OFFICE OF THE
CORRECTIONS
OMBUDS

Monthly Outcome Report
December 2023

UNEXPECTED FATALITY REVIEWS: 4

CASE INVESTIGATIONS: 232

Assistance Provided: 48
Information Provided: 102
DOC Resolved: 30
Insufficient Evidence to Substantiate: 15
No Violation of Policy: 37
Substantiated: 0

INTAKE INVESTIGATIONS: 89

Administrative Remedies Not Pursued: 64
Declined: 9
Lacked Jurisdiction: 5
Person Declined OCO Involvement: 8
Person Released from DOC Prior to OCO Action: 3

Resolved Investigations:

325

Assistance or Information Provided in

65%

of Case Investigations

OCO Casework Highlights

December 2023

Assistance Provided

Reported Concern: Person reported he is unable to provide urinalysis (UA) samples within the timeframe allowed by policy. He was able to get a Health Status Report after being asked for a UA, but not before being written an infraction.
OCO Actions: The OCO contacted DOC facility leadership and requested a review of the infraction with information found during the OCO investigation. OCO staff found the person had been asked for a urinalysis (UA) sample before he was seen by Health Services for an initial evaluation, where he would have been able to request the Health Status Report.
Negotiated Outcomes: DOC agreed to overturn the infraction and remove it from the person's record.

Assistance Provided

Reported Concerns: Several individuals reported that DOC was not allowing people to use the Securus phone app during count times unlike the higher custody level, MI3.
OCO Actions: The OCO contacted the Superintendent to request a change.
Negotiated Outcomes: The facility agreed to resolve this issue by allowing individuals to use Securus during count.

Assistance Provided

Reported Concerns: Individual reports retaliation by DOC staff after they filed a Resolution Request regarding staff misconduct.
OCO Actions: The OCO confirmed that this individual was infracted multiple times for allegedly falsifying information in their Resolution Requests and that the individual was placed in IMU. Following an in-person visit, the OCO requested that the facility review all the infractions, as filing a Resolution Request is considered a legally protected act.
Negotiated Outcomes: Although the DOC did not dismiss the first infraction, DOC agreed to dismiss the subsequent infractions and the individual was returned to general population.

Assistance Provided

Reported Concerns: The individual reported that people in the IMU are only getting toilet paper on certain days and if someone runs out before a toilet roll exchange day, staff will not give individuals more.
OCO Actions: The OCO contacted the facility and asked that they speak to staff about providing toilet paper for reasonable requests.
Negotiated Outcomes: DOC agreed to meet with IMU staff to ensure they are accommodating reasonable requests for more toilet paper outside of the scheduled toilet roll exchange days.

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-23-010: The Unexpected Fatality Review Committee reviewed the unexpected death of a person in his 30s in July 2023. The Unexpected Fatality Review Committee Report, dated November 21, 2023, and the Corrective Action Plan, dated December 1, 2023, are publicly available documents.

UFR-23-011: The Unexpected Fatality Review Committee reviewed the unexpected death of a 34-year-old person in July 2023. The Unexpected Fatality Review Committee Report, dated November 27, 2023, is a publicly available document. The UFR Committee did not offer recommendations for corrective action.

UFR-23-013: The Unexpected Fatality Review Committee reviewed the unexpected death of a person in his 30s in August 2023. The Unexpected Fatality Review Committee Report, dated December 11, 2023, and the Corrective Action Plan, dated December 21, 2023, are publicly available documents.

UFR-23-014: The Unexpected Fatality Review Committee reviewed the unexpected death of a 51-year-old person in August 2023. The Unexpected Fatality Review Committee Report, dated December 21, 2023, and the Corrective Action Plan, dated December 29, 2023, are publicly available documents.

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: DECEMBER 2023

	COMPLAINT SUMMARY	OUTCOME SUMMARY	CASE CLOSURE REASON
UNEXPECTED FATALITY REVIEWS			
Airway Heights Corrections Center			
1.	Incarcerated individual died of an overdose.	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-23-011 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. OCO comments accompanied this report. There were no DOC Corrective Action Plans for this UFR.	Unexpected Fatality Review
Clallam Bay Corrections Center			
2.	Incarcerated individual died of an overdose.	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-23-013 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. A Corrective Action Plan was also published for UFR-23-013 and the OCO encouraged DOC to explore options to expand substance use treatment services.	Unexpected Fatality Review
Reentry Center - Bishop Lewis			
3.	Incarcerated individual died of an overdose.	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-23-014 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. OCO recommendations and Corrective Action Plans (CAPs) accompanied the report.	Unexpected Fatality Review
4.	Incarcerated individual died of an overdose.	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-23-010 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. OCO comments and DOC's Corrective Action Plan accompanied the report.	Unexpected Fatality Review

CASE INVESTIGATIONS

Airway Heights Corrections Center

5.	External person reports an individual experienced mental health issues at camp and asked to transfer back to medium custody. He was told no and received an infraction when he refused housing.	The OCO reviewed this infraction. It did fit the criteria for a 724 serious infraction for refusing housing and the infraction was never appealed. This office was able to provide assistance by contacting the facility and asking for mental health to meet with this individual and assess his needs. He was then assessed by mental health staff and referred for additional services.	Assistance Provided
6.	Incarcerated individual reports he is trying to get information about the status of an appeal and DOC staff are unwilling to assist him in getting information about the status of the appeal.	The OCO provided assistance. This office spoke with staff at the facility and confirmed that the individual's appeal has been reviewed and responded to. The DOC staff offered to resend the appeal response to the individual and check in with him after being contacted by this office.	Assistance Provided
7.	Incarcerated individual expressed concerns about an infraction.	The OCO provided assistance by contacting DOC about this infraction as the individual had a medical reason for testing positive on a urinary analysis (UA). As a result, the infraction was dismissed at the hearing.	Assistance Provided
8.	Incarcerated individual reports issues accessing mandatory programming due to a lack of staff to teach the classes. The individual reports this lack of programming is blocking him from employment. The individual requests OCO assist him in accessing the class.	The OCO provided assistance. The OCO spoke with facility staff in education and job programming. This office was told the class instructor will not be hired until next year. Based on this information, the job programming staff agreed to make an exception and will allow him to work before completing the course. Once an instructor is hired, the individual will be placed into the class.	Assistance Provided
9.	The individual reported that people with walkers are sitting at tables designated for people with wheelchairs in the dining hall. The individual says that he often has to wait for a table that can accommodate his wheelchair. The person has tried to resolve this by working with DOC staff, but keeps being directed to speak to someone else and no one has been able to resolve this concern.	The OCO provided assistance. This office spoke with DOC staff at the facility who confirmed that individuals with walkers should not be using tables in the dining hall designated for wheelchairs unless they have a Health Status Report (HSR) allowing them to. Facility staff verified that this has been relayed to shift operations who will ensure that only individuals in wheelchairs or who have an HSR will be allowed to sit at the tables that accommodate wheelchairs.	Assistance Provided
10.	Incarcerated individual reports concern regarding an infraction they received. The individual reports they purchased the book through an approved vender and received the book through the facility mailroom. Later during a cell search, the book was confiscated and he was infracted	The OCO provided assistance. The OCO reviewed the infraction and spoke with facility leadership to understand the infraction rationale. The OCO requested and facility leadership was willing to speak with DOC headquarters staff to ask them to review the infraction. DOC HQ agreed to review the infraction, but ultimately did not dismiss the infraction.	Assistance Provided

