 700.000 Work Programs in Prisons states: "Work programs are privileges and may be restricted based on risk, behavior, and/or other factors reviewed by multidisciplinary screening committees or Facility Risk Management Teams (FRMTs) per RCW 72.09 and DOC 300.380 Classification and Custody Facility Plan Review." DOC is within policy to restrict what jobs he's eligible for based on infraction behavior. The OCO reviewed DOC records and found that he is being screened for other jobs.	No Violation of Policy
Larch Corrections Center			
74.	External person reported that individuals are missing visits for DNR.	The OCO asked the DOC to review the visitation rules at this facility. Individuals are allowed to have visits when they are on DNR. Clarification was shared with the DOC staff and this office verified that this individual did not miss a visit.	Information Provided
Monroe Correctional Complex			
75.	Patient reported issues with the DOC Care Review Committee (CRC) generally as well as specific medical access concerns. Person reported DOC has not followed through on surgeon's recommendations related to chronic back pain and DOC denied Health Status Reports (HSRs) for other medical conditions.	The OCO provided assistance by elevating the concern through health services leadership. After OCO outreach, DOC agreed to re-review the patient's HSR for disposable cleaning wipes through the Care Review Committee (CRC) based on information that was not included in the initial review. Disposable medical wipes are typically considered by the CRC as an alternative to the peri bottle and cloths if the patient has confirmed mobility limitations. DOC reviewed the specialist's recommendations and found not all recommendations are covered in the DOC Health Plan. The patient was referred to the pain management clinic for further treatment planning, and the OCO added this case to the appointment tracker to confirm scheduling.	Assistance Provided
76.	Person reported that he requested his medications to be renewed and to see his provider several times without receiving an appointment. The patient reports it took several months to get his medication orders fixed.	The OCO provided assistance. OCO staff reviewed patient records and substantiated the gaps in access to the medication in the patient's treatment plan. OCO verified the patient had active orders for the medication. OCO staff also elevated this concern to the Health Services administrators and the Director of Pharmacy. The OCO provided	Assistance Provided

		recommendations for the related policies and protocols that are currently under review with the DOC.	
77.	Patient reported concerns about DOC response to a medical emergency, which was substantiated through DOC resolution process. The person requested staff be retrained regarding medical emergencies and rules regarding what constitutes a medical emergency reviewed.	The OCO provided assistance by elevating the substantiated incident to health services leadership. DOC agreed to review and follow up on handling of medical emergencies. The OCO is in continued conversations with DOC Health Services about the process for reporting and following up on medical emergencies.	Assistance Provided
78.	Patient reported that he has broken implanted hardware. The patient states he has been trying to get the hardware removed for some time, but his request had been denied.	The OCO provided assistance to the patient by contacting Health Services management to verify access to treatment. OCO staff monitored the patient consult on the HS tracker and communicated with Health Services until surgery was scheduled.	Assistance Provided
79.	Person reported that his custody facility plan stated he would go to a lower level of confinement upon arriving at his new facility, but he is still at maximum level solitary confinement.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reached out to this individual's counselor, who confirmed that this individual is now at a lower level of confinement.	DOC Resolved
80.	Person reported that there was a miscalculation on his sentence. Person said he would accept the miscalculation if DOC told him what happened and how his sentence is now being calculated.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed this individual's resolution request investigation and found that DOC told him his Earned Release Date was changed due to an error in the calculation of credits and provided a pathway for him to find out more information.	DOC Resolved
81.	Patient reported he was misdiagnosed with a skin condition and was denied a specialist appointment by the Care Review Committee.	DOC staff resolved this concern prior to OCO involvement. OCO staff contacted Health Services Management and were informed that the patient had been reevaluated and a consult to see a specialist was approved and scheduled.	DOC Resolved
82.	A loved one reported that an incarcerated individual's Custody Facility Plan (CFP) was completed without his knowledge or input and he would have to wait a year to participate in his next CFP. They also reported that this individual was placed in solitary confinement after expressing concern about his new cellmate.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and found that a new CFP was conducted that included this individual's input. The OCO could not substantiate that this individual was placed in solitary confinement because of expressing concern about his new cellmate.	DOC Resolved

83.	Person said that women staff were not using the doorbell when they enter the tier. Person reported filing a resolution request on the issue.	DOC staff resolved this concern prior to the OCO taking action on this complaint. This individual reported that after he wrote the resolution request, DOC fixed the doorbell and now women staff will use the doorbell when entering the tier.	DOC Resolved
84.	Loved one expressed concerns about an incarcerated individual's placement in segregation as the result of an infraction.	The OCO confirmed the individual has since been released from segregation and found no violation of DOC Policy 460.000 in reviewing the infraction narrative.	Information Provided
85.	Person reported that work equipment he was using broke and he sustained serious injuries as a result. Person reported that the work equipment had not been replaced in many years and was a safety hazard. Person stated he is trying to get a copy of the investigation of the incident from the safety team, but they have not responded to his kites.	The OCO provided information about filing a public records request to get the investigation from the safety team. The OCO reviewed the resolution request investigation, and found that his concern was substantiated by DOC, who found multiple pieces of work equipment were out of compliance and have removed that equipment and ordered replacements.	Information Provided
86.	Loved one expressed concerns about an incarcerated individual being placed in IMU without an infraction.	The OCO reviewed the individual's administrative segregation hearing and confirmed that due to a recent infraction the individual was no longer deemed appropriate for their facility.	Information Provided
87.	External person reported concerns about their loved one being discharged from the residential treatment unit.	The OCO reviewed the patient's mental health records and elevated this concern through DOC headquarters health services leadership. This office provided the patient with information about pathways for being reconsidered for residential treatment in the future. The patient was referred for outpatient treatment and assigned to a new provider. After OCO outreach, the patient was scheduled with their new provider to discuss mental health care plan.	Information Provided
88.	Person reported DOC denied his ADA accommodation requests. He requested the accommodations be approved and to receive information about the process for receiving treatment for traumatic brain injury (TBI) symptoms.	The OCO contacted ADA and health services leadership. DOC agreed to review the ADA accommodations and determined they were not medically indicated. The OCO provided the patient with information about next steps for official TBI assessment and pathway for addressing medications.	Information Provided
89.	The individual reported concerns with the resolution requests he has filed. He reports that several of his resolution requests were sent back	The OCO provided information. This office reviewed the resolution requests that the individual referenced and verified that it did not appear that the rewrites were received	Information Provided

	for rewrites, but the resolution requests were closed saying that the rewrite was not received within the timeframes given.	within the given timeframes. Per the Resolution Program Manual (RPM) all rewrite requests should be received within 10 working days of the issuance of the rewrite request (unless specified otherwise by the Resolution Specialist for circumstances that require more time).	
90.	Person reported facility issues about water. Person said that the condition of confinement at SOU are extremely poor. Rusty water is coming out in the shower and the pipes and it is irritating to the skin, and many people stop taking showers. The water is a reddish color that stains the walls.	The OCO visited this individual in person and spoke with them about their concern. The OCO checked the water while onsite and could not find evidence to substantiate the water was rusty. This office did confirm that there is an ongoing plumbing project at the facility.	Information Provided
91.	Individual reported IIU has blocked his brother's number and they will not respond to his kites.	The OCO contacted the facility leadership and asked for a review of this individual's blocked callers. The facility verified that this individual does not have any phone numbers that the DOC has blocked.	Information Provided
92.	Incarcerated individual expressed concerns about changes to the in-cell hobby program policy.	The OCO informed the individual that this office confirmed the changes made to DOC Policy 540.105 are currently being revised.	Information Provided
93.	An anonymous individual reported concern regarding the showers. The individual requested that DOC add shower curtains to the lower tier showers.	The OCO provided information. The OCO spoke with headquarters leadership about the concern on multiple occasions. The DOC explained they went to MCC to view the showers and spoke with staff about them. DOC Headquarters leadership asked if they were aware of any concerns from individuals housed at MCC TRU regarding lower tier showers. DOC staff explained that they have options available for people who are uncomfortable using the lower tier showers, they are able to use the upper tier showers in their units and/or shower while count is being performed. DOC will not add a curtain to the lower tier showers as it would create a security concern.	Information Provided
94.	Incarcerated individual has an ongoing concern about his mental health provider.	The OCO provided information about how to file a complaint with the Department of Health (DOH) about patients' concerns with the quality and consistency of behavioral health care provided by the DOC. The mailing address to file a complaint with the DOH is: Washington State Department of Health Health Systems Quality Assurance	Information Provided

		Complaint Intake P.O. Box 47857 Olympia, WA 98504-7857	
95.	Incarcerated Individual has an ongoing concern about his mental health provider.	The OCO provided information about how to file a complaint with the Department of Health (DOH) about patients' concerns with the quality and consistency of behavioral health care provided by the DOC. The mailing address to file a complaint with the DOH is: Washington State Department of Health Health Systems Quality Assurance Complaint Intake P.O. Box 47857 Olympia, WA 98504-7857	Information Provided
96.	The individual reports concerns regarding how tier representatives are chosen.	The OCO provided information. This office shared this concern with the superintendent of the facility who is aware of the ongoing concerns around the selection of tier representatives.	Information Provided
97.	Incarcerated individual has an ongoing concern about his mental health provider.	The OCO provided information about how to file a complaint with the Department of Health (DOH) about patients' concerns with the quality and consistency of behavioral health care provided by the DOC. The mailing address to file a complaint with the DOH is: Washington State Department of Health Health Systems Quality Assurance Complaint Intake P.O. Box 47857 Olympia, WA 98504-7857	Information Provided
98.	Person reported ongoing issues with Securus and attorney and family numbers being blocked.	The OCO provided information about how to request a meeting with a Securus representative or filing a help ticket to get the numbers unblocked. The OCO is actively monitoring the transition to Securus and is still gathering information. The OCO does not have jurisdiction over Securus but is in discussion with DOC regarding their contract with Securus and is bringing issues and concerns from incarcerated individuals to DOC's attention.	Information Provided
99.	Incarcerated individual relayed concerns regarding their eligibility under the new DOC memo to have an infraction dismissed.	The OCO informed the individual that DOC has not yet published an official policy regarding the process changes to the presumptive drug testing. However, based on the September 6, 2023 DOC memo, headquarters has compiled a list of all	Information Provided

		individuals who are eligible to have their infractions overturned from the past two years and is sending letters to those who have had changes made to their records as a result.	
100.	Incarcerated individual reported multiple concerns. The individual reports DOC staff are forcing him to live with incompatible roommates and are performing frequent cell searches. The person also reports he has received unjustified infractions and is being blocked from the DOC resolutions program. The individual has been unable to gain employment and believes this is a result of the staff retaliation and targeting reported.	The OCO provided the individual with information regarding how to access employment. The OCO reviewed the individual's infractions and found them to be upheld in compliance with DOC 460.140 Hearings and Appeals. The OCO spoke with facility staff who were unable to find evidence to support targeting or retaliation; all searches were per policy and the OCO confirmed all cell assignments were generated per DOC protocol. The OCO found the individual has been promoted to a lower custody facility. At a lower custody facility, the individual will have access to more employment and programming. The OCO explained to the individual how to express interest in available employment and programming at the new facility.	Information Provided
101.	Incarcerated individual has an ongoing concern about his mental health provider.	The OCO provided information about how to file a complaint with the Department of Health (DOH) about patients' concerns with the quality and consistency of behavioral health care provided by the DOC. The mailing address to file a complaint with the DOH is: Washington State Department of Health Health Systems Quality Assurance Complaint Intake P.O. Box 47857 Olympia, WA 98504-7857	Information Provided
102.	Patient reported concerns accessing medical care related to pain management and requested increased prescription.	The OCO elevated the concerns to health services leadership and confirmed the case was reviewed through the Care Review Committee (CRC). Lidocaine was not medically recommended at a higher dose and the individual was approved for temporary prescription options while pending pain management specialist appointment. The OCO also confirmed the patient was scheduled with oncology. This information was provided to the patient via closing letter and the OCO encouraged the individual to follow up if they have ongoing or future concerns related to their medical care. An	Information Provided