	for having sexually explicit material. The individual requests the OCO review the infraction and recommend DOC dismisses it.		
11.	Patient reports concerns about being transferred to a different facility.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The individual's Custody Facility Plan (CFP) was updated and he will remain at AHCC.	DOC Resolved
12.	Person reports that he has been trying to get boots from medical for several months and has not received them.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO reviewed the person's appointments and verified he had picked up his shoes.	DOC Resolved
13.	Person said that he has been approved for transfer to a Reentry Center months ago, but has not transferred yet. Person said he has spoken to his counselor, who said they are just waiting for a bed date.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and reached out to this individual's counselor, who initially said that they are still waiting for a bed date, and that there are more people on the waiting list than there are available beds, and that he has explained this to the individual. The counselor reached out to the OCO a week later and said that he has been finalized for transfer to the Reentry Center today, which the OCO verified in DOC records.	DOC Resolved
14.	The individual reported that he requested an IPIN change due to it being used by another incarcerated individual but says that his IPIN has not been changed.	DOC staff resolved this concern prior to the OCO taking action on this complaint. This office spoke with DOC staff who verified that the individual was issued a new IPIN shortly after reporting this concern to the OCO.	DOC Resolved
15.	External person reports that her loved one is attempting to get a medication to aid in weight loss and was denied by DOC. The person stated that he needs to lose weight to improve his chronic health condition.	OCO staff provided information. OCO staff reviewed the requested medication and confirmed the medication was made for people with a specific diagnosis that the patient does not have. That medication is also not in the DOC Formulary. OCO staff provided medication information to the patient.	Information Provided
16.	Incarcerated individual expressed concerns about points being lost as the result of an infraction.	The OCO reviewed the relevant policy and informed the individual that per DOC policy 300.380 category A infractions will result in a deduction of 20 points for a period of 24 months, a 633 or 704 infraction will result in the deduction of 15 points for a period of 12 months, all other category B infractions will result in a deduction of 10 points for a period of 6 months, category C or D infractions will result in a deduction of 5 points for a period of 6 months.	Information Provided
17.	Incarcerated individual expressed concerns about their time being improperly calculated.	The OCO reviewed the individual's record and relayed information that DOC had already provided to the individual about their recalculated time calculation.	Information Provided
18.	Incarcerated individual expressed several concerns about systemic	The OCO noted the individual's desired changes and will consider these requests when these DOC	Information Provided

	changes including staff conduct, inmate banking (cost of incarceration, mandatory savings), quarterly dues for weight lifting and RCWs, DOC disciplinary process, holding DOC punitively responsible, DOC's philosophies and processes, and regular oversight of conditions of confinement.	policies are up for review. The OCO also provided the individual with information about providing feedback when DOC policies are open for public comment.	
19.	Incarcerated individual reports concerns regarding access to a cell that meets his mobility needs and an infraction he received that will jeopardize his good conduct time restoration plan. The individual requests the OCO assist him in being moved into an accessible cell have DOC agree to restore his good conduct time.	The OCO provided information about how to work with DOC medical to access a cell that meets his mobility needs. The OCO spoke with DOC staff who shared the individual was determined to be able to live in his current cell. The OCO reviewed the individual's infraction and found the individual admitted to the infraction behavior and did not appeal the infraction. The OCO reviewed the individuals' sanctions and found them to be issued per DOC 460.140 Hearings and Appeals.	Information Provided
20.	Incarcerated individual reports concerns regarding the AHCC mailroom and their application of copying mail. The individual reports the OCO shared in a Monthly Outcome Report that staff are not allowed to copy mail moving forward.	The OCO provided clarification about what OCO shared in the Monthly Outcome Report. The OCO reviewed the Monthly Outcome report in question and found this office reported that DOC has issued the directive for facilities to not print in color as not all mailrooms have color printers and to not copy photos. If a copy is incomplete, the individual can contact the mailroom and they will make another copy as the originals are retained. This means that DOC staff can copy mail if they feel there is a threat to security, but will not copy photos to be given to incarcerated individuals. The OCO shared this information with the individual.	Information Provided
21.	Incarcerated individual requests information about changes to the Washington Administrative Code (WAC) governing sexually explicit material.	The OCO provided information regarding DOC 450.100 Mail for Individuals in Prison. The OCO spoke with DOC staff who explained that the changes to the policy are finalized and will be effective by the first of the year (2024). The OCO provided the individual with resources to stay updated on DOC policy changes.	Information Provided
22.	Individual reports concerns about ABHS scoring people high on their assessments and DOC not having the space or staff to provide the required programming. This is impacting releases.	The OCO provided information about assessment criteria based on DSM5. This office substantiated staff shortages related to SUD/OUD treatment programming.	Information Provided
23.	Person reported that he has been in solitary confinement, and that his custody facility plan has not been completed by its scheduled review date.	The OCO provided information. The OCO reviewed DOC records and found that this individual has been transferred out of solitary confinement and is pending transfer to a different facility, and that he has a new pending infraction. This office	Information Provided

		encourages this individual to reach out to his counselor for more information about when his custody facility plan will be completed. The OCO found that his custody facility plan is still within guidelines in DOC Classification and Custody Facility Plan Review 300.380.	
24.	Person reported that he lost his headphones while being moved to solitary confinement. Person said that DOC asked him if he would be willing to accept a replacement pair, but he has still not gotten the headphones.	The OCO provided information about filing a tort claim. The OCO reviewed his resolutions investigation, which did not substantiate his claim because his headphones were missing at the time of his move to solitary confinement. DOC 120.500 states "All incarcerated individual tort claims alleging personal property damage/loss must be filed by the individual with the Washington State Department of Enterprise Services (DES) Risk Management Division". 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
25.	Person reported that two days before his planned release date, he was told there was an error and his release date is now next year. Person reported that he wants to be approved for graduated reentry or reentry center due to the emotional distress for the mistake.	The OCO provided information. The OCO reviewed DOC records that showed that the courts made a mistake, and that DOC updated his release date based on the court's intent for his Judgement and Sentencing. The OCO encouraged this individual to reach out to his counselor about GRE and reentry center opportunities.	Information Provided
26.	Person reported placement concerns.	The individual contacted the OCO with updated concerns regarding medical access and identified medical as their primary concern. The OCO informed the individual that a new case would be created for this new concern. Individual requested no action regarding past housing complaint.	Information Provided
27.	The individual reported concerns regarding his interstate compact. The person said that his current sentence is being violated based on what the interstate compact is saying compared to what the DOC is saying.	The OCO provided information. This office reviewed documentation regarding the individual's sentence and interstate compact and was unable to find any discrepancy or documented concerns related to his sentence. The OCO informed the individual that he may contact this office again with specific information regarding his concern and it may be reviewed further.	Information Provided
28.	The individual reported that he had a Correctional Industries (CI) job in the kitchen but was fired when he received an infraction. The hearings officer found the individual not guilty of the infraction, but he was not allowed to return to his job.	The OCO provided information. Per DOC 700.000, Work Programs in Prisons, assignment to a work program may be suspended/terminated based on security/disruption concerns resulting from, but not limited to, an alleged violation or pending investigation. CI does not have to rehire an individual because their infraction was dismissed.	Information Provided