		OCO Review Request Form was included with the closing letter for reporting new issues or updated concerns.	
103.	Incarcerated individual has an ongoing concern about his mental health provider.	The OCO provided information about how to file a complaint with the Department of Health (DOH) about patients' concerns with the quality and consistency of behavioral health care provided by the DOC. The mailing address to file a complaint with the DOH is: Washington State Department of Health Health Systems Quality Assurance Complaint Intake P.O. Box 47857 Olympia, WA 98504-7857	Information Provided
104.	Incarcerated individual has an ongoing concern about his mental health provider.	The OCO provided information about how to file a complaint with the Department of Health (DOH) about patients' concerns with the quality and consistency of behavioral health care provided by the DOC. The mailing address to file a complaint with the DOH is: Washington State Department of Health Health Systems Quality Assurance Complaint Intake P.O. Box 47857 Olympia, WA 98504-7857	Information Provided
105.	Incarcerated individual has an ongoing concern about his mental health provider.	The OCO provided information about how to file a complaint with the Department of Health (DOH) about individual patient's concerns with the quality and consistency of behavioral health care provided by the DOC. The mailing address to file a complaint with the DOH is: Washington State Department of Health Health Systems Quality Assurance Complaint Intake P.O. Box 47857 Olympia, WA 98504-7857	Information Provided
106.	Patient reported new medical concerns.	The OCO scheduled a phone call with the individual to gather more details. The patient confirmed the original medical issues were addressed and his most recent concern is about systemic issues with health service handling of appointments and kites. The OCO provided the individual with more information about OCO's intake process and closed case review forms via phone. This	Information Provided

		office is reviewing appointment scheduling and kite response concerns statewide.	
107.	Incarcerated individual reports he is not receiving kosher meals.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO verified that this individual is on the kosher diet and was not able to locate evidence to substantiate the individual received incorrect meals.	Insufficient Evidence to Substantiate
108.	The individual reports that he is not receiving legal mail. He reports he has not received his legal mail or mail rejection notices.	The OCO was unable to substantiate the concern due to insufficient evidence. This office spoke with DOC staff at the facility who verified that the mailroom is not holding or discarding any of the individual's legal mail, and there are no pending rejection notices for the individual. DOC staff also confirmed that the most recent piece of legal mail sent to the individual was given to him.	Insufficient Evidence to Substantiate
109.	Person reported concerns about getting denied for Graduated Re-Entry (GRE). Person stated that he was originally told a warrant made him ineligible, but after he handled his warrant he said he's still being denied based on his past history.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The OCO reviewed DOC records and found that this individual was denied GRE due to safety concerns. DOC Graduated Reentry 390.590 I. states "D. The Graduated Reentry Administrator may administratively deny or terminate participation in Graduated Reentry when: 1. Circumstances of placement create a risk to anyone."	No Violation of Policy
110.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction narrative and was unable to locate a violation of DOC Policy 460.000 as the individual's behavior met the "some evidence" standard utilized by DOC.	No Violation of Policy
111.	Person reported that he was revoked from Graduated Reentry (GRE) and sent back to prison, and that he did not have a hearing, and was told it was because he did not get a job fast enough.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed DOC records and found that this individual was revoked from GRE because of community safety concerns. The OCO could not find a violation of DOC 390.590 Graduated Reentry.	No Violation of Policy
112.	The individual reported that he has been approved for Extended Family Visits (EFVs) with his mother and sister for several years, but EFVs with his wife were denied citing a domestic violence (DV) indicator but reports he does not have any history related to DV.	The OCO was unable to substantiate a violation of policy by DOC. This office spoke with DOC HQ staff who verified that the individual was denied EFVs with his wife per DOC 590.100, Extended Family Visiting, which states that an individual may be denied based on the nature of the crime, criminal history, and current/prior behavior. If there is reason	No Violation of Policy

		to believe that an eligible individual is a danger to self, the visitor(s), or the orderly operation of the program, the Superintendent/designee may exclude the individual from the program. DOC staff confirmed that the nature of the relationship of an incarcerated individual and the visitor who is applying for EFVs is taken into consideration when reviewing the EFV application, which is why immediate family may be approved while a spouse may not be. The individual and their loved one may reapply for EFVs one year from receiving the outcome of the appeal.	
113.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction narrative and contacted DOC regarding a potential dismissal of the infraction as it appeared to occur during a mental health consultation. DOC was unwilling to dismiss the infraction as it was not apparent whether the individual was actually reporting a mental health concern or was lying.	No Violation of Policy
	Olympic Corrections Center		
114.	Incarcerated individual reported concern regarding the behavior incentive program at OCC. The individual reports when a person is transferred to OCC they are placed in a specific unit and DOC confiscates their TV while living in this unit. The individuals are required to earn the personal TV back with good behavior. The individual requested the OCO investigate if this practice is a policy violation.	The OCO provided assistance. The OCO spoke with facility leadership and confirmed incarcerated individuals were having their personal TVs confiscated as part of the incentive program. The OCO verified that this practice does not occur at other camps and recommended that the individuals be allowed their personal TVs. DOC leadership agreed and is implementing a process to allow everyone in the unit to have their personal TVs.	Assistance Provided
115.	Incarcerated individual 8 reported concern regarding the behavior incentive program at OCC. The individual reports when a person is transferred to OCC they are placed in a specific unit and DOC confiscates their TV while living in this unit. The individuals are required to earn the personal TV back with good behavior. The individual requested the OCO	The OCO provided assistance. The OCO spoke with facility leadership and confirmed incarcerated individuals were having their personal TVs confiscated as part of the incentive program. The OCO verified that this practice does not occur at other camps and recommended that the individuals be allowed their personal TVs. DOC leadership agreed and is implementing a process to allow everyone in the unit to have their personal TVs.	Assistance Provided

	investigate if this practice is a policy violation.		
116.	Incarcerated individual 4 reported concern regarding the behavior incentive program at OCC. The individual reports when a person is transferred to OCC they are placed in a specific unit and DOC confiscates their TV while living in this unit. The individuals are required to earn the personal TV back with good behavior. The individual requested the OCO investigate if this practice is a policy violation.	The OCO provided assistance. The OCO spoke with facility leadership and confirmed incarcerated individuals were having their personal TVs confiscated as part of the incentive program. The OCO verified that this practice does not occur at other camps and recommended that the individuals be allowed their personal TVs. DOC leadership agreed and is implementing a process to allow everyone in the unit to have their personal TVs.	Assistance Provided
117.	Incarcerated individual 1 reported concern regarding the behavior incentive program at OCC. The individual reports when a person is transferred to OCC they are placed in a specific unit and DOC confiscates their TV while living in this unit. The individuals are required to earn the personal TV back with good behavior. The individual requested the OCO investigate if this practice is a policy violation.	The OCO provided assistance. The OCO spoke with facility leadership and confirmed incarcerated individuals were having their personal TVs confiscated as part of the incentive program. The OCO verified that this practice does not occur at other camps and recommended that the individuals be allowed their personal TVs. DOC leadership agreed and is implementing a process to allow everyone in the unit to have their personal TVs.	Assistance Provided
118.	Incarcerated individual 7 reported concern regarding the behavior incentive program at OCC. The individual reports when a person is transferred to OCC they are placed in a specific unit and DOC confiscates their TV while living in this unit. The individuals are required to earn the personal TV back with good behavior. The individual requested the OCO investigate if this practice is a policy violation.	The OCO provided assistance. The OCO spoke with facility leadership and confirmed incarcerated individuals were having their personal TVs confiscated as part of the incentive program. The OCO verified that this practice does not occur at other camps and recommended that the individuals be allowed their personal TVs. DOC leadership agreed and is implementing a process to allow everyone in the unit to have their personal TVs.	Assistance Provided
119.	Incarcerated individual 6 reported concern regarding the behavior incentive program at OCC. The individual reports when a person is transferred to OCC they are placed in a specific unit and DOC confiscates their TV while living in	The OCO provided assistance. The OCO spoke with facility leadership and confirmed incarcerated individuals were having their personal TVs confiscated as part of the incentive program. The OCO verified that this practice does not occur at other camps and recommended that the individuals be	Assistance Provided

	this unit. The individuals are required to earn the personal TV back with good behavior. The individual requested the OCO investigate if this practice is a policy violation.	allowed their personal TVs. DOC leadership agreed and is implementing a process to allow everyone in the unit to have their personal TVs.	
120.	Incarcerated individual 2 reported concern regarding the behavior incentive program at OCC. The individual reports when a person is transferred to OCC, they are placed in a specific unit and DOC confiscates their TV while living in this unit. The individuals are required to earn the personal TV back with good behavior. The individual requested the OCO investigate if this practice is a policy violation.	The OCO provided assistance. The OCO spoke with facility leadership and confirmed incarcerated individuals were having their personal TVs confiscated as part of the incentive program. The OCO verified that this practice does not occur at other camps and recommended that the individuals be allowed their personal TVs. DOC leadership agreed and is implementing a process to allow everyone in the unit to have their personal TVs.	Assistance Provided
121.	Incarcerated individual 5 reported concern regarding the behavior incentive program at OCC. The individual reports when a person is transferred to OCC they are placed in a specific unit and DOC confiscates their TV while living in this unit. The individuals are required to earn the personal TV back with good behavior. The individual requested the OCO investigate if this practice is a policy violation.	The OCO provided assistance. The OCO spoke with facility leadership and confirmed incarcerated individuals were having their personal TVs confiscated as part of the incentive program. The OCO verified that this practice does not occur at other camps and recommended that the individuals be allowed their personal TVs. DOC leadership agreed and is implementing a process to allow everyone in the unit to have their personal TVs.	Assistance Provided
122.	External person contacted the OCO to ask for help finding legal representation.	The OCO provided information at the time of contact advising that the OCO does not provide legal advice or referrals to legal representation.	Information Provided
	Other - Jail/County/City		
123.	Individual reported concerns regarding a county jail.	The OCO provided information over the phone about how to report concerns related to the county jail and explained OCO's jurisdiction. The OCO cannot review concerns about county jails.	Information Provided
124.	Person reported not being given the full amount of credit for time served while in county jail and described issues with how his time was calculated.	The OCO provided information about writing to DOC Records and requesting an audit of his time calculation.	Information Provided

Stafford Creek Corrections Center			
125.	An anonymous person reported that the mailroom is not properly handling OCO letters and is processing it like legal mail.	The OCO contacted the Superintendent to discuss this concern. The Superintendent will remind the mailroom staff not to process the OCO mail the same as legal mail.	Assistance Provided
126.	Incarcerated person reported an issue related to an infraction.	DOC staff resolved this concern prior to the OCO taking action on this complaint. IGN identified by incarcerated person does not appear in the incarcerated person's records any longer.	DOC Resolved
127.	Person reported that a DOC substantiated his resolution request regarding a refund that was supposed to be transferred to his account, but the refund has not happened yet.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reached out to the finance and accounts office at the facility, and they confirmed that the refund was transferred to this individual's account.	DOC Resolved
128.	Loved one expressed concerns about an incarcerated individual transferring facilities and not getting access to their property.	The OCO reviewed the grievance the individual filed regarding this concern and confirmed the individual was placed on the call out to receive their property, thus, DOC resolved this concern prior to OCO involvement.	DOC Resolved
129.	Incarcerated individual expressed concerns about an infraction they received.	The OCO confirmed the infraction was dismissed by DOC prior to OCO involvement.	DOC Resolved
130.	Incarcerated individual reported concerns with the AMEND program and reports the program is not being facilitated as it was said to be. The individual requests more information about the AMEND program, and how DOC intends to implement it.	The OCO provided the individual with information about the AMEND program at the facility they are located. The OCO shared that briefly the AMEND program was halted, but is now in operation. The OCO shared with the individual how to request more information about the AMEND program in this state, and how to discuss concerns directly with onsite staff members.	Information Provided
131.	Incarcerated individual expressed concerns about the denial of a visitor.	The OCO provided information to the individual about the visitation denial reason.	Information Provided
132.	Person reported filing a tort claim but has not received a response to the tort. Person requested information about contacting the Department of Enterprise Services Office of Risk Management.	The OCO provided information over the hotline about how to write to the Department of Enterprise Services Office of Risk Management. The OCO lacks jurisdiction over the Department of Enterprise Services and does not have access to their records.	Information Provided
133.	Incarcerated individual reported they were removed from their unit unjustly by DOC staff. The individual	The OCO provided the individual with information about how to be considered for placement into the unit he wishes to be in.	Information Provided

	asks that the OCO assist him by requesting DOC transfer him back into the unit he was removed from.	The OCO reviewed the DOC's reason to remove the individual and found the move was required for safety reasons. The individual was screened for the unit after he was removed and denied due to continued infraction behavior. The OCO shared with the individual how to request to be re screened after he has remained infraction free and shown positive behavior per the DOC protocol.	
134.	Incarcerated individual relayed concerns regarding their eligibility under the new DOC memo to have two 752 (positive urinary analysis) infractions dismissed.	The OCO informed the individual that DOC has not yet published an official policy regarding the process changes to the presumptive drug testing, however, based on the September 6, 2023 DOC memo, headquarters has compiled a list of all individuals who are eligible to have their infractions overturned from the past two years and is sending letters to those who have had changes made to their records as a result.	Information Provided
135.	Incarcerated individual relayed concerns regarding changes in DOC policy that negatively impact incarcerated artists.	The OCO provided the individual with information that confirmed the changes made to DOC Policy 540.105 are currently being revised.	Information Provided
136.	Person reported that his property was damaged by staff. Person said that he filed a tort claim and it was rejected by the Department of Enterprise Services.	The OCO provided information. The OCO lacks jurisdiction over the Department of Enterprise Services and cannot take any action when they have rejected a tort claim. RCW 4.92.100 states, "(1) All claims against the state, or against the state's officers, employees, or volunteers, acting in such capacity, for damages arising out of tortious conduct, must be presented to the Office of Risk Management."	Information Provided
137.	Incarcerated individual reported concerns regarding SCCC taking out the paper towel dispensers in the minimum security units. The individual reports this decision is unsanitary as the new process to dry one's hands is to be issued reusable hand towels to dry their hands.	The OCO provided information regarding DOC's decision to remove paper towels from he bathrooms. The OCO spoke with SCCC leadership who reported that due to the excessive use of paper towels from the bathroom, and in an effort to be more environmentally conscious they are not going to allow paper towels in the bathroom further.	Information Provided
138.	A former DOC employee reported concerns about healthcare staff conduct.	The OCO documented the reported incidents and provided the individual with information via phone about additional outlets for addressing these concerns including the WA	Information Provided