	The person says that he has not been able to get another job since.	The OCO verified that the individual currently has referrals for other jobs, and he may reapply for a CI job in the future. The individual's classification counselor confirmed that he has been working with the individual to find suitable work programs.	
29.	The individual reported that he has an upcoming court hearing with the small claims court, and he hasn't been placed on the call out.	The OCO provided information. This office advised the individual to contact the Legal Liaison Office at the facility for information regarding all court related concerns. Individuals may also file a resolution request regarding concerns with legal access.	Information Provided
30.	The individual reported that he was previously assigned a single cell due to safety concerns, but the DOC is going to take his single cell away. The individual said that he has been assaulted numerous times in the past and fears what may happen without a single cell.	The OCO provided information. This office reviewed the individual's Single Cell Screening and found that the DOC did not determine a need for a single cell. If the individual continues to have safety concerns, this office encouraged him to discuss this with DOC staff at his upcoming Facility Risk Management Team review.	Information Provided
31.	The individual reported that the copy machine in the State Library has been broken for a while. The person said that he wanted to get some pages of a book through an inter-library loan, but was told by DOC staff that he is not able to use the copy machines in other parts of the facility.	The OCO provided information. This office spoke with the State Librarian who verified that the copy machine did break and a replacement has been ordered. The facility initially tried to repair the copy machine but found a replacement was needed. The library is awaiting its arrival and individuals will then be able to use the new machine.	Information Provided
32.	The OCO received a Closed Case Review request for this case: Incarcerated individual relayed concerns regarding getting a behavior observation entry (BOE) and an infraction for the same issue.	The OCO conducted a closed case review and found there was an error in casework. The reviewing team agreed that the case closure reason should be changed from “No Violation of Policy” to “Insufficient Evidence to Substantiate.”	Insufficient Evidence to Substantiate
33.	Incarcerated individual relayed concerns regarding grieving a concern about incorrect pay and getting a negative behavior observation entry (BOE) in retaliation.	The OCO reviewed the individual's grievance history and was unable to locate a grievance related to pay. Because it was not possible to verify if or when the complainant had taken a legally protected action (grieving), this office was unable to establish a connection between a protected act and the issuance of the BOEs and therefore unable to substantiate retaliation.	Insufficient Evidence to Substantiate
34.	Person reports he has a severe condition that caused him to have a seizure when he was returned from the emergency room. The patient is requesting to be sent back to the hospital to receive care for a chronic issue.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff contacted Health services management and reviewed the patient's medical records. There is insufficient evidence to support the reported event. The OCO is not able to recommend a patient be moved to the community hospital without clinical indication. Outside medical trips must be ordered by a	Insufficient Evidence to Substantiate

		medical provider and approved through the proper channels for extended care stays.	
35.	Incarcerated individual expressed concerns about an infraction after testing positive for marijuana despite recently entering prison.	The OCO reviewed the infraction materials and confirmed that it had been several months since the individual entered prison. Thus, the OCO was unable to locate a violation of DOC Policy 460.000.	No Violation of Policy
36.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC Policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
37.	Incarcerated person requests to be moved out of restrictive housing and states they have been in restrictive housing for a month.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Individual was moved to restrictive housing following DOC IIU investigation policy and was returned to general population after the investigation was completed.	No Violation of Policy
38.	Person reported that DOC put a no-contact order against multiple people who were previously on his visitor list, saying they were his victims. Person felt that he is being retaliated against because of these visitors filing forms with DOC. Person stated that he cannot contact his family or friends at all now.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed kites and resolution requests on this issue and found that there is no restriction against this individual contacting his family or friends. The OCO reached out to the Correctional Program Manager who confirmed that phone, mail, video, and Securus contact has been reinstated, but they are not allowing in-person visitation for these specific individuals due to the risk of their behaviors while in the community. The OCO could not find a court ordered no-contact order in DOC records. The OCO spoke with the individual's counselor who described the behavior in the community that led to DOC concern. The counselor said that she explained to this individual multiple times why the prohibitive contact reviews were filed. The OCO reviewed multiple police reports involving this individual and the three people who were removed from his visitation lists. DOC 450.300 Eligibility Requirements for Visitors (Attachment 1) states that "persons identified as a safety/security concern, or who have facilitated/allowed an individual to violate Department or court-ordered conditions while in the community, may be denied all facility visit privileges."	No Violation of Policy
39.	The individual reported concerns regarding his facility placement. The individual said that he was told by DOC staff that he is supposed to transfer to a different facility and no longer has a medical hold.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the individual's recently completed Custody Facility Plan (CFP) and verified that the DOC decided to retain him at his current facility. This office verified that individual's CFP was completed per DOC 300.380, Classification and Custody Facility Plan Review.	No Violation of Policy
40.	The individual reported that he has filed over a dozen emergency	The OCO was unable to substantiate a violation of policy by DOC. Per page 11 of the Resolution	No Violation of Policy

	resolution requests for safety concerns and said that the DOC is interpreting the emergency resolution request procedure incorrectly. The individual says that the emergency resolution requests are regarding staff conduct but the DOC is saying that it has to be life threatening for an emergency resolution request to be accepted.	Program Manual (RPM), emergency resolution requests must fall under the following criteria: involve a potentially serious threat to the life or health of an individual or employee/contract staff/volunteer; relate to severe pain being suffered but the individual; or involve a potential threat to the orderly operations of a facility. The OCO reviewed the individual's recent emergency resolution requests and did not find that they met the criteria of an emergency per the RPM.	
41.	The individual reported that he wants to transfer to another facility before his loved one has surgery. The person said that he is getting different answers from DOC staff and feels that no one is trying to assist him, even though he is able to go to any facility.	The OCO was unable to substantiate a violation of policy by DOC. Per DOC 300.380, Classification and Custody Facility Plan Review, determining facility placement will be consistent with Department needs, address safety issues, and meet requirements of the individual's custody level and health services needs. The individual was transferred to another facility on the west side of the state. The OCO also verified that the individual did not attend his Facility Risk Management Team (FRMT) review, which is important to ensure the individual is able to express their concerns and wishes regarding facility placement and other factors.	No Violation of Policy
Cedar Creek Corrections Center			
42.	Anonymous individual reports black mold in the bathroom.	The OCO provided assistance by sharing this information with the Superintendent. Facility leadership will follow-up on the concern.	Assistance Provided
43.	Incarcerated individual relayed concerns regarding an infraction appeal not being responded to within the allotted timeframe and the belief that as a result the infraction should be dismissed.	The OCO informed the individual that WAC 137-28-400 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.”	Information Provided
44.	Individual is unclear if they were approved for re-entry center. It was recommended in their last custody facility plan, however it has not been finalized.	The OCO reviewed the custody facility plan. This individual was recommended for re-entry center, however the transfer date has not been finalized. Re-entry center transfers are based on bed availability and programming needs per DOC 300.500. This office cannot provide a date of when the transfer will occur.	Information Provided
45.	The individual reported that he has an upcoming Earned Release Date (ERD) and was assigned programming that takes eight months. The individual says he would like to go to a facility which would allow him time to transition to work release. The person reported that DOC staff are not helping him change his	The OCO was unable to substantiate a violation of policy by the DOC. This office reviewed the individual's Custody Facility Plan (CFP) and found that he must stay at his current facility, and the DOC is unwilling to transfer him for treatment. The OCO verified that individual's CFP was completed per DOC 300.380, Classification and Custody Facility Plan Review.	No Violation of Policy