		State Ethics Board and whistleblower program with the WA State Auditor. The OCO lacked jurisdiction over the complaint because the complaint was not about an incarcerated individual.	
139.	Incarcerated individual reported concern about DOC rejecting items used for tabletop role playing games. The individual had questions about how to resolve this within DOC and shared information about this concern they thought might be helpful to us in resolving this issue.	The OCO provided information regarding how to have the concerns addressed by the DOC. The OCO also shared that DOC is working to identify what items for tabletop role playing games will be accepted into the facility. Currently DOC mailrooms are allowing property to enter DOC facilities in compliance with the current DOC policies.	Information Provided
140.	Incarcerated individual reported concerns regarding SCCC taking out the paper towel dispensers in the minimum security units. The individual reports this decision is unsanitary as the new process to dry one's hands is to be issued reusable hand towels to dry their hands. The individual reports concerns about this process during a COVID-19 outbreak.	The OCO provided information regarding DOC's decision to remove paper towels from he bathrooms. The OCO spoke with SCCC leadership who reported that due to the excessive use of paper towels from the bathroom, and in an effort to be more environmentally conscious they are not going to allow paper towels in the bathroom further.	Information Provided
141.	Incarcerated person reported he has negative BOEs and states he is being antagonized by a CO in the IMU.	The OCO visited this individual in person to discuss this concern. During the visit, the individual indicated he was not concerned about this complaint any longer and wanted to talk about his property. This office verified that the individual has multiple negative BOEs from multiple staff members regarding abusive language and sexual comments.	Insufficient Evidence to Substantiate
142.	Patient reported issues accessing pain medication for an injury.	The OCO was unable to substantiate the concern due to insufficient evidence. This office contacted health services to confirm current access to treatment.	Insufficient Evidence to Substantiate
143.	An external person reported that the incarcerated individual was placed under an investigation which had a due date, but the date has passed and the person has not received any paperwork or information regarding an infraction or an extension.	The OCO was unable to substantiate a violation of policy by DOC. This office verified that the individual did receive an infraction, and the infraction and hearing were completed per DOC 460.000, Disciplinary Process for Prisons.	No Violation of Policy
144.	The individual reported that he was denied Extended Family Visits (EFVs) with his wife. He reports that he provided the DOC with	The OCO was unable to substantiate a violation of policy by DOC. Per DOC 590.100, Extended Family Visiting, an individual may be denied based on the nature of the crime,	No Violation of Policy

	documentation regarding the Domestic Violence (DV) indicator to show that it was related to divorce proceedings and should not be reason for denying him and his wife EFVs.	criminal history, and current/prior behavior. If there is reason to believe that an eligible individual is a danger to self, the visitor(s), or the orderly operation of the program, the Superintendent/designee may exclude the individual from the program. This office spoke with DOC HQ staff who confirmed there are safety and security issues from a previous incident involving the individual and their visitor and he was not denied due to DV indicators. The individual and his loved one may reapply for EFVs one year from receiving the outcome of the appeal.	
145.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction narrative and was unable to locate a violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
	Washington Corrections Center		
146.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction and appeal narrative and found the individual was able to provide a witness statement that another individual claimed possession of the contraband, thereby meeting the WAC requirement laid out in WAC 137-96-100 that states "each offender of a multiple offender cell will be held accountable for an infraction that occurs within the confines of such cell unless they can establish a lack of involvement in the infraction. All individual's assigned to the cell are infracted and it rests upon the individual to present evidence at the disciplinary hearing to establish lack of involvement in the incident." As a result, the OCO contacted DOC about dismissing the infraction and DOC agreed.	Assistance Provided
147.	Person reported that he was left without necessary medications for two weeks despite having sent a kite to medical for the orders to be renewed. The incident resulted in the patient having seizures on the unit.	The OCO provided assistance. OCO staff reviewed medical records and kites and determined that DOC staff did not forward the patient's request because his kite request required action by two separate healthcare disciplines. Per the Pharmaceutical Management and formulary manual it is the patient's responsibility to notify the pharmacy of a refill need by available means. The protocol does not indicate that a patient needs to send separate kites to each healthcare discipline. OCO staff elevated this	Assistance Provided

		concern to DOC Health Services administration and DOC Health Services leadership. OCO staff are also working with DOC Health Services leadership on updates to the current pharmacy protocols.	
148.	External individual expressed concerns about an incarcerated individual not being able to have visits as the result of an infraction.	The OCO informed the individual that per DOC policy 460.050, there is a mandatory 180 day suspension of visitation for a 603 introduction of drugs infraction.	Information Provided
149.	Person reported that he was told that DOC medical denied surgery for a medical condition.	The OCO provided information to the patient regarding the DOC Health Plan and care review committee appeal process. OCO staff contacted Health Services management and were informed that surgery is not clinically indicated at this time.	Information Provided
150.	An external person reported that the incarcerated individual was transferred to a facility where he has safety concerns. The person reports that DOC staff said he may be transferred out of state. The person says that the individual would like to stay on the west side of the state to be closer to family.	The OCO provided information. This office reviewed the individual's Custody Facility Plan (CFP) and found that it was completed per DOC 300.380, Classification and Custody Facility Plan Review. The individual has multiple keep separates at several facilities, which limits his placement options in WA DOC. Per DOC 330.600, Prison Compact, "Individuals under the Department's jurisdiction may be considered for a Prisons Compact transfer for safety/security." The OCO verified that the DOC is working on his out of state placement. Policy does not dictate timeframes for finding an out of state placement.	Information Provided
151.	Incarcerated individual relayed concerns regarding an infraction they received, not having Ombuds forms and not being able to access the law library.	The OCO reviewed the infraction and confirmed that it was dismissed by DOC prior to OCO involvement. This office also provided the CUS with an Ombuds Review Request form in the event that the units runs out and provided the individual with the process to access the law library.	Information Provided
152.	Person reported that they were put in a dry cell because someone reported that while he was visiting with his family, they had passed drugs to him. During their time in the dry cell, they were put on "boats" which is hard sandwiches and a piece of fruit to eat. They were also given a super hard mattress to sleep on. Every 8 hours there is supposed to be a lieutenant	The OCO reviewed DOC 420.311 to verify if the DOC was in compliance with policy. The placement in dry cell was within policy and he was returned to general population after three bowel movements. The conditions of confinement in policy list one mattress and one pillow, however it does not specify what kind of mattress, it also does not specify what kind of food should be served. The OCO confirmed the initial temperature check was done upon placement but could not confirm	Information Provided

	on shift who is checking the temp of the room, and that never happened. He only saw a lieutenant twice.	if it was done after that. Individuals who have been harmed or who have suffered loss as a result of a negligent action by a state employee or agency can submit a tort claim to DES Office of Risk Management. The OCO provided information on how to file a Tort claim if he feels he was injured or harmed during this incident.	
153.	Incarcerated individual expressed concerns about an infraction they received.	The OCO provided the individual with information regarding the lowering of an infraction to a general and the restoration of good conduct time.	Information Provided
154.	Incarcerated individual expressed frustrations with the interest that accrues on the mandatory savings account.	The OCO informed the individual that DOC policy 200.000 Trust Accounts which includes inmate banking is not currently up for review, but once this policy does become eligible for public comment, the OCO will consider this concern in the policy comments this office provides to DOC.	Information Provided
155.	The individual reported that he asked to have certain names removed from his JPay account, but DOC instead restricted those people and he is unable to write to them through Securus.	The OCO provided information. The individual may kite IIU to have a person unrestricted from their Securus contacts.	Information Provided
156.	Incarcerated individual reported his cell was flooding bio-waste and DOC staff did not take him out of the cell.	The OCO provided information about why the individual was not immediately removed from the cell. The OCO spoke with facility staff and they explained that incarcerated individuals were taken out of their cells during the flooding three at a time due to threats being made toward staff on the tier. DOC staff determined there could be a safety issue if the individuals were all allowed to move at the same time, due to the threats being made toward DOC staff. The DOC explained that they were unable to substantiate that the flooding water was bio-waste.	Information Provided
157.	External person requested information from the OCO via the OCO hotline.	The OCO provided information at the time of the original phone call.	Information Provided
158.	Incarcerated individual reported concerns with the housing voucher program.	The OCO provided information regarding the housing voucher program. The OCO found the individual is not yet release planning. This office shared that once his release planning starts, it's important to communicate with the classification counselor. If after the	Information Provided

		release planning starts and there are still concerns or delays, please call this office again for further assistance.	
159.	The individual reported that his Extended Family Visits (EFVs) were terminated and says the reasons given by the DOC were not accurate.	The OCO provided information regarding why the individual's EFVs were terminated. The individual received an infraction which flagged DOC HQ staff to review his EFVs. The infraction was ultimately dismissed but this caused the DOC to review the individual's EFVs. Per DOC 590.100, Extended Family Visiting, the applicant must be on the individual's approved visitor list per DOC 450.100, Visits for Incarcerated Individuals, and have previously visited the individual a minimum of six times, to include video visits, within the last 12 months. This office informed the individual that he may reapply after one year of his EFVs being terminated, and will need to meet the regular visitation requirements per policy.	Information Provided
160.	Person stated he has tried to contact medical several time to access care for multiple health concerns. The person states that his kites have gone unanswered.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff reviewed the patient records and were unable to substantiate that DOC staff did not respond to the patient. OCO staff confirmed the patient has received care for multiple issues.	Insufficient Evidence to Substantiate
161.	An external person reported that they were removed from another incarcerated individual's visiting list due to introduction of contraband. The person is now trying to visit another incarcerated individual but was denied due to the past incident.	The OCO was unable to substantiate a violation of policy by DOC. Per DOC 450.300, Visits for Incarcerated Individuals, Persons identified as being involved in attempting/conspiring to introduce, or aiding and abetting another to introduce contraband, in any way, will have their visit privileges suspended or terminated. Visitors who receive notification that their opportunities for appeal have been exhausted may resubmit an application after one year to be considered for restoration of modified or full visit privileges.	No Violation of Policy
162.	Person reported DOC is still requiring COVID testing prior to dental procedures. The person is requesting that testing be stopped because staff no longer have to test before coming to work.	The OCO was unable to substantiate a violation of policy by DOC. Per the DOC COVID-19 testing and Infection Control protocol, Healthcare providers may require testing prior to surgical, dental, or other aerosolizing procedures. Until that protocol is rescinded by DOC it is valid, regardless of the	No Violation of Policy

		community infection mitigation efforts changing.	
163.	Person reported that books and photos are being rejected by the mailroom, and that he has been approved correspondence through education. Person reported that he has gotten his books, but he received them late.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The OCO reviewed the rejected messages and found that they were personal messages rejected as sexually explicit material following DOC's current interpretation of WAC 137-48-20 (13). The OCO could not find any rejected mail containing books or educational materials.	No Violation of Policy
164.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction narrative and found the individual's behavior met the infraction elements, and was thus unable to locate a violation of DOC policy 460.000.	No Violation of Policy
165.	External person reported an incarcerated individual is being housed in segregation without valid cause.	The OCO was unable to substantiate a violation of policy by the DOC. The OCO reviewed the DOC's decision to place the individual in segregation was within policy and completed for safety reasons until the DOC can transfer him to another facility. The OCO verified that the DOC completed this placement in compliance with DOC 450.050, Prohibited Contact.	No Violation of Policy
Washington Corrections Center for Women			
166.	The individual reported concerns with the Resolution Program. The person says that when they file resolution requests the issue is not resolved or responded to which makes it difficult to exhaust administrative remedies before filing lawsuits. The individual believes that this the DOC is doing this deliberately to prevent legal action against the DOC. The individual also reports that the law library application has been not been working, which is preventing legal access for incarcerated individuals at the facility.	The OCO provided assistance. This office spoke with DOC HQ staff who confirmed that the law library application is now working after having the tablets reset by Securus. The OCO also reviewed the individual's resolution requests and found that most were not appealed within the Resolution Program Manual (RPM) timeframes and thus the appeals were not accepted.	Assistance Provided
167.	Incarcerated person reported they are not able to appeal a resolution request due to no forms being available	The OCO provided assistance. The OCO reached out to staff at the facility and asked them to refill forms. Verified incarcerated person filled a new form on 09/07	Assistance Provided
168.	Person reported being on maximum custody for months and was told she	DOC staff resolved this concern prior to the OCO taking action on this complaint. The	DOC Resolved