	programming to something which would conclude prior to his ERD.		
Clallam Bay Corrections Center			
46.	Person reported that he has been trying to work with mental health to get a Health Status Report (HSR) for alternative drug testing methods. The person was denied the HSR despite it being supported by his care provider and is requesting assistance to get it approved.	The OCO provided assistance to this person. OCO staff reviewed the resolution documents and found the reason for denial of the Health Status Report (HSR) was not congruent with the DOC urinary analysis (UA) policy. OCO then addressed this with DOC Health Services leadership. OCO staff contacted the patient during the course of the investigation to provide self-advocacy and policy information to aid in the resolution process. OCO staff confirmed the patient was approved for the HSR for one year.	Assistance Provided
47.	Person reports he is having difficulties getting DOC to provide tinted eyeglasses that were recommended by a specialist.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff contacted Health Services management and were informed the glasses were approved and ordered. The recommendation had to be reviewed by multiple providers as the DOC health plan does not typically cover tinted lenses. Once the recommendation was determined to be medically necessary the glasses were ordered and DOC notified this office when the glasses were issued to the patient.	DOC Resolved
48.	Person reported concern about discriminatory comments that another incarcerated individual said against him.	DOC staff resolved this concern prior to the OCO taking action on this complaint. This individual called the OCO and said that he spoke with his custody unit supervisor and resolved the issue and wanted this case to be closed.	DOC Resolved
49.	Patient reports concerns about placement. Person requested to be placed at a medical facility and for the OCO to contact the medical directors to request he be transferred immediately.	The OCO contacted health services leadership and requested more information about the patient's access to treatment and facility placement. DOC health services reviewed and determined transferring facilities may impact the timeline of his care since he is already scheduled for follow up and the facility can provide the level of care currently needed. The OCO provided the individual with more information about the pathway for changing facilities for ADA needs in the future.	Information Provided
50.	Person reports that he needs to be in a single cell but was denied by DOC. The person is also requesting a specific medication that he received in the community.	The OCO provided information to the person regarding the single cell review process and the DOC Formulary Manual. OCO staff confirmed the person has not had a single cell review in several years and advised the person how to pursue that process. The medication the patient requested is on the restricted formulary and must be approved by the Care Review Committee, even if they were on the medication in the past.	Information Provided

51.	Incarcerated individual expressed concerns about a sanction they received as the result of an infraction.	The OCO contacted DOC to obtain clarification regarding the sanction concern and provided the individual with the information regarding this.	Information Provided
52.	Incarcerated individual reports concerns regarding his release planning and access to a TV in his current pod.	The OCO provided information regarding the individuals release planning and TV access in his pod. The OCO reviewed the individual's file and found he is past his release date due to being ineligible for the Earned Release Date (ERD) Housing Voucher and lacking available release options. The individual has recently been approved for the housing voucher and release planning is actively occurring. Per DOC facility staff, they do not have the ability to install cable into the individual's pod, though DOC is trying to get the resources needed to complete the project to allow individuals to have access to TV. The OCO confirmed individuals in this pod have access to dayroom TVs.	Information Provided
53.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found the individual's behavior met the infraction elements, thereby substantiating the infraction in accordance with DOC Policy 460.000.	No Violation of Policy
54.	Incarcerated individual relayed concerns regarding being unfairly infracted and losing their job.	The OCO reviewed the infraction materials as well as the individual's most recent custody facility plan and found no violation of DOC Policy 460.000 as the infraction was substantiated because the individual's actions met the infraction elements. The OCO advised the individual that due to their custody level, they are not eligible for a job at this time and would require a custody promotion in order to get a job.	No Violation of Policy
Coyote Ridge Corrections Center			
55.	Person reports he was transferred to a new institution and has not been seen by a medical provider. The person was scheduled multiple times and each appointment was cancelled.	The OCO provided assistance. OCO staff reviewed the patient's appointments and noted that an interpreter flag was not used to indicate the provider would need interpretation. OCO staff confirmed there were multiple delays in the patient receiving a physical assessment due to language barrier. OCO staff contacted Health services management and requested that an appointment be made with a note to prepare for interpretation services. OCO staff also requested staff be reminded to use the "interpretation needed" flag when scheduling patients who speak a language other than English.	Assistance Provided
56.	Individual reports DOC is not allowing individuals to use the Securus phone app during count times unlike the higher custody level, MI3.	The OCO reviewed this concern and contacted the Superintendent. The facility is aware of this concern and agreed to resolve this issue by allowing individuals to use Securus during count.	Assistance Provided

57.	Individual reports DOC is not allowing individuals to use the Securus phone app during count times unlike the higher custody level, MI3.	The OCO reviewed this concern and contacted the Superintendent. The facility is aware of this concern and agreed to resolve this issue by allowing individuals to use Securus during count.	Assistance Provided
58.	Patient reports medical concerns and issues related to his underlying conviction.	The OCO provided assistance by contacting health services leadership. After OCO outreach, the patient was scheduled with a provider to discuss incontinence care options and the patient's requested resolution of a catheter was provided. Per RCW 43.06C.040(2)(e), the OCO lacks jurisdiction to investigate a person's underlying criminal conviction.	Assistance Provided
59.	Individual reported DOC is not allowing individuals to use the Securus phone app during count times unlike the higher custody level, MI3.	The OCO reviewed this concern and contacted the Superintendent. The facility is aware of this concern and agreed to resolve this issue by allowing individuals to use Securus during count.	Assistance Provided
60.	Individual reports DOC is not allowing individuals to use the Securus phone app during count times unlike the higher custody level, MI3.	The OCO reviewed this concern and contacted the Superintendent. The facility is aware of this concern and agreed to resolve this issue by allowing individuals to use Securus during count.	Assistance Provided
61.	Individual reports DOC is not allowing individuals to use the Securus phone app during count times unlike the higher custody level, MI3.	The OCO reviewed this concern and contacted the Superintendent. The facility is aware of this concern and agreed to resolve this issue by allowing individuals to use Securus during count.	Assistance Provided
62.	Incarcerated individual relayed concerns regarding not being allowed to use the Securus phone app during count while higher custody levels are allowed to do so.	The OCO contacted DOC regarding this concern and the Superintendent is aware of the issue and is currently working to resolve it.	Assistance Provided
63.	Incarcerated individual relayed concerns regarding not being allowed to use the Securus phone app during count while higher custody levels are allowed to do so.	The OCO contacted DOC regarding this concern and the Superintendent is aware of the issue and is currently working to resolve it.	Assistance Provided
64.	Incarcerated individual relayed concerns regarding not being allowed to use the Securus phone app during count while higher custody levels are allowed to do so.	The OCO contacted DOC regarding this concern and the Superintendent is aware of the issue and is currently working to resolve it.	Assistance Provided
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66.	Individual reports DOC is not allowing individuals to use the Securus phone app during count	The OCO reviewed this concern and contacted the Superintendent. The facility is aware of this	Assistance Provided