	was supposed to be given more privileges as a result of good behavior. Person was also told that she would be assigned a behavioral program, but that has not happened yet.	OCO reviewed DOC records and found that this individual has been promoted to a lower level of confinement. The OCO verified that she has not been placed in the behavioral program yet, but that it is listed as a requirement on her Custody Facility Plan.	
169.	The individual reported concerns regarding the visiting room at the facility being exceptionally hot during warm summer days. The individual reports she has asked for fans, ice, or doors to be left open but DOC staff have not followed through with any of the proposed solutions. The individual reports that her mother suffered due to the extreme head during a visit.	The OCO provided information. This office is not able to resolve a past issue, but will review heat mitigation plans at the facility when the weather changes next year.	Information Provided
170.	Person reported that she has had to explain her religious restrictions to receiving certain types of care to multiple specialists. She is requesting that DOC send her to a specialist that she had in the community who is aware of these restrictions so she doesn't have to keep explaining them.	The OCO provided information to the person regarding the informed consent process. For every medical procedure there are associated risks that must be addressed prior to the procedure. If the patient chooses to decline potentially lifesaving measures, that must be discussed before every procedure.	Information Provided
171.	External individual reported concerns that DOC is not allowing an incarcerated individual live in the same unit as their sibling. The external individual reports there is no reason they cannot be housed in the same area.	The OCO provided the individual with information. The OCO verified by speaking with DOC staff that the siblings were not separated due to being related. The OCO found the individuals were separated due to behavioral issues while in the same unit and due to an unrelated custody demotion of one individual that resulted in a transfer. The DOC staff explained they have no issue in allowing family members to reside in the same unit.	Information Provided
172.	Patient reported her Suboxone dose has been changed multiple times and requested a higher dose.	The OCO elevated this concern to health services leadership at the facility. After initial outreach, the OCO confirmed the patient was scheduled and met with her provider to address concerns about medication dose, which was increased at this appointment. The patient was scheduled for a follow up but the appointment was no showed. The OCO provided the patient with information about how to follow up for the missed appointment and pathway for addressing medication doses in the future.	Information Provided

173.	Person reported staff conduct and access concerns related to therapeutic community (TC). Person requested to be removed from TC and to talk with a mental health provider.	The OCO elevated this concern through DOC leadership. This office confirmed an active PREA investigation and therapeutic programming to be determined at conclusion of investigation. The OCO confirmed the patient was scheduled with mental health. In the meantime, the patient can also discuss intensive outpatient or day treatment options with the Substance Abuse Recovery Unit (SARU). A new case was opened for staff conduct and retaliation updates.	Information Provided
174.	Incarcerated individual expressed concerns about their custody facility plan and custody score.	The OCO reviewed the individual's custody facility plan and explained to the individual the rationale for why they were placed at said custody score.	Information Provided
175.	The individual reported that she attended in her Facility Risk Management Team Review and appealed her Custody Facility Plan (CFP) but has not been notified of the outcome of the appeal.	The OCO provided information. This office verified that the individual is approved for a reentry center so long as she is willing to participate in mandatory programming.	Information Provided
176.	Person reported wanting to go back to living with her old cellmate again.	The OCO provided information about requesting a courtesy move through the Custody Unit Supervisor.	Information Provided
177.	The individual reported that she was approved for Graduated Reentry (GRE) last year but was told she was denied this year due to being returned as a Drug Offender Sentencing Alternative reclassification. The individual does not understand why she was later denied.	The OCO was unable to substantiate a violation of policy by the DOC. Per DOC 390.590, Graduated Reentry, Individuals who have already served time in partial confinement during the current Prison sentence and have been returned to total confinement as a Community Custody Prisons or Drug Offender Sentencing Alternative reclassification, may not be eligible for placement or for the full amount of participation time per statute.	No Violation of Policy
178.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction narrative and contacted DOC regarding the potential to have the infraction dismissed due to the limited nature of the evidence, however, DOC upheld the guilty finding.	No Violation of Policy
179.	Person reported that she was moved to a dormitory unit in retaliation for complaining about being targeted by a DOC staff member. Person said that she is being forced to participate in a program so that she can leave the dormitory.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed DOC documents and found that this person has been moved out of the dorm. The OCO found that the program she was enrolled in was required by her Judgement and Sentencing and does not violate DOC policy.	No Violation of Policy

180.	The individual reported that she is not allowed to participate in Graduated Reentry. She wants to release to a reentry program to increase her changes of success on the outside, but she is being prevented from participating in these programs.	The OCO was unable to substantiate a violation of policy by the DOC. Per DOC 390.590, Graduated Reentry, Referrals to Graduated Reentry may be made up to 30 months before the Earned Release Date (ERD). The OCO verified that the individual entered prison at six months to her ERD.	No Violation of Policy
Washington State Penitentiary			
181.	Person reported that an out of state warrant detainer was supposed to be lifted, because he has been tried on those charges and they are supposed to run concurrent to his current sentence. Person said his Judgement and Sentencing was sent to his counselor, but DOC Records has not updated or resolved the issue within the timeline they were supposed to.	The OCO provided assistance. The OCO reviewed the warrant detainers and reached out to DOC Records, who clarified that the detainers will remain until he is finished with his sentence in Washington, because he will be transferred out of state to complete his sentence on these new charges. DOC Records acknowledged that they failed to update this individual on the issue, and reached out to the individual to update him upon the OCO's request.	Assistance Provided
182.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction and appeal narrative and found the individual was able to provide a witness statement that another individual claimed possession of the contraband, thereby meeting the WAC requirement laid out in WAC 137-96-100 that states "each offender of a multiple offender cell will be held accountable for an infraction that occurs within the confines of such cell unless they can establish a lack of involvement in the infraction. All individual's assigned to the cell are infracted and it rests upon the individual to present evidence at the disciplinary hearing to establish lack of involvement in the incident." As a result, the OCO contacted DOC about dismissing the infraction and DOC agreed.	Assistance Provided
183.	An individual reported that an incarcerated individual was treated poorly by a DOC staff member and unjustly placed in segregation.	The OCO spoke with facility staff and assisted by requesting that the incarcerated individual be released from segregation. However, 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 further assistance.	Assistance Provided

184.	Incarcerated individual reported concern regarding potential maximum custody placement. The person reported that they were experiencing distress and had concern for their mental wellbeing.	The OCO provided assistance. The OCO immediately made outreach to DOC staff to ensure mental health staff were aware of the concern. Due to OCO outreach, the individual was able to speak with mental health staff the same day. The OCO also shared information with the individual regarding the custody facility plan (CFP) process and how to be an active part of it. The OCO recommended that he appeal the classification decision by completing DOC 07-037 Classification Appeal within 72 hours of receiving the decision.	Assistance Provided
185.	Person reported they appealed mental health committee decision to transfer facilities and has not received a response from DOC.	The OCO provided assistance by contacting the Director of Behavioral Health about the issue. DOC agreed to provide an appeal response.	Assistance Provided
186.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the individual's infraction history and did not see an infraction matching the provided description that occurred on or about the date given. Thus, the data in the person's electronic file indicated that the infraction had been dismissed prior to OCO involvement.	DOC Resolved
187.	Person reported that he was qualified for Graduated Reentry (GRE) and was approved for a reentry center. Person said that a warrant was preventing his transfer, and that after he cleared the warrant his file still reflected his old warrant status.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and found that this individual has been transferred to the reentry center.	DOC Resolved
188.	Person reported he has a medical condition that requires different shoes than are provided by the DOC. He is also supposed to be seen by a podiatrist in the community.	DOC staff resolved this concern prior to OCO involvement. OCO reviewed records and verified the patient's appointment was scheduled and that the necessary Durable Medical Equipment was ordered. OCO staff will monitor the appointment on the tracker until completion.	DOC Resolved
189.	Person reported that an infraction made him ineligible for a DOC housing voucher, which led to concerns that his release plan might not get approved because he would not have enough money for his approved housing option.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and found that this individual's release plan was approved and that he was released.	DOC Resolved

190.	External person reported that inaccurate records are being shared amongst DOC staff.	The OCO has reviewed this concern multiple times regarding this issue. The records in question, have been corrected in the DOC system. However, the original record, from the courts, cannot be altered. The OCO has verified that most DOC staff have access to all records in the OMNI system and suggested a change in access based on staff positions.	Information Provided
191.	Incarcerated individual reported that DOC resolutions does not have a proper protocol for addressing emergency resolutions requests. The individual requests the DOC change their process to respond to emergency resolution requests within five minutes.	The OCO provided information about how to provide suggestions to the DOC resolutions program at DOC headquarters. The OCO has taken the suggestions into consideration and may utilize the suggestions in conversations with DOC.	Information Provided
192.	The individual reported that the Law Librarian asked him to write the case numbers on forms DOC 19-084, Legal Copy/Indigent Postage Scanning Request, because he has multiple court cases, but he reports there isn't a place on the form to write the case numbers.	The OCO provided information. This office informed the individual that he will need to use one form per cause/case number.	Information Provided
193.	The individual reported that the facility recently increased the amount of minutes of yard time and decreased the number of times DOC staff come through per shift from three times to two times. The individual reports that the amount of time in yard is very long without access to water, toilets, or pull-up bars. The individual says that the increase in yard time is just for optics and hardly anyone remains in yard for that long.	The OCO provided information. This office spoke with the Correctional Unit Supervisor (CUS) of the IMU who reports individuals are offered up to three hours of yard time seven days per week, and unit staff conduct checks every 30 minutes. If an individual needs to use the bathroom or drink water, they will be taken back to their cell. Individuals in the IMU are made aware of their yard schedule and are given notice before their yard time so they may use the bathroom or drink water. The unit does not currently have the resources to escort individuals to and from yard to their cells, so if they request to return to their cell they will not be taken back to yard. The facility currently has plans to build outside recreation areas for individuals in the IMU which will have bathrooms and drinking water for the population to use during yard time.	Information Provided
194.	Person reported ongoing issue after DOC policy revision of policy 300.380. The revisions eliminated family as a consideration for	The OCO is currently drafting comments for multiple DOC policies that are up for review, including DOC 300.380.	Information Provided

	placement in any prison and took away hardship and prisoner ability to request transfer to another facility unless promoting or demoting custody levels.		
195.	Incarcerated person called hotline to request information on the hours.	The OCO provided information regarding the Office of the Corrections Ombuds hotline schedule.	Information Provided
196.	An incarcerated person contacted the OCO to report that a newspaper subscription they pay for was not delivered to their cell and was held at the desk in the unit they were housed in. As a result DOC staff kept the paper and read it and they never got the July paper. They report they have received the August and September issues.	The OCO provided information regarding the process taken to review their complaint and that the OCO is unable to find their missing newspaper.	Information Provided
197.	Incarcerated individual reported concern regarding legal financial obligations (LFO's). The individual was concerned about a document they received related to LFO's.	The OCO provided information about how to gain more information about his LFO's. The OCO shared that the document the individual was concerned about is a document to initiate a funds transfer. Individuals can request information about their current LFO's by sending a kiosk message to the facility records department. The OCO also shared that if the individual has specific concerns with their LFO's they can file a resolution request to have DOC staff review the concern.	Information Provided
198.	Person reported concerns about sanitation and access to hygiene items including razors for shaving while in the Close Observation Unit.	The OCO elevated the concerns to health services leadership who conducted a COA walk through and interviewed staff. Patients in COA are provided hygiene items to include toothbrush, toothpaste, soap, and shampoo. Razors are restricted in the COA due to safety risks and some items may be restricted for individuals based on their Conditions of Confinement. The OCO provided the individual with information about related policy DOC 320.265 Close Observation Areas.	Information Provided
199.	Incarcerated individual relayed concerns regarding changes in DOC policy that limit the allowable curio items.	The OCO provided information to the individual that confirmed the changes made to DOC Policy 540.105 are currently being revised.	Information Provided
200.	Incarcerated individual suggests DOC change to resolution request form to add boxes to let the	The OCO provided information about how to provide suggestions to the DOC resolutions program at DOC headquarters. The OCO has	Information Provided

	program know if a concern is urgent or if video would need to be held.	taken the suggestions into consideration and may utilize the suggestions in conversations with DOC.	
201.	Person reported that he when he was transferred to a new facility, many of his items did not arrive. Person reported that he already filed a tort claim, but that it was denied.	The OCO provided information. The OCO reviewed the resolutions request investigation, which stated that his new facility had received all of the property they had for him, and that his previous facility said they did not have any property for him in their property room, and recommended filing a tort claim. The OCO lacks jurisdiction over the Department of Enterprise Services Risk Management Division and cannot assist if a tort claim is denied.	Information Provided
202.	Incarcerated individual reported he wants to transfer to Graduated Re-Entry (GRE) or a re-entry center a soon as possible. The individual requests the OCO assist him in the transfer.	The OCO provided information. The OCO spoke with the classification counselor and requested she speak with him about GRE and re-entry center possibilities. The counselor was willing to discuss his applications with him and shared the status of his applications. Currently, the GRE approval is at DOC headquarters. The individual will get a final answer from DOC headquarters if he has not already.	Information Provided
203.	Person reported the Department of Health was at the facility recently and is wanting people to contact them to open investigations into mental healthcare. He is requesting information about how to contact them.	The OCO provided information about DOH's new complaint process, including mailing address and information from the DOH website.	Information Provided
204.	The individual reported concerns related to suicides at WSP.	The OCO provided information about the Unexpected Fatality Review Committee. 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 suicides at the facility. These cases were reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report was delivered to the Governor and state legislators for each review. Reports are also publicly available on the DOC website and through request in the Law Library.	Information Provided

205.	Person reported concerns about DOC throwing away commissary items after 30 days while in restricted housing for protective custody.	The OCO provided information about recent updates to WSP 440.000 Operational Memo related to management of consumable items in restrictive housing. DOC agreed to OCO's recommendation to update this policy, which now "allow[s] for property room employees to send allowable consumable items to the individuals living unit after appropriate inventory has occurred; additionally, if an individual has an approved transfer within 60 days of arriving in restrictive housing all consumables will be transferred with the individual. Consumable items will continue to not be sent to long-term storage."	Information Provided
206.	Person reported concern with separation orders and feels that others are using them to remove him from the unit, and that there is no process to appeal these keep separate orders.	The OCO provided information. The OCO reviewed this individual's separation orders. Per DOC 320.180 Separation and Facility Prohibition Management, an individual's separation/prohibition status is confidential, and case managers and investigative employees will discuss specific information with the individual to determine the need for continued separation. Separation orders are regularly reviewed, re-verified, and documented during regular review periods, to see if the risk still exists. The OCO could not find a violation of DOC 320.180 Separation and Facility Prohibition Management.	Information Provided
207.	Incarcerated individual reported cameras in solitary are facing the shower and requested OCO review. Person also requested to be released from solitary to general population upon completing program.	The OCO provided information about the pathway to general population. This office could not identify a related grievance for the shower concern and provided the individual with information about attempting resolution with DOC prior to OCO outreach. The OCO is planning a visit to the facility and will review the reported shower issue in person.	Information Provided
208.	External person reported the incarcerated individual has possibly attempted suicide three times in the span of a few weeks.	The OCO was unable to substantiate the concern due to insufficient evidence. This office contacted the facility Health Service Managers, reviewed records, and could not confirm the reported claim. The incarcerated individual communicated that they were not actively suicidal and requested the family member stop reporting this to DOC and others. The OCO provided information about how the incarcerated person can request assistance from the OCO directly.	Insufficient Evidence to Substantiate

209.	The individual reported concerns regarding the denial of a visitor.	The OCO was unable to substantiate a violation of policy by the DOC. This office verified that the individual and his visitor were denied per DOC 450.050 and DOC 490.800 and may reapply after three years.	No Violation of Policy
210.	The individual reported that his rights were violated when the DOC rejected his outgoing mail.	The OCO was unable to substantiate a violation of policy by DOC. Per DOC 450.100, Mail for Individuals in Prison, Attachment 1, Unauthorized Mail, mail may be rejected if it contains correspondence, information, or other items relating to another Washington State incarcerated individual(s) without prior approval from the Superintendent/designee, or attempts or conveys unauthorized correspondence between incarcerated individuals.	No Violation of Policy
211.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction narrative and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
212.	Person reported that the transport officers did not give him privacy in the restroom when out of the facility. The person reports that staff would not remove his cuffs for him to use the bathroom.	The OCO was unable to substantiate a violation of policy by DOC. Per DOC 420.100 officers are required to maintain a visual and auditory presence, including in the restroom. Per DOC 420.250 the officers cannot remove restraints without prior clearance. The OCO cannot recommend that DOC staff disregard policy.	No Violation of Policy
213.	The individual reported that he has not received all of the jail credits that he should have.	The OCO was unable to substantiate a violation of policy by DOC. This office spoke with DOC Records who verified that the individual was being held on both a DOC warrant as well as new local charges. As the individual was already under sentence obligations to report to the DOC, his supervision time is tolled (paused) while serving time on local charges, as he was not available for supervision and does not receive those credits towards his WA DOC sentence.	No Violation of Policy

INTAKE INVESTIGATIONS			
Airway Heights Corrections Center			
214.	Incarcerated individual expressed concerns about an infraction they received.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed an appeal as required by RCW 43.06C.	Administrative Remedies Not Pursued
215.	Incarcerated individual relayed concerns regarding Senate Bill 5131 not being followed regarding commissary.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
216.	Incarcerated individual expressed concerns about an infraction they received.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
217.	Incarcerated individual expressed concerns about DOC violating policy when conducting a cell search.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
218.	Incarcerated individual relayed concerns regarding their property missing.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
219.	Incarcerated individual relayed concerns regarding frustrations with facility placement.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
220.	Incarcerated individual expressed concerns about their curio disposition.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request as required by RCW 43.06C.	Administrative Remedies Not Pursued
221.	Incarcerated individual relayed concerns regarding the way a cell search was conducted and resulting staff conduct.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal,	Administrative Remedies Not Pursued

		or sought other administrative remedies as required by RCW 43.06C.	
222.	Incarcerated individual relayed concerns regarding issues with getting the proper shoes.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
223.	Incarcerated individual expressed a desire to have legal assistance.	The OCO declined to investigate this concern per WAC 138-10-040(3)(e) as the requested resolution is not within the ombuds' statutory power and authority.	Declined
224.	A loved one reported that an incarcerated individual is being targeted and harassed by staff.	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
	Clallam Bay Correctional Complex		
225.	The individual reports a medical concern related to a diagnosis he received last year. He has had a rash for over a year, and the nurse tells him there is no treatment.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
226.	Incarcerated individual expressed concerns about an infraction they received.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed an appeal as required by RCW 43.06C.	Administrative Remedies Not Pursued
227.	Loved one expressed concerns about staff misconduct.	The OCO declined to investigate this concern per WAC 138-10-040(3)(d) as the complaint does not allege a violation of policy, procedure of law due to no details regarding the staff misconduct being included in the complaint.	Declined
228.	A loved one called asking OCO for help getting an incarcerated person moved to a facility closer to her.	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
	Coyote Ridge Corrections Center		
229.	Incarcerated person reports they were sent a check but it has not been added to their account yet.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through	Administrative Remedies Not Pursued

		the DOC internal grievance process, administrative, or appellate process.	
230.	Incarcerated individual expressed concerns about their property missing.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
231.	Incarcerated individual relayed concerns regarding missing property.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
232.	Incarcerated person reports a concern related to DOC understaffing.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
233.	The incarcerated person reports the phones are cut off during count, and he is not allowed to file a resolution request because he is past his limit.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
234.	Incarcerated person reports an issue with gratuity pay but has not yet filed a resolution request.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process	Administrative Remedies Not Pursued
235.	Incarcerated individual expressed concerns about various issues at the facility they are housed at.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
236.	Incarcerated individual relayed concerns regarding an infraction they received despite having an HSR.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal,	Administrative Remedies Not Pursued

		or sought other administrative remedies as required by RCW 43.06C.	
237.	Person reports they are not receiving medical treatment - person has not filed a resolution request regarding lack of medical treatment.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
238.	Person reports a medical staff member left the patient observation post. The person also stated that the staff member took away someone's Health Status report and claims that staff member does not have authority to do so. He is requesting this person be removed from their position.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. The OCO does not have disciplinary authority over DOC staff and cannot impact the requested resolution.	Administrative Remedies Not Pursued
239.	The individual reports their community custody officer is blackmailing them and that a Police Department is covering up the issue.	The OCO lacks jurisdiction to review concerns regarding outside law enforcement and Community Custody concerns.	Lacked Jurisdiction
240.	A loved one reported that an incarcerated individual was given an infraction.	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
241.	Person reports he is disabled and dropped his glasses. When he asked for help, he said the CO would not help him and was rude.	The OCO reviewed this concern and the Resolution Request was found to be substantiated. The staff member was addressed regarding the issue and the incarcerated individual has since been released.	Person Released from DOC Prior to OCO Action
	Larch Corrections Center		
242.	The incarcerated individual reports receiving an infraction earlier this year and disagrees with the infraction narrative.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
	Monroe Correctional Complex		

243.	Incarcerated individual relayed concerns regarding community work crew.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
244.	The individual reports they are being denied a gate card because they declared a mental health emergency earlier this year.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
245.	Person reports that he used to have a Health Status Report (HSR) for medical shoes but the HSR expired and his provider is not renewing the HSR.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
246.	Incarcerated individual relayed concerns regarding their glasses being confiscated.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
247.	Incarcerated individual relayed concerns regarding problems surrounding job assignments.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
248.	Incarcerated person reports they were infracted for something that was the responsibility of another incarcerated person.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
249.	Incarcerated individual reports concerns regarding a strip search.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued

250.	Incarcerated individual expressed concerns about staff misconduct and an infraction they received.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
251.	Incarcerated individual relayed concerns regarding deductions from a spendable account.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
252.	Incarcerated individual relayed concerns regarding access to the law library.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
253.	The individual reports that an officer inappropriately touched him during a pat-down search.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
254.	Incarcerated person reports the ventilation system in the facility where they reside has visible dust clumps in the vents and is blowing dirty air. The person also reported they had not filed a resolution request about the issue.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
255.	An incarcerated person reports that an issue with a broken item in the unit.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. The Level 1 response provided to the resolution request on file indicates that the item has been fixed or is now working.	Administrative Remedies Not Pursued
256.	Incarcerated individual relayed concerns regarding their counselor's conduct.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued

257.	Incarcerated individual expressed concerns about their sentence.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Declined
258.	External person reports a concern related to conditions in the IMU. A letter was sent to the incarcerated person to ask if they wished OCO to assist. Additionally, no Grievance/RR has been filed.	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.	Declined
259.	CCR Reviewed 08/31/2023: Person reported that DOC staff jeopardized his safety because a corrections officer told him to call his relatives. Person feels that he was given a directive that put him in danger.	The OCO has declined to investigate this concern. Per WAC 138-10-040 (d), the ombuds may decline to investigate any complaint or may close any investigation of any complaint for any of the following reasons: The complaint does not allege violation of policy, procedure, or law. CCR completed 08/31/2023: CCR Committee reviewed, and no error was found in casework no change to Case Closure Reason.	Declined
260.	Person reports concerns about access to medical care and requested out of state transfer. Person also reported that he cannot access his legal documents.	The OCO confirmed legal access issue was addressed via an informal resolution where the person was added to the Law Library Priority Access List. As described in WAC 138-10-040(3), the OCO declined to investigate the complaint beyond the intake investigation phase because the requested resolution was not within the ombuds' statutory power and authority.	Declined
261.	Incarcerated individual expressed concerns about a CCP revoke that occurred 10 years ago.	The OCO declined to investigate the concern per WAC 138-10-040(3)(f) as the alleged violation is a past rather than ongoing issue.	Declined
262.	Incarcerated individual expressed concerns about wanting assistance getting songs copyrighted.	The OCO declined to investigate this concern per WAC 138-10-040(3)(e) as the requested resolution is not within the ombuds' statutory power and authority.	Declined
263.	Incarcerated Person requests help with finding legal representation and contacting the court.	Per RCW 43.06C.040(2)(e), the OCO lacks jurisdiction to investigate this complaint because the complaint relates to the person's underlying criminal conviction.	Lacked Jurisdiction
264.	External person reports that their friend is not receiving mental health and medical help.	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