	times unlike the higher custody level, MI3.	concern and agreed to resolve this issue by allowing individuals to use Securus during count.	
67.	Individual reports DOC is not allowing individuals to use the Securus phone app during count times unlike the higher custody level, MI3.	The OCO reviewed this concern and contacted the Superintendent. The facility is aware of this concern and agreed to resolve this issue by allowing individuals to use Securus during count.	Assistance Provided
68.	Individual reports DOC is not allowing individuals to use the Securus phone app during count times unlike the higher custody level, MI3.	The OCO reviewed this concern and contacted the Superintendent. The facility is aware of this concern and agreed to resolve this issue by allowing individuals to use Securus during count.	Assistance Provided
69.	Incarcerated individual relayed concerns regarding not being allowed to use the Securus phone app during count while higher custody levels are allowed to do so.	The OCO reviewed this concern and contacted the Superintendent. The facility is aware of this concern and agreed to resolve this issue by allowing individuals to use Securus during count.	Assistance Provided
70.	Person reports he followed the steps provided to him in a previous OCO case but has not received the Health Status Report that he needs.	The OCO provided assistance by contacting Health Services management to ask if the request had been reviewed by the Care review Committee(CRC). In their review of the concern, DOC HS management found that the CRC review had happened but was not yet reflected in the patient's Health Status reports. The Health Status report has been entered into the system.	Assistance Provided
71.	Person shared concerns that DOC staff are turning the unit he is housed in into a political unit and those who are in that unit for safety reasons no longer feel safe.	The OCO provided assistance by sharing this concern with the Superintendent. Facility leadership will follow-up on this issue.	Assistance Provided
72.	Person reports he has been waiting on a brace after an unsuccessful surgery. The person states that he was fitted for the brace by medical staff but never heard anything further about the brace.	The OCO provided assistance by contacting Health Services management to request a review of the patient's records for the order. DOC staff met with the patient and the provider, and the brace is being ordered.	Assistance Provided
73.	Person reports he is unable to provide urinalysis (UA) samples within the timeframe allowed by policy. He was able to get a Health Status report after being asked for a UA, but not before being written an infraction.	The OCO provided assistance by contacting DOC facility leadership and requested a review of the infraction with information found during the OCO investigation. OCO staff found the person had been asked for a urinalysis (UA) sample before he was seen by Health Services for an initial evaluation, where he would have been able to request the Health Status Report DOC agreed to overturn the infraction and remove it from the person's record.	Assistance Provided
74.	Person states that his Health Status Report for a mobility device was removed based on custody involvement.	DOC staff resolved this concern prior to OCO action. OCO staff reviewed the person's records and found the Health Status Report was reordered.	DOC Resolved

75.	Person reports they were transferred due to medical reasons and his property was not correctly packed out. The person reports he is missing the contents of a locker and his dentures.	The OCO provided information to the person regarding the tort claim process. OCO staff contacted Health Services management to confirm the patient would be receiving replacement dentures. OCO staff contacted DOC staff in both facilities to attempt to find the property. All facilities involved stated that all property was sent. Individuals who have been harmed or who have suffered a loss as a result of negligent actions by a state employee or agency can submit a tort claim to the Office of Risk Management (ORM). ORM is required by law (RCW Chapter 4.92) to receive these claims.	Information Provided
76.	Incarcerated individual relayed concerns regarding wanting the extended family visit (EFV) policy to change.	The OCO noted the individual's desire for the EFV policy to change and will consider this once this policy undergoes revision with DOC. Once the policy is up for review, the individual was informed they are also able to submit comments regarding their desired changes directly to DOC.	Information Provided
77.	Person reported that individuals are being taxed for bead orders, but their families are not being taxed when they purchase bead orders for individuals.	The OCO provided information. The OCO reached out to the Correctional Program Manager and the Religious Coordinators at the facility. The Religious Coordinator explained the two ways that incarcerated individuals can purchase beads. The first way is through the hobby process, the money for the purchase is taken from their personal money account which is taxed when the money lands in their funds (Legal Financial Obligations, mandatory savings, etc). The other way is through religious programming, in which an incarcerated individual may receive religious items, including beads, purchased by their family, and in that way is not taxed. The Religious Coordinator said that these have been the two options for a long time and have not changed recently.	Information Provided
78.	The individual reported concerns regarding the discrepancy in his paycheck from his job from one month to the next.	The OCO provided information. This office spoke with DOC staff at the facility who verified that the individual's job works more hours per week during the summer, and hours are reduced during autumn and winter, hence the discrepancy in his paychecks. The OCO verified that the individual is being paid for all hours worked.	Information Provided
79.	Incarcerated individual reports concerns regarding his release. The individual reports his counselor has forwarded the release plan to the Community Corrections Officer (CCO) and the plan has not been finalized.	The OCO provided information regarding the individual's release plan. The OCO spoke with DOC staff who confirmed the plan needs to be finalized by the CCO. The DOC staff sent a reminder to the CCO and the plan was finalized shortly after the outreach. The individual now has a planned release date.	Information Provided
80.	Person reports the glasses he was provided by DOC are not effective.	The OCO provided information to the person regarding the Patient Paid Health plan to access a	Information Provided

	The person also reports issues with the care received by optometry and requests to see a different provider.	second opinion. DOC has a limited amount of optometrist available to provide optical care. It is not possible for DOC to accommodate the request to see another optometrist. Per DOC 600.020, patients may submit a request to purchase medical, mental health, dental care, and medications not covered per the Washington DOC Health Plan by completing DOC 13-460 Patient Request for Outside Health Services and submitting it to the facility Business Office.	
81.	Person reported an incident in which a correctional officer called him a racial slur.	The OCO provided information. The OCO reviewed the resolutions request investigation regarding this incident and found that DOC could not substantiate this because there was no audio recording or other evidence, and said they spoke with the corrections officer and reviewed DOC policy about treating all incarcerated individuals with respect and dignity. The OCO brought this concern to the attention of the facility superintendent, who said that while she could not substantiate this incident due to lack of evidence, she is working with her staff to ensure a professional and respectful environment.	Information Provided
82.	Person reported that DOC's contract attorney is not responding to his request for legal assistance. Person said his understanding is that contract attorneys are obligated to acknowledge the reception of an incarcerated individual's legal assistance request, as well as provide assistance under said contract and/or deny any request for assistance.	The OCO provided information. The OCO encourages this individual to speak with the law library for further assistance, and to file a resolution request specifically about this issue. 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
83.	Incarcerated individual expressed concerns about the new protocol for urinalysis (UA) testing as a result of the September 6th Presumptive Drug Testing memo from DOC.	The OCO discussed this concern with DOC headquarters and verified that the protocol for a UA test has not changed, as an individual still has the opportunity to request the UA be sent to the lab for confirmation at the time of testing, at which point an individual is notified in writing while signing the UA paperwork.	Information Provided
84.	Person reported that he and other individuals were moved to a medium unit for an investigation, even though they were not demoted or infracted. Person reported that he lost his job and some property during the move. Person also expressed that he does	The OCO provided information. The OCO reviewed DOC records and reached out to this individual's classification counselor and asked why this individual was moved. The classification counselor said that the move was not punitive, and that they attempted to place him in a minimum unit, but he refused. The counselor shared that this individual has a job referral in his new unit and explained the process for him to get a new job. The counselor	Information Provided