Other			
265.	Incarcerated individual requested assistance obtaining criminal records.	The OCO declined to investigate this concern per WAC 138-10-040(3)(e) as the requested resolution is not within the ombuds' statutory power and authority.	Declined
266.	Incarcerated individual expressed concerns about their sentencing structure.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint as the individual is not within Washington DOC custody.	Declined
267.	Incarcerated individual expressed concerns about ineffective assistance of counsel.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Declined
268.	Incarcerated individual relayed concerns regarding a requested continuance for their DOSA revoke being denied.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Declined
269.	External person is requesting information/records from a county jail relating to a person incarcerated with DOC.	The OCO lacks jurisdiction to investigate the concern as the complaint relates to an action by an agency other than WA DOC, including other WA state agencies, local jurisdictions such as jails, or in another state.	Lacked Jurisdiction
270.	Individual relayed concerns regarding ADA access while on community custody.	The OCO was unable to further investigate this concern as the OCO lacks jurisdiction over community custody concerns.	Lacked Jurisdiction
271.	External individual expressed concerns about an individual not getting medical attention in jail.	The OCO is unable to further investigate this concern as the OCO lacks jurisdiction over jail facilities.	Lacked Jurisdiction
272.	Individual expressed concerns about lack of access to medical marijuana while on community custody.	The OCO was unable to further investigate this concern as the OCO lacks jurisdiction over community custody concerns.	Lacked Jurisdiction
273.	Complaint filed on behalf of a person incarcerated in the state of Oregon.	The OCO lacks jurisdiction to investigate this complaint because the complaint does not involve a person committed to the physical custody of the DOC.	Lacked Jurisdiction
Stafford Creek Corrections Center			
274.	Person reported DOC is sending him to a specialist for a medical condition. This person would prefer that his family be allowed to send in shoes that he knows will work rather than trying shoes from the specialist. The person is also requesting higher levels of pain management.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued

275.	Incarcerated individual expressed concerns regarding their pay.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request as required by RCW 43.06C.	Administrative Remedies Not Pursued
276.	An incarcerated person reports that DOC took a deduction out of a check inappropriately in 2020.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
277.	Incarcerated individual relayed concerns regarding scheduling conflicts with school and work.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
278.	Person reports he has issues with his Durable Medical Equipment (DME). He has requested the issue be fixed but has not been completed yet.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
279.	An incarcerated person contacted the OCO regarding a complaint related to the behavior of a DOC staff member.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process	Administrative Remedies Not Pursued
280.	Incarcerated individual relayed concerns regarding staff misconduct.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
281.	An incarcerated person called to report staff mistreating another incarcerated person.	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
282.	Individual reports difficulty finding a release address that meets his accessibility needs and is concerned this will delay his release.	The OCO met with the individual in-person during a facility visit. This office confirmed the individual was approved for housing and released from prison.	Person Released from DOC Prior to OCO Action

283.	Person reports they have not been provided an ADA accessible room. The person also reported that medical has not treated an injury and that his medical information was inappropriately shared.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
Washington Corrections Center			
284.	Incarcerated person reported being put in GED classes, but he already has a high school diploma. He is being told that the diploma is "being verified" but in the meantime he is being kept in the GED classes and not able to work. Says he does not have a long time in prison and wants to work.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. Additionally, this person was released prior to the OCO taking action on the complaint.	Administrative Remedies Not Pursued
285.	Incarcerated individual expressed concerns about potentially losing their job.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
286.	Incarcerated individual relayed concerns regarding the grievance process.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
287.	Complaint filed by external contact regarding an infraction.	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
288.	Person reported that he was supposed to be issued a Securus tablet, but that has not occurred yet.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
Washington Corrections Center for Women			
289.	Incarcerated individual relayed concerns regarding frustrations with the running of the Therapeutic Community program.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
290.	The individual reports that a false PREA was filed against them and the person who reported it was lying.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a	Administrative Remedies Not Pursued

	They are frustrated that the other incarcerated individual is not being held responsible for their actions.	complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	
291.	Incarcerated individual relayed concerns regarding staff conduct.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
292.	An incarcerated person reports that they are having issues with DOC banking but they have not filed a resolution request regarding the issue.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
293.	The incarcerated individual reports that the DOC has taken money from her account and is not explaining where the money is going.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
294.	Incarcerated individual expressed concerns about an infraction they received.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
295.	The individual reports that staff are ignoring her requests for toilet paper and soap.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
296.	Incarcerated person reports their meds were documented as being administered at 7pm but were not given until almost 12am.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
297.	Incarcerated individual expressed concerns about trash not being picked up and causing bugs.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated	Administrative Remedies Not Pursued

		individual filed a resolution request as required by RCW 43.06C.	
298.	The individual reports concerns regarding deductions taken from her accounts.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
Washington State Penitentiary			
299.	Incarcerated individual expressed concerns about staff misconduct.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
300.	Incarcerated individual expressed concerns about an infraction they received.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
301.	Incarcerated individual relayed concerns regarding staff conduct, appointment access and safety concerns.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
302.	Incarcerated individual expressed concerns about their sentence.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request as required by RCW 43.06C.	Administrative Remedies Not Pursued
303.	Incarcerated individual relayed concerns regarding changes Correctional Industries (CI) made to the butter and condiment packages.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	Administrative Remedies Not Pursued
304.	Person reports that staff are doing things to his food and had moved his belongings out of his cell when he was out for medical procedures. He has transferred and is no longer at the facility where this occurred.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
305.	Incarcerated individual relayed concerns regarding getting a photo confiscated.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated	Administrative Remedies Not Pursued

		individual filed a resolution request, appeal, or sought other administrative remedies as required by RCW 43.06C.	
306.	Incarcerated individual expressed concerns about several infractions they received.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed an appeal as required by RCW 43.06C.	Administrative Remedies Not Pursued
307.	Incarcerated person called OCO to report that they are unable to call their loved ones from the phone in the common area. States that they think their loved one's numbers are being blocked.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
308.	The individual reports the last three deposits his family made had deductions of 55%. He reports that due to his life without parole sentence, his deductions should total no more than 15%. He is requesting the deductions be reviewed and his money refunded.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
309.	Incarcerated individual expressed concerns about staff conduct.	At this time, the OCO is unable to further investigate the concern because this office is unable to verify that the incarcerated individual filed a resolution request as required by RCW 43.06C.	Administrative Remedies Not Pursued
310.	External individual expressed concerns about retaliation.	The OCO declined to investigate the concern per WAC 138-10-040(3)(d) as the details of the complaint do not allege a violation of policy, procedure, or law due to a lack of information contained in the filed complaint.	Declined
311.	Incarcerated individual relayed concerns regarding the fire suppression system at the facility and a desire to be in charge of the fire suppression system personally.	The OCO declined to investigate this concern per WAC 138-10-040(3)(e) as the requested resolution is not within the ombuds' statutory power and authority.	Declined
312.	A loved one of the incarcerated individual reports concerns regarding the denial of Extended Family Visits (EFVs).	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

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

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

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

Abbreviations & Glossary

ADA: Americans with Disabilities Act

AHCC: Airway Heights Corrections Center

ASR: Accommodation Status Report

BOE: Behavioral Observation Entry

CBCC: Clallam Bay Corrections Center

CCCC: Cedar Creek Corrections Center

CI: Correctional Industries

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

CO: Correctional Officer

CRC: Care Review Committee

CRCC: Coyote Ridge Corrections Center

CUS: Correctional Unit Supervisor

DES: Department of Enterprise Services

DOSA: Drug Offender Sentencing Alternative

EFV: Extended Family Visit

ERD: Earned Release Date

GRE: Graduated Reentry

HCSC: Headquarters Community Screening Committee

HSR: Health Status Report

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

J&S: Judgment and Sentence

MCC: Monroe Correctional Complex

MCCCW: Mission Creek Corrections Center for Women

OCC: Olympic Corrections Center

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

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

SCCC: Stafford Creek Corrections Center

SOTAP: Sex Offender Treatment and Assessment Program

SVP: Sexually Violent Predator

TC: Therapeutic Community

WaONE: Washington ONE ("Offender Needs Evaluation")

WCC: Washington Corrections Center

WCCW: Washington Corrections Center for Women

WSP: Washington State Penitentiary

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-005

Report to the Legislature

As required by RCW 72.09.770

September 14, 2023

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

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Unexpected Fatality Review Committee Report

UFR-23-005 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

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

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on August 10, 2023:

DOC Office of the Deputy Secretary

- Sean Murphy, Deputy Secretary

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr Karie Rainer, Director- Mental Health
- Dr. Zainab Ghazal, Administrator – Health Services
- Rae Simpson, Quality Systems Director
- Mary Beth Flygare, Project Manager
- Deborah Roberts, Program Manager
- Danielle Moe, Director of Nursing

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Jack Warner, Superintendent A -MCC/SOU/IMU
- Lorne Spooner, Correctional Operations Program Manager
- Jason Bennett, Superintendent SCCC

DOC Risk Mitigation

- Michael Pettersen, Director

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Brittany Tybo, Director – Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Judy Zerzan, Medical Director

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

Fatality Summary

Date of Birth: 1968 (55-years-old)

Date of Incarceration: March 2011

Date of Death: May 2023

At the time of his death, this incarcerated individual was housed in a residential treatment unit. The cause of death was blunt force injury to the head and torso. The manner of death was suicide.

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

Day of Injury	Event
20:25 hours	• Incarcerated individual (I/I) walked upstairs to the 2nd tier, walked past showers, approached the railing on the 2nd tier, stood on the railing and jumped.
20:26 hours	• Medical emergency called.
20:27 hours	• Head/Neck supported by custody officer.
20:28 hours	• 911 was notified.
20:29 hours	• Medical staff arrive on unit.
20:30 hours	• C- Collar attempted by RN2.
20:35 hours	• IV placed by RN2.
20:37 hours	• Emergency Medical Services (EMS) arrived on grounds.
20:38 hours	• C-Collar placed by RN2.
20:41 hours	• Emergency Medical Services (EMS) arrived in unit.
21:03 hours	• I/I was transported to hospital by ambulance.
Day of Death	**Event**
04:06 hours	• I/I was pronounced deceased by hospital staff.

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 that the incarcerated individual did not choose to engage with the primary care team significantly in his life. His last primary care visit was in 2021. The committee members felt that having an established primary care rapport may have added to his protective factors.

   2. The committee recommended DOC Health Services (HS) work to make an annual primary care visit standard for each resident in prisons.

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

   1. The Critical Incident Review found no deviations from policy or operational procedures and determined the medical emergency response to be appropriate for both the custody and health services staff.

   2. The CIR had the following recommendations:

      a. DOC should install linear barriers that continue to the ceiling on the 2nd tier in the residential treatment units to prevent the opportunity of jumping. Additional barriers should be put on the stairs.

      b. DOC should explore options for peer programming support groups to educate incarcerated individuals in suicide prevention.

C. The Department of Health (DOH) representative supported the Department's recommendations regarding annual primary care visits, peer support and training, and extended barriers on the tiers.

   1. DOH also offered to support the recommendations by providing resources on Adverse Childhood Experiences (ACES), trauma informed care, and peer support groups.

   2. The DOH representative inquired about the post care for staff that witnessed the incident. *Note: DOC's Director of Behavioral Health shared that services were provided and are continuing to be provided. In addition, information and check ins were provided to incarcerated individuals.*

D. The Office of the Corrections Ombuds (OCO) offered the following information and input:

1. The OCO asked for information on the wellness checks for incarcerated individuals on the tier after the suicide. The OCO asked that the wellness checks happen quickly after a significant event.
2. The OCO recommends DOC advertise the 988-suicide prevention hotline in prisons and have a memorandum of understanding with the 988 program to communicate emergent situations in need of DOC follow-up.
3. The OCO encouraged DOC to highlight the difficulty locating housing and treatment to support the community reentry of hard-to-place individuals. The OCO asked that DOC consider adding a trigger point for case management staff to request additional support when appropriate post-release housing cannot be located.

E. The Health Care Authority (HCA) representative supported the Department's recommendations regarding annual visits, peer training and support, and extended bars on the tiers.

Committee Findings

The incarcerated individual died as a result of suicide. The cause of death was blunt force injury to the head and torso after jumping from the 2nd tier railing.

Committee Recommendations

Table 1. UFR Committee Recommendations
1. DOC should install linear barriers that continue to the ceiling on the 2nd tier in the residential treatment units and the stairs.

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

1. The OCO highlighted the need for greater awareness of the lack of statewide post-prison housing and treatment resources for hard-to-place individuals which may impact release date. OCO requested DOC consider including a trigger for case managers to ask for additional supports in locating housing.

2. DOC should explore options for peer programming support groups to educate incarcerated individuals in suicide prevention**.**

3. DOC Health Services should explore proactively offering annual primary care visits for each incarcerated individual that has not been seen in the last calendar year.

4. DOC should explore options for utilization of the 988-suicide prevention hotline.

Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-23-005

Report to the Legislature

As required by RCW 72.09.770

September 24, 2023

DOC Corrective Action, Publication Number 600-PL001

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

Unexpected Fatality Review
DOC Corrective Action Plan

DOC Corrective Action Publication Number 600-PL001

Legislative Directive

Engrossed Substitute Senate Bill 5119 (2021)

Unexpected Fatality Review Governance

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

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

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

Unexpected Fatality Review Committee Report

The department issued the UFR committee report 23-005 on September 14, 2023 (DOC publication 600-SR001). This document includes the required corrective action plan. The department is required to implement the corrective actions within 120 days of the publication of the committee report.