	not want to be moved to a minimum unit.	said that he has discussed these concerns with this individual multiple times, including the concern about moving to a minimum unit, and explained that he will have to go to minimum per policy guidelines. The OCO could not find a violation of DOC Classification and Custody Facility Plan Review 300.380. The counselor also stated that he has spoken to the Custody Unit Supervisor, who is working to address his property concerns. The OCO shared information about how to address his property and employment concerns.	
85.	Person reports he has an eye infection and the officer in the living unit took his eye drops without explanation.	The OCO provided information to the patient regarding the eye drops that were taken. The medicated eye drops had been recalled by the manufacturer and had to be confiscated for patient safety.	Information Provided
86.	Person reports there is a custody officer that is mistreating him and other individuals. The person reports he has had medical appointments cancelled because of the officer's actions. The person is requesting that officer be removed from their post.	The OCO provided information to the person regarding the staff conduct investigation. OCO leadership took this concern to the Superintendent who confirmed corrective action was taken. The OCO does not have authority to dictate staff discipline.	Information Provided
87.	The individual reported that the facility is blocking mail from his loved one, but he has not received any mail rejection notices. The person feels that this is racially motivated.	The OCO was unable to substantiate the concern due to insufficient evidence. This office spoke with mailroom staff at the facility who reported that the individual does not have any restrictions regarding receiving mail. DOC staff also reviewed mail rejection notices from the past year and did not find that any of his mail was rejected.	Insufficient Evidence to Substantiate
88.	Incarcerated individual expressed concerns regarding asking for a urinalysis (UA) to be sent to the lab but it was not sent, and the individual states the officer admitted to not asking them if they wanted it sent out.	The OCO independently verified and confirmed with DOC that the individual signed DOC form 14-002ES which states one can send the sample to a lab if they request to do so. This office also confirmed with DOC that the individual verbally declined to have the sample sent out. Thus, this office is unable to substantiate the individual's account of the events that led to the infraction.	Insufficient Evidence to Substantiate
89.	An external person reported concerns regarding the individual being denied visitation with his minor children.	The OCO was unable to substantiate a violation of policy by DOC. Per DOC 450.300, Visits for Incarcerated Individuals, if the Judgment and Sentence (J&S) states no contact with minors, the application will be denied. This office verified that this is a court ordered condition of the individual's J&S.	No Violation of Policy
90.	The individual reported that he is being held past his Earned Release Date (ERD) for reasons that are not his fault. The person said that there	The OCO was unable to substantiate a violation of policy by DOC. Per DOC 350.200, Transition and Release, individuals requiring an approved release address may be held in confinement up to the maximum expiration date until an approved	No Violation of Policy

	have been issues with housing being approved.	release address is secured. This office verified that the individual did have his housing approved and has since released.	
91.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials 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
92.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC Policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
93.	Incarcerated individual relayed concerns regarding denial of visitors.	The OCO was unable to locate a violation of DOC policy as the OCO spoke with DOC headquarters and verified that the visitors were denied due to the violation of several judgment and sentence conditions as well as safety concerns.	No Violation of Policy
94.	Person reports he has not been able to switch out his contacts in a very long time. He has contacts that were purchased prior to incarceration and is requesting to be allowed to have them. The person reports DOC has declined to allow the contacts even though they are sealed.	The OCO was unable to substantiate a violation of policy by DOC. All packages must comply with DOC 450.100 Mail for Offenders. Package contents must comply with DOC 440.000 Personal Property for Offenders. OCO staff verified the person was given instructions on how to get contacts approved through the correct channels.	No Violation of Policy
95.	The individual reported that his family member sent him money but did not note on the money order that it was meant for commissary. The person said that per policy, family members can designate that the money order is for the subaccount commissary and funds will go directly to that account and will not have deductions taken from it. Because his family member did not do this, deductions were taken from the money order. The individual wants DOC to reverse the transaction and deductions so that the full amount will go into his commissary account.	The OCO was unable to substantiate a violation of policy by DOC. Per DOC 200.000, Trust Accounts for Incarcerated Individuals, funds will be deposited into a subaccount, as defined per Attachment 5, designated by the sender. If no subaccount is specified, the deposit will be posted to the spendable subaccount. The individual filed a resolution request regarding this concern, and the DOC was unwilling to reverse the transaction and deductions. The OCO encouraged the individual to communicate with his loved ones to ensure that they designate the subaccount where they wish the money to be deposited.	No Violation of Policy
96.	Person reported working double shifts as a custodian, was told he would be paid for working both shifts, but only received his regular pay. Person said that after filing a resolution request about the staff person responsible for hiring, he was fired and infracted.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed his resolution request and found inconsistencies in the response, and that one was not accepted because he received an infraction. The OCO reached out to the Resolutions Department at DOC Headquarters asking if they would accept the request because of the inconsistencies and that it is about a staff conduct concern. The Resolutions Department	No Violation of Policy

		acknowledged the inconsistencies, but said they were correct in not accepting the staff conduct concern because of how the complaint was worded, and that he is now outside of the timelines per the Resolutions Program Manual. The OCO reviewed the infraction packet and could not verify that DOC reviewed all of the evidence during the appeals investigation. The OCO spoke with the Associate Superintendent and requested they review more evidence, which resulted in finding evidence which substantiates that this individual stopped coming to work, which meets the criteria for the infraction he received.	
97.	The individual reported concerns regarding being told to move to a different unit where security threat group (STG) members are housed. The person said that he is not in an STG and is concerned about moving units. The individual was infracted for refusing housing.	The OCO was unable to substantiate a violation of policy by DOC. This office spoke with DOC staff who verified that the individual was told to move because he was promoted from medium to MI3 and his name came up by seniority based on promotion date. The DOC bases its movement of individuals based on custody level, medical/mental health needs, program needs, and safety and security. Intelligence and Investigations at the facility and headquarters level make suggestions on where individuals will go based on STG involvement and determined that the individual did not have any factors that would likely make him unsafe in the new unit. The OCO was unable to find a violation of DOC 300.380, Classification and Custody Facility Plan Review.	No Violation of Policy
Larch Corrections Center			
98.	Incarcerated individual relayed concerns regarding the tamper proof seal not being placed on their urinary analysis (UA).	The OCO confirmed that in the infraction packet there is a document from DOC staff stating the individual initialed and dated the seal. This office is unable to substantiate the claim that the tamper proof seal was not placed on the UA.	Insufficient Evidence to Substantiate
Mission Creek Corrections Center for Women			
99.	Person reports that she declared a medical emergency for a dental issue and was dismissed by medical. The person states that the nurse determined her issue was not an emergency and she was only given over the counter medications. The patient was transferred soon after the medical emergency and had to go to the emergency room because the issue had escalated. The patient believes that if she had been given antibiotics when she declared the medical emergency, she would not	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff reviewed the emergency response notes and found that nursing staff evaluated the patient and consulted with the on-call provider for the plan of care. The patient transferred before follow-up with her medical provider could be scheduled. OCO staff provided the person with tort claim information. Individuals who have been harmed or who have suffered a loss as a result of negligent actions by a state employee or agency can submit a tort claim to the Office of Risk Management (ORM). ORM is required by law (RCW Chapter 4.92) to receive these claims.	Insufficient Evidence to Substantiate