Corrective Action Plan

CAP ID Number:	UFR-23-005-1
Finding:	The current railing did not prevent jumps from the upper tier.
Root Cause:	Current safety barriers did not reach the ceiling on the upper tier.
Recommendation:	DOC should install safety barriers that continue to the ceiling on the upper tier in the residential treatment unit.
Corrective Action:	Install additional safety barriers on the upper tier of the residential treatment unit.
Expected Outcome:	Improved safety for incarcerated individuals and staff.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-006

Report to the Legislature

As required by RCW 72.09.770

September 22, 2023

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

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Unexpected Fatality Review Committee Report

UFR-23-006 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

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

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on August 24, 2023:

DOC Health Services

- Dr Frank Longano, Chief Medical Information Officer
- Mark Eliason, Deputy Assistant Secretary, Health Services
- Dr. Tracy Drake, Chief of Psychology – MCC
- Danielle Moe, Director of Nursing
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

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

DOC Community Corrections Division

- Kristine Skipworth, Regional Administrator – E. Region
- Kelly Miller, Administrator – E. Region

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Hannah Carmichael, Health Services Consultant 3 – Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Dan Lessler, Associate Medical Director

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

Fatality Summary

Date of Birth: 1988 (34-years-old)

Date of Incarceration: August 2022

Date of Death: May 2023

At the time of his death, this incarcerated individual was participating in the Graduated Reentry (GRE) Program. His cause of death was combined fentanyl and methamphetamine toxicity. The manner of his death was an accident.

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

Days Prior to Death	Event
11 weeks before death	• He was approved to reside at a sober living transition house.
9 weeks before death	• He met with a Reentry Navigator and a Corrections Specialist to get assistance applying for benefits in the community.
5 weeks before death	• A pre-transfer urine drug screen was conducted with negative results.
5 weeks before death	• He participated in the GRE intake before being transported to his approved residence: ○ An electronic home ankle monitor was placed. ○ An intake drug screen was completed with negative results. ○ He was informed of the program participation requirements including: • Obtaining a substance use assessment and following any treatment recommendations; • Attending two self-help meetings per week; • Completing the Thinking for Change program; • Obtaining employment and; • Completing other programming assigned.
The month prior to death	• He remained compliant with all check-in and drug screening requirements with the following exceptions: ○ He did not obtain a substance use assessment prior to his death, and ○ An oral swab for drug screen was collected which was positive for methamphetamine. The results were not received until after his death.
Three days after death	• The transition house reported that the incarcerated individual passed away 3 days earlier.

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 that the incarcerated individual did not choose to engage significantly with the DOC primary care team. The committee members felt that having an established primary care rapport may have been beneficial.
   2. The committee recommended transitional housing keep a stock of naloxone readily available for use and that all individuals releasing to the community are offered naloxone kits.

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

   A. The Critical Incident Review found:

      a. Face-to-Face visits occurred per DOC policy 390.590 Graduated Reentry (GRE), and
      b. Drug tests were collected per DOC policy 390.590. Of note, fentanyl testing required additional steps on the requisition form.
      c. The incarcerated individual had not completed a substance use assessment, attended support group meetings, or enrolled in the Thinking for Change program prior to his death as required for GRE program participation.
      d. There was no documentation that he was provided a Narcan kit or overdose education upon transferring to the GRE program.
      e. The transition house where he was residing had Narcan but there is no evidence it was used prior to emergency medical services' arrival.

   B. The Critical Incident Review had the following recommendations:

      a. The Corrections Specialist should establish a short timeline for individuals to obtain a substance abuse evaluation upon transfer to GRE.
      b. Reentry staff should ensure that transition houses have Narcan and that all residents know the location and use of Narcan.
      c. DOC should work with the contracted lab to obtain timely drug screen test results or pursue other options for lab testing.

C. The Department of Health (DOH) representative made the following observations, inquiries, and recommendations:

1. The DOH representative shared that incarcerated individuals reentering the community are at increased risk of overdose due to decreased tolerance and being in a stressful environment that may have easier access to drugs.

2. DOH observed that the incarcerated individual in this case was working closely with a reentry care navigator. DOH asked whether reentry kits provided to incarcerated individuals could include overdose education and a naloxone kit.

   Note: DOC stated that initially a naloxone kit was only provided to individuals with a history of opioid use. Now that more resources have become available, GRE is providing naloxone kits to all individuals upon transfer to GRE.

3. DOH recommended that DOC staff and individuals under their care should receive naloxone training and know where naloxone kits are located. They also requested that overdose education and substance abuse education be offered and or provided for the transition house managers to support and assist them to address possible relapses in GRE participants.

   Note: DOC stated that all staff are trained on naloxone use, and DOC is providing naloxone training to individuals at the time of their transfer into the GRE program. DOC also stated they can work with the corrections specialist for the transition houses to increase SUD and overdose awareness. Additionally, DOC has initiated an interagency task force to address fentanyl overdoses.

4. The DOH representative expressed concern that the transition house manager did not feel comfortable talking to the individual about his possible relapse.

   Note: The DOC GRE Administrator responded that GRE staff will explore options to provide more information to DOC housing vendors.

5. The DOH representative also offered support and resources for DOC related to SUD, overdose, and training on trauma informed care.

D. The Health Care Authority (HCA) representative made the following inquiries and recommendations:

1. HCA asked if the conditions of GRE participation required no substance use, and why random drug screens are conducted.

   Note: The DOC GRE Administrator explained that all participants are prohibited from using illicit substances. If an individual has a positive drug screen, DOC offers the individual two options, in-patient substance use treatment or a return to full prison incarceration.

2. HCA asked what the DOC follow-up has been with the lab vendor that did not supply test results in a timely manner.

Note: The DOC GRE Administrator advised the committee that the forensic lab testing department had relocated to another state which negatively impacted receipt of test results. DOC has been working with the lab vendor to obtain timely results and will terminate the contract if the issue is not resolved.

E. The Office of the Corrections Ombuds (OCO) representative offered the following discussion and recommendations:

1. The OCO Director continued the conversation regarding timely lab results by requesting DOC explore the possibility of moving the lab services contract under health services instead of custody.
2. The OCO representative asked if DOC would update the lab requisition form to ensure we do not have to take additional steps to test for fentanyl.

   Note: The DOC GRE Administrator said the form request has been submitted and new forms should be received soon.
3. The OCO asked whether a substance use disorder assessment was completed prior to this individual's death?

   Note: The DOC GRE Administrator indicated that the corrections specialist assigned to his case did not give a timeframe for completing the assessment and did not follow up with the incarcerated individual as required. –This issue was addressed with the corrections specialist.

Committee Findings

The incarcerated individual died due to combined fentanyl and methamphetamine toxicity. The manner of his death was accidental overdose.

Committee Recommendations

Table 1. UFR Committee Recommendations
1. GRE case managers should establish a deadline for participants to obtain a substance use assessment upon transfer to the GRE program and follow-up to ensure completion.
2. GRE case managers should provide naloxone kits to all GRE participants.
3. DOC should enforce contract requirement for lab vendors to provide lab results.

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

DOC should investigate partnering with DOH to enhance overdose education support for contracted transitional housing staff.

Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-23-006

Report to the Legislature

As required by RCW 72.09.770

October 2, 2023

DOC Corrective Action, Publication Number 600-PL001

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

Unexpected Fatality Review
DOC Corrective Action Plan

DOC Corrective Action Publication Number 600-PL001

Legislative Directive

Engrossed Substitute Senate Bill 5119 (2021)

Unexpected Fatality Review Governance

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

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

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

Unexpected Fatality Review Committee Report

The department issued the UFR committee report 23-006 on September 22, 2023 (DOC publication 600-SR001). This document includes the required corrective action plan. The department is required to implement the corrective actions within 120 days of the publication of the committee report.

Corrective Action Plan

CAP ID Number:	UFR-23-006-1
Finding:	GRE participant had not completed the participation requirements (substance use assessment, attending self-help meetings, etc.).
Root Cause:	There was no deadline for completion of GRE participation requirements and no follow-up.
Recommendation:	DOC should establish a deadline for participants to obtain a substance use assessment upon transfer to the GRE program.
Corrective Action:	GRE leadership recommend policy language or create a protocol to establish timelines for completion of GRE participant requirements and follow-up requirements.
Expected Outcome:	DOC would have increased opportunity to provide supports for individuals with substance use disorder.
CAP ID Number:	UFR-23-006-2
Finding:	There was no indication that GRE participant received a naloxone kit or overdose education when transferring into the GRE program.
Root Cause:	In the past, GRE participants without a diagnosis of opioid use disorder or self-reported opioid use were not receiving naloxone kits or overdose education due to limited supply.
Recommendation:	GRE case managers should provide naloxone kits to all participants transferring into the GRE program.
Corrective Action:	Within available resources, DOC will distribute naloxone kits to participants transferring into the GRE program.
Expected Outcome:	Participants in the GRE program would have additional protection against from opioid accidental overdose.
CAP ID Number:	UFR-23-006-3
Finding:	DOC did not receive positive drug screen test results in a timely manner which prohibited them from interceding to offer in-patient treatment or return participant to confinement for their safety.
Root Cause:	The DOC contracted testing lab transitioned their operations to an out of state testing site resulting in delays in receiving results.
Recommendation:	DOC should enforce contract requirements for lab vendor to provide timely lab results.
Corrective Action:	DOC will seek contracts with other lab vendors if current vendor is unable to comply with contract requirements.
Expected Outcome:	DOC will receive timely lab test results to support GRE participants.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-007

Report to the Legislature

As required by RCW 72.09.770

October 9, 2023

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
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Unexpected Fatality Review Committee Report

UFR-23-007 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

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

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on March 9, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Karie Rainer, Director-Mental Health
- Dr. Zainab Ghazal, Administrator
- Patty Peterson, Director of Nursing
- Rae Simpson, Director – Quality Systems
- Dawn Williams, Program Manager – Substance Abuse Recovery Unit
- Brooke Amyx, Reentry Administrator
- Mary Beth Flygare, Project Manager
- Deborah Roberts, Program Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Lorne Spooner, Correctional Operations Program Manager
- Jason Bennett, Superintendent Stafford Creek Corrections Center
- Don DeShazer, Correctional Unit Supervisor, Airway Heights Corrections Center

DOC Risk Mitigation

- Michael Pettersen, Director

DOC Reentry Centers

- Scott Russell, Deputy Assistant Secretary
- Susan Leavell, Senior Administrator

DOC Graduated Reentry – Community Corrections

- Kristine Skipworth, Regional Administrator – East
- Kelly Miller, Administrator
- Autumn Dell-Witten, Administrator

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Hannah Carmichael, Health Services Consultant 3 – Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Judy Zerzan, Medical Director

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

Fatality Summary

Year of Birth: 2000 (23-years-old)

Date of Incarceration: February 2022

Date of Death: June 2023

The incarcerated individual was a 23-year-old man who had his first admission to prison in June 2022. He was housed in a mental health residential treatment unit. His cause of death was blunt force trauma to the head due to a fall. The manner of his death was suicide.

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

Day of Death	Event
13:35 hours	• He exits his cell, ascends the tier stairs, climbs the railing, leans over, and falls to the floor.
13:36 hours	• Custody staff arrive and begin first aid to include CPR.
13:38 hours	• Medical staff arrive and began directing first aid efforts.
13:47 hours	• Fire Department Emergency Medical Services arrive and assume care.
13:52 hours	• He was pronounced deceased by Emergency Medical Services.

Committee Discussion

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

1. The individual arrived at the reception center taking suboxone for opioid use disorder and was tapered off per DOC protocol due to the length of his sentence.
2. He had episodic follow up with Primary Care.
3. The incarcerated individual was appropriately coded as seriously mentally ill and:
    a. He was in a highly structure residential treatment unit to closely monitor his status and encourage pro-treatment behaviors:
    b. He had a positive trusting relationship with his primary therapist;
    c. He had relatively few protective factors including lack of family support and few prosocial peers;
    d. He was housed without a cellmate;

e. He had a history of substance use including increased coffee intake;

f. He had minimal adherence to treatment recommendations; and

g. His symptoms did not rise to the level of requiring court ordered involuntary medication administration.

4. He took his own life by jumping from the upper tier in his living unit causing head injuries incompatible with life.

5. DOC Staff and community Emergency Medical Services (EMS) were unable to return spontaneous circulation and he was declared deceased at the scene.

6. The committee identified a missed opportunity for a relationship with the primary care team which could have acted as an additional supportive factor.

7. The committee supports health services working towards offering an annual primary care visit for each incarcerated individual.

8. The Mortality review committee did not identify any opportunities to prevent a similar death in the future.

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

1. The incarcerated individual was appropriately followed and supported by his mental health treatment team. It was noted that some mental health treatment plans, a suicide risk screening, and a mental health screening were not completed within policy timeframes. This did not appear to have an impact on his treatment or the outcome.

2. There were no safety barriers on the upper tiers of the residential treatment units. Safety barriers are being installed.

3. The CIR recommendations did not directly correlate to the cause of death and will be remediated per DOC Policy 400.110 Reporting and Reviewing Critical Incidents.

C. The Department of Health (DOH) representative offered the following input and recommendations:

1. DOH asked if all incarcerated individuals are tapered off suboxone at the reception center.

Note: DOC shared that due to current funding capacity, individuals with a sentence longer than 6 months are tapered off medication assisted treatment for opioid use disorder. If the individual's sentence is shorter than 6 months, DOC continues providing the medication assisted treatment.

2. DOH recommends DOC explore options for monitoring coffee intake and the possibility of limiting caffeine intake while still supporting the incarcerated individual's decisional autonomy.

3. The DOH representative supported the recommendations discussed within the committee.

D. The Health Care Authority (HCA) representative noted that patients with persistent mental health conditions will use coffee intake to self-medicate to alleviate symptoms. HCA supports all proposed recommendations.

E. The Office of the Corrections Ombuds (OCO) discussed their analysis of the case, asked for additional information, and submitted the following for UFR committee discussion:

1. The OCO continued the conversation on coffee intake and asked if all the coffee available to purchase is instant coffee. The OCO encourages DOC to explore other options for providing coffee to residential treatment unit residents similar to the coffee program in the Norway Amend program.

   Note: DOC responded that currently, all coffee available through the DOC commissary is instant coffee.

2. OCO requests a discussion of the dynamics related to suicide risk factors when being housed alone without cellmates in the residential treatment unit.

   Note: DOC explained that historically, single person cells were thought to provide more privacy and a quieter environment which would assist incarcerated individuals with their mental health conditions. Additionally, some individuals have difficulty having a cellmate due to their behavioral issues and vulnerability. Currently, many of the cells are set up for single person housing. DOC acknowledges that being housed without a cell mate eliminates one possible protective factor for the incarcerated individual.

3. OCO inquired about DOC's determination of mental health coding of incarcerated individuals.

   Note: DOC explained that an individual's mental health code indicates their current level of functioning and their active mental health symptoms. Codes are intended to be fluid.

Committee Findings

The incarcerated individual died as a result of suicide. The cause of death was blunt force trauma to the head secondary to a fall.

Committee Recommendations

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

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

1. DOC should explore options for coffee access in residential treatment units.
2. DOC should continue to pursue an electronic health record as full legislative funding becomes available.
3. DOC should continue to pursue options for utilization of the 988-suicide prevention hotline.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-008

Report to the Legislature

As required by RCW 72.09.770

October 10, 2023

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
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Unexpected Fatality Review Committee Report

UFR-23-008 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on August 24, 2023, or the follow-up meeting on September 11, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Karie Rainer, Director – Behavioral Health
- Dr. Zainab Ghazal, Administrator
- Dr Frank Longano, Chief Medical Information Officer
- Mark Eliason, Deputy Assistant Secretary
- Dr. Tracy Drake, Chief of Psychology
- Danielle Moe, DNP Director of Nursing
- Patty Paterson, MSN Director of Nursing
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Jeremy Turner, Associate Superintendent CRCC
- Melissa Moore, Correctional Program Manager CRCC
- Lorne Spooner, Correctional Operations Program Manager

DOC Community Corrections Division

- Kristine Skipworth, Regional Administrator – E. Region
- Kelly Miller, Administrator – Graduated Reentry

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Hannah Carmichael, Health Services Consultant 3, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Dan Lessler, Associate Medical Director

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

Fatality Summary

Year of Birth: 1988 (35-years-old)

Date of Incarceration: July 2022

Date of Death: June 2023

At the time of his death, this incarcerated individual was housed in a residential mental health treatment unit. The cause of death was ligature strangulation resulting in an anoxic brain injury incompatible with life. The manner of death was suicide.

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

2 Days Prior to Death	Event
14:34 hours	• Routine tier check conducted.
14:36 – 14:39 hours	• Incarcerated individual's door slightly opens and closes several times.
15:11 hours	• Routine tier check conducted. • Officer discovered individual unresponsive after self-harm and radioed for help.
15:13 – 15:15 hours	• 911 was called. • Two other incarcerated individuals assisted the officer to support his body. • Second officer arrived with a noose cutter and ligature is removed. • Additional custody and nursing staff respond initiating lifesaving efforts.
15:28 hours	• Community Emergency Medical Services (EMS) arrived on unit.
15:54 hours	• Incarcerated individual is transported to the hospital by community EMS.
Day of Death	**Event**
17:01 hours	• Individual was pronounced deceased by community hospital staff.

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 psychological autopsy, the care delivered, and provided the following findings. They did not identify any additional

recommendations to prevent a similar fatality in the future.

1. The incarcerated individual had been diagnosed with anxiety and schizophrenia with psychosis for which he was appropriately treated by his mental health team with only episodic follow up in primary care.
2. Throughout his incarceration, he consistently denied being suicidal or depressed and had no previous history of suicide attempts.
3. While staff and EMS were able to return spontaneous circulation at the facility, he died because of his injuries.

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

1. The pill line nurse did not follow Medication Administration Nursing Protocol N-306 when they failed to notify the psychiatric provider after the first medication dose that the individual had missed prior to his death.
2. DOC does not have an electronic health record or electronic medication administration system (E-MAR) which would automate these provider notifications.
3. The CIR recommendations were related to administrative changes or upgrades to current infrastructure and did not directly correlate to the cause of death. These recommendations will be remediated per DOC Policy 400.110 Reporting and Reviewing Critical Incidents.

C. The Department of Health (DOH) representative supported the recommendations for administrative improvement.

D. The Health Care Authority (HCA) representative inquired about DOC suicide prevention protocols and support available for individuals expressing suicidal ideation and experiencing anxiety about the pending transfer into the community. They supported the recommendations for improvement.

Note: DOC provides annual suicide prevention training for staff. Incarcerated individuals receive information regarding suicide risk factors and prevention in the DOC Orientation Handbook. There are suicide prevention posters in all living units and healthcare locations. More information can be found here News Spotlight: Humanity in Corrections - Suicide Prevention in Prisons | Washington State Department of Corrections

E. The Office of the Corrections Ombuds (OCO) offered the following information and input:

1. The OCO requested DOC provide incarcerated individuals information on the 988-Suicide prevention hotline resource.
2. The OCO had questions regarding the review of medications, medication changes made prior to the incarcerated individual's death and the side effects of those medications.

Note: DOC clinical staff reviewed the medication records and found no correlation to the death.

Committee Findings

The incarcerated individual died as a result of suicide. The cause of death was anoxic brain injury secondary to ligature strangulation.

Committee Recommendations

The UFR committee members did not offer any recommendations for corrective actions.

Consultative Remarks

A. DOC should continue working toward implementation of an electronic medication administration record (E-MAR) system.

B. DOC HS should work toward making an annual primary care visit standard for each resident in prisons.

C. DOC should continue to pursue an EHR when legislative funding becomes available which would support automatic notifications if an individual has not had a routine primary care visit in the last year.

D. DOC should continue to pursue options for utilization of the 988-Suicide prevention hotline.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-009

Report to the Legislature

As required by RCW 72.09.770

October 13, 2023

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
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Unexpected Fatality Review Committee Report

UFR-23-009 Report to the Legislature–600-SR001

Legislative Directive and Governance

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UFR Committee Members

The following members attended the UFR Committee meeting held virtually on September 11, 2023:

DOC Health Services

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

DOC Prisons Division

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

DOC Risk Mitigation

- Mick Pettersen, Director

DOC Reentry Centers

- Susan Leavell, Senior Administrator

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Hannah Carmichael, Health Services Consultant 3, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Judy Zerzan, Medical Director

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

Fatality Summary

Year of Birth: 1994 (29-years-old)

Date of Incarceration: February 2021

Date of Death: June 2023

At the time of his death, this incarcerated individual was housed in a mental health residential treatment unit. The cause of death was closed traumatic head injury causing anoxic brain injury. The manner of death was suicide.

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

One day prior to death	Event
07:23 hours	• 3rd tier cell doors opened after tier check.
07:24 hours	• Incarcerated individual exits his cell, climbs railing, and dives to the floor. • Medical staff arrive and begin rendering aid.
07:28 hours	• Mental health and classification staff arrive on tier.
07:29 hours	• CPR initiated.
07:39 hours	• Community emergency medical services (EMS) arrive on unit and assume resuscitation efforts.
07:54 hours	• Community EMS transport the individual to the hospital.
Day of death	**Event**
07:49 hours	• Incarcerated Individual was pronounced deceased by hospital staff.

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 members considered the information from both reviews in formulating recommendations for corrective action.

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

1. The committee found:

a. The incarcerated individual to be a 29-year-old man housed in a mental health residential treatment unit carrying diagnoses of schizophrenia, schizoaffective disorder, psychosis, bipolar disorder, anxiety, and substance use disorder.

b. He had episodic, problem-focused primary care visits.

c. He took his own life by jumping from the upper tier in his living unit causing anoxic brain injury and multiple closed fractures of the thoracic and lumbar vertebrae.

d. Staff and EMS were able to return spontaneous circulation and he died the next morning at the hospital.

2. The committee noted that consuming too much coffee by those housed in a residential treatment unit may exacerbate their mental health symptoms and recommended exploring options to limit the amount of coffee purchased by residents.

3. The committee recommended making an annual primary care visit standard for each incarcerated individual in prison.

4. The committee recommended continuing to pursue an electronic health record (EHR) when legislative funding becomes available to facilitate team communication and automate notifications if an individual has not had a routine primary care visit in the last year.

5. Upon conclusion of this review, no corrective action items were identified. The committee noted that safety screens and barriers were already being installed on the second and third tiers of the mental health residential treatment units.

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:

1. The incarcerated individual was housed in a mental health residential treatment unit. Residential treatment is provided for individuals with significant mental disorders resulting in serious impairment in adaptive functioning and may include a safety risk for the individual and/or others.

2. The incarcerated individual received an intake mental health screening but was not prioritized for a mental health appraisal at the reception center. He received the appraisal four months after his transfer to the parent facility. He did receive a psychiatric assessment within three weeks of transferring to his parent facility. The delay in completing the formal mental health appraisal did not appear to impact his treatment.

3. Documentation and interviews reflect that he did not indicate he was experiencing suicidality during his time in the residential treatment unit.

4. Upon conclusion of this incident review, no corrective actions were identified except for safety screens/barriers being installed on the second and third tiers of the residential treatment units. At the time of the incident review, this infrastructure upgrade had already started.

5. Additional CIR recommendations did not directly correlate to the cause of death and will be remediated per DOC Policy 400.110 Reporting and Reviewing Critical Incidents.

C. The Department of Health (DOH) representative supported the recommendations and requested further discussion regarding electronic health records, safety barriers, and the

delay in receiving a mental health appraisal. DOH recommended that DOC investigate how other systems have limited coffee intake and still preserve an incarcerated individual's rights. The DOH representative provided kudos to the staff proving the emergency response.

Note: DOC discussed the delay in completing the mental health appraisal. The initial delay did not have a long-term impact on his care.

D. The Health Care Authority (HCA) Representative provided information on caffeine intake and mental illness. The HCA representative had no additional recommendations and appreciated the hard work happening to prevent these cases.

E. Office of the Corrections Ombuds (OCO) discussed their analysis of the case and submitted the following recommendations for UFR committee discussion:

1. The OCO continued the discussion regarding coffee intake. The OCO supports DOC's exploration of a "barista" program which could help to reduce caffeine intake. The OCO pointed to models including the one in operation at Clallam Bay Corrections Center pre-COVID and one observed in operation at a prison in Norway.
2. The OCO discussed the delayed mental health appraisal and asked whether the improved confidential space at the reception center is reducing system delays.

   Note: DOC indicated they are reviewing the intake process on a systems level and will address the factors that may be creating current delays. The incarcerated individual was admitted to DOC during the COVID pandemic which negatively impacted timeframes.
3. The OCO inquired into whether a timely mental health appraisal would have prevented the need for the incarcerated individual to request protective custody or be placed in a close observation area (COA).

   Note: DOC shared the possibility that the individual may not have chosen protective custody, but there is no way to assess if he would have been directly referred to residential treatment level housing from the initial appraisal. He may not have been exhibiting significant mental health symptoms at that time. Individuals are placed in the COA for safety regardless of where they are housed.

Committee Findings

The manner of the incarcerated individual's death was suicide. The cause of death was closed traumatic head injury causing anoxic brain injury.

Committee Recommendations

The UFR Committee did not offer any recommendations for corrective action.

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

A. The UFR committee recommended exploring options to limit the amount of coffee purchased by residents of a residential treatment unit.

B. The committee recommended making an annual primary care visit standard for each incarcerated individual in prison.

C. The committee recommended continuing to pursue an electronic health record (EHR) when full legislative funding becomes available to automate notifications if an individual has not had a routine primary care visit in the last year.

D. The committee recommended DOC conduct an educational Morbidity & Mortality conference to educate staff.