	have had to go to the emergency room in the community.		
Monroe Correctional Complex			
100.	Incarcerated individual reports concerns that he cannot contact his family member due to an issue with them being restricted. The individual reports he has tried to report the concerns to DOC staff and has gotten no response.	The OCO provided assistance. This office spoke to the investigation's unit at the facility and the investigations unit spoke with the administrator of Securus operations who reported that there are no restrictions with the family member in question. The OCO requested DOC staff share this information with the individual and DOC staff agreed to share that there are currently no people restricted from his list. DOC recommended that the visitor reach out to Securus directly to troubleshoot issues with signing up for services.	Assistance Provided
101.	Individual reported that she is being stalked by another individual at the facility.	The OCO reviewed this concern and contacted facility leadership. They arranged for the Lieutenant to meet with her and discuss her safety concern. This office verified she does not share a unit with this individual who she states is stalking her.	Assistance Provided
102.	Patient reports he has been on chronic medication for pain management for several years and is facing the possibility that he will be taken off of them. The patient is requesting that OCO contact the Deputy Chief Medical Officer and the Pain Specialist and make sure they are part of the conversation since they are the most familiar with his history.	The OCO provided assistance by contacting DOC Health Services leadership. OCO staff was able to verify that the patient's care plan is being reviewed by each provider familiar with patient's history, as requested by the patient. Additionally, the OCO will provide the patient with information regarding the Care Review Committee decision.	Assistance Provided
103.	Incarcerated individual expressed concerns about a grievance that was incorrectly closed as a duplicate.	The OCO reviewed the grievances associated with this concern and confirmed that the grievances were about two separate issues and the one should not have been closed as a duplicate. The OCO reached out to DOC regarding this concern and upon OCO outreach, DOC agreed to reopen the grievance and review it as a new grievance, not a duplicate.	Assistance Provided
104.	External person reports concerns about their loved one being transferred and requested they remain at their current facility until their upcoming release date. The person is being told they have to transfer to complete programming that they are not required to complete and that would impact their release date.	The OCO elevated this concern through DOC leadership at headquarters. As a result, the transfer was put on hold and the individual will remain at their current facility after discovering an error in programming requirements.	Assistance Provided

105.	Person reports past incidents and requested OCO ensure his safety from self-harm.	The OCO reviewed incident reports and confirmed the individual has received medical care for past self-harm injuries. During a facility visit, the patient provided updated concerns/resolutions which this office discussed with unit leadership. The individual was then approved for Residential Treatment Unit (RTU) placement.	Assistance Provided
106.	External person reports their loved one is being held in DOC custody, but is not incarcerated by DOC. They have medical issues and require expensive medication. They are requesting that this person be released and allowed to get healthcare in the community.	DOC staff resolved this concern prior to OCO action. OCO staff contacted Health Services management and verified the medication was available for the patient.	DOC Resolved
107.	Individual reports he has been stuck in solitary confinement since September and was not allowed to go to the transfer pod. In addition, he had a medical hold that he said was unnecessary.	The OCO reviewed this concern and verified the individual has been transferred and is now in general population. This office released a public report on September 22, 2023, regarding medical holds and how medical holds impact individuals while they are housed in solitary confinement. The OCO continues to monitor these concerns.	DOC Resolved
108.	Incarcerated person reports they were visited by records to update their photo in preparation for release but they needed the DOC staff member to wait a moment and they did not wait so they missed their appointment. They asked OCO to make sure the appointment was rescheduled.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The person was rescheduled for their photo and The OCO was able to verify in OMNI that a new photo was taken with no outreach by the OCO.	DOC Resolved
109.	Person reports he has been without his hearing aids for over a month after sending them to be repaired.	DOC staff resolved this concern prior to OCO action. OCO staff contacted Health Services management who verified the patient has the hearing aids.	DOC Resolved
110.	Person reports that he needs to change pain management medications. The person was told he was on a waiting list, but it has been 7 weeks with no changes.	DOC staff resolved this issue prior to OCO involvement. OCO staff reviewed the person's available records and found that he was started on the requested medication.	DOC Resolved
111.	Person reports that multiple documents from appointments were not entered into his medical file. The patient is requesting those notes be added to his record.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff contacted Health Services Management to have the documents located. DOC staff were able to locate the documents already in the patient's medical file.	DOC Resolved
112.	Person reported that his counselor made a mistake in writing the release address and the community corrections officer went to the wrong address to inspect for	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and found that DOC addressed the error and this individual released on his earned release date.	DOC Resolved

	release. Person said this mistake delayed his release planning and expressed concerns that he will not be released on his planned release date.		
113.	Person reports he has been waiting months to receive shoes from medical.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff contacted Health Services management and were informed the patient had already picked up the new shoes.	DOC Resolved
114.	Person states he has not seen his provider in a few months, but his medication orders are ending. The person is requesting follow up with his provider and more information regarding his diagnostic results.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff contacted Health Services management and were informed the patient was referred to a specialist and that appointment was already scheduled. OCO staff also verified that the patient had additional related follow up scheduled in the facility. OCO staff advised the patient to kite the Patient Care Navigator for more information about his diagnostic results.	DOC Resolved
115.	Person described ongoing issues with getting violent cellmates and said that he feels concerned for his safety with his current cellmate. Person said that the shift Sergeant is not doing anything to address his concerns.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and found that this individual was given a different cellmate.	DOC Resolved
116.	Person reports he has not received follow up after being in a motor vehicle accident during DOC transport.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff contacted Health Services management and were informed the person had recently been seen for follow up and the plan of care was updated. OCO staff verified the person had received care the day of the incident and that another follow-up appointment was requested by the provider in the future.	DOC Resolved
117.	Person requests information about DOCs dental coverage of crowns and root canals.	The OCO provided information to the person regarding the dental protocol and DOC Health Plan. Per the DOC Health Plan, Dental crowns, implants and veneers are considered by DOC to be Level 3: not medically necessary care and not authorized to be provided. Services associated with the diagnoses listed in Level 3, even if appropriate, cannot be authorized by an individual provider or Care Review Committee (CRC). Incarcerated individuals may receive Level 3 care under DOC 600.020 Patient Paid Health Care at their own expense, if certain conditions are met.	Information Provided
118.	Person reports delayed processing of their DOC 02-420 Preferences	The OCO elevated the concern and confirmed the form has now been processed and the individual was referred to the next steps in the protocol.	Information Provided

	Request form related to gender identity.		
119.	Patient reports he requested to have his Health Status Report renewed to not be housed with someone who used oils or perfumes.	The OCO provided information regarding the Care Review Committee (CRC) decision. OCO staff also provided self-advocacy information for future requests that must go through the CRC.	Information Provided
120.	Patient expressed mental health symptoms and requested medication access.	The OCO provided information regarding a pathway for specific medication access and Care Review Committee (CRC) appeal process. This office confirmed DOC Formulary option prescribed.	Information Provided
121.	A loved one reported that they have been unable to obtain video of a DOC hearing that resulted in an incarcerated individual being sent back to prison and requested the OCO's help in getting that video.	The OCO provided information. The OCO reviewed DOC records and found that this individual chose to self-terminate from Graduated Re-entry to maintain his good conduct time and get out of prison sooner. The OCO also found that this person has now been released. The OCO is unable to provide this video, and provided information about how this individual can publicly request the record from DOC.	Information Provided
122.	Person reports they are not being given access to report PREA concerns. Person also states they have not been given their CPAP machine.	The OCO provided information to the person regarding the investigation process for PREA concerns. OCO staff verified that the reported concern was documented appropriately and the investigation was open. DOC must complete the PREA investigation before the OCO can review the investigation. OCO staff also provided information to the patient regarding self-advocacy steps to receive the requested medical equipment.	Information Provided
123.	Incarcerated individual reports concerns regarding his placement in solitary confinement and requests OCO assistance to be released from segregation. The individual also reports concern regarding his Custody Facility Plan and reports DOC is not completing it per policy.	The OCO provided information regarding how to appeal custody facility plans (CFP) and information about the outcome of his recent CFP. The OCO found DOC determined that they will retain the individual in the same unit as his custody points are appropriate to do so, and the OCO confirmed the individual is out of segregation. This office also verified the individuals CFP was completed per DOC 300.380.	Information Provided
124.	Patient reports concerns about delayed medical care, pain medication, and grievance responses related to a broken hand and requested legal support.	The OCO confirmed medical grievance responses. OCO cannot provide attorney referrals and provided the individual with information regarding tort claims since the resolution request was related to legal support.	Information Provided
125.	Person requested help getting money and music from his old JPay account to his Securus account.	The OCO provided information about how to request a meeting with a Securus representative. 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	Information Provided

		incarcerated individuals to DOC's attention. Because this involves money in a Securus account, not DOC accounts, neither DOC nor the OCO has jurisdiction to assist.	
126.	Person reported that his classification counselor is not helping with his release, and said that he is being denied housing. Person said that he is months past his Earned Release Date (ERD), and no one is telling him what is going on.	The OCO provided information. The OCO reviewed DOC documents, including his release plan and End of Sentencing Review. The OCO reached out to this individual's classification counselor, who said that she informed this individual about the results of the End of Sentencing Review and how that is impacting his release. The classification counselor also stated that she submitted a public records request to DOC Headquarters so that he can receive his own copy of that document.	Information Provided
127.	Person reports he has had a Health Status Report (HSR) for an extra hour to provide a urinalysis for several years. It expired recently and he has not been able to get it renewed. He is requesting his HSR be reinstated.	The OCO provided information to the patient. OCO staff reviewed the Care Review Committee (CRC) consult and noted the review had not been scheduled yet. The request must be approved through the CRC. If denied, the decision can be appealed within 5 days of receipt.	Information Provided
128.	Incarcerated person filed a complaint related to DOC policy asks OCO to review and intervene.	The OCO provided information regarding how to appeal resolution program responses. The incarcerated person has appealed the resolution response and DOC is in the process of reviewing and providing the next level of response.	Information Provided
129.	The individual reported that he is not being given an hour out each day. The person also said that his food trays are not being picked up regularly and he has to repeatedly ask for cleaning supplies and linens. The individual also said that he has tried sending kites but it has been taking a long time to receive a response.	The OCO provided information. This office spoke with DOC staff at the facility who verified that the patient was in medical isolation when the concern was reported. DOC staff were following isolation and quarantine protocols per DOC 670.000. Staff had limited access to the individual due to having to follow necessary measures and protocols to prevent transmission. OCO staff verified the patient's correspondence had been responded to by DOC.	Information Provided
130.	Patient reports he has been requesting to have a serious surgical procedure but has not been able to have it approved. The patient is requesting assistance in getting the provider to agree to the treatment.	The OCO provided information to the patient regarding the DOC health plan and the steps needed to be approved for surgery. OCO staff contacted health services management and verified the patient's care plan had been updated recently and that follow up appointments were scheduled. OCO staff monitored the appointment on the appointment tracker and followed up with the facility after the specialist appointment was attended. The OCO also provided information to the patient regarding the DOC Patient Paid Health Plan, if the patient is interested in getting a second opinion from a specific care provider.	Information Provided
131.	Person reports he has been trying to access the mobility weight deck	The OCO provided information to the patient regarding the criteria for accessing the mobility	Information Provided

	call out. The patient states he has requested a Health Status Report (HSR) from his provider but was told that he does not need one and that the provider could not write the HSR.	gym call out. The patient may need to have multiple Health Status Report (HSRs) approved through the Care Review Committee before they meet criteria to access the mobility gym.	
132.	Patient reports she was injured last year and did not receive treatment causing her to have a chronic injury. The patient is requesting an MRI.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff contacted Health Services management and were provided details of the care provided to the patient at the time of injury. OCO staff also verified follow up was scheduled for the patient. Per the patient's care team, the requested resolution is not currently clinically indicated.	Insufficient Evidence to Substantiate
133.	Person reports he has multiple medical concerns that are not being addressed by DOC. The person reports that he needs a Health Status Report that excludes him from working. The person also states he has an ongoing infection that has not been resolved. He is asking that DOC be held accountable for not providing healthcare.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff contacted Health Services management and received input from the person's medical provider. The medical provider gave this office the most updated treatment plan for this patient and information about the care provided already. There was insufficient evidence to substantiate the patient's medical needs were not being addressed by DOC.	Insufficient Evidence to Substantiate
134.	Person reported staff conduct concerns following an interview for his resolution request, and requests that the OCO review the incident and the incident that occurred after to substantiate retaliation.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the resolution request and infractions that were applied after and were unable to find that the same officer was involved in the infraction and resolution request interview. To substantiate retaliation, the OCO must be able to prove that a negative action from a DOC staff member is not only linked close in time to an incarcerated individual’s protected action but there must be evidence of a clear relationship between the two acts.	Insufficient Evidence to Substantiate
135.	Incarcerated individual expressed concerns about an infraction they received for failure to provide a urinary analysis (UA) when they had a Health Status Report (HSR).	Upon a closed case review request, the OCO reworked this case and confirmed that the individual should have had an HSR in place at the time of the infraction, however, it had not been entered into the system. As a result, the OCO reached out to DOC to request dismissal of the infraction, to which DOC agreed.	Assistance Provided
136.	The individual reported that he was placed in the Intensive Management Unit (IMU) for Involuntary Protective Custody after being assaulted. The person said they were held in the IMU for five months pending the	The OCO was unable to substantiate a violation of policy by DOC. Per DOC 320.200, Administrative Segregation, an individual may be assigned to administrative segregation when the individual is deemed by employees/contract staff to require protection. This office verified that the individual has since returned to general population.	No Violation of Policy

	completion of the housing protocol. The individual said that they are awaiting transfer but have not been given any information about what is happening.		
137.	Person reports helping to plan the facility's PRIDE event, but was later told she cannot attend.	The OCO contacted the facility and found that individuals must be 90-days infraction free in order to attend. Because of this, the person did not meet this requirement, their denial of participation was within policy.	No Violation of Policy
138.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and contacted DOC to see about the possibility of overturning the infractions due to the low evidentiary standard used to substantiate the infractions, however, DOC was unwilling to overturn the infraction. The OCO was unable to identify a violation of DOC Policy 460.000.	No Violation of Policy
139.	Incarcerated individual reports DOC changed his release date incorrectly and requests the OCO review DOC's action for policy and legal compliance.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the resolution request investigation which states per RCW 9.92.151 this individual is not eligible for the jail time credit because the initial term of confinement imposed under a previous sentence is not eligible for earned release.	No Violation of Policy
140.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
Olympic Corrections Center			
141.	Person reports he is requesting to be transferred to a work camp but is being told he needs medical clearance. He reports this was already done at his last facility and he should not have to wait over a month to be seen again.	The OCO provided assistance. OCO staff reviewed the patient's job screening and noted it was only partially completed. OCO staff contacted Health Services management and requested an update as to when the documentation would be completed. OCO staff verified the record was updated.	Assistance Provided
142.	Incarcerated individual reports programming is not allowing him to transfer to Graduated Reentry (GRE). Individual requests the OCO review the current policy and how it impacts individuals access to GRE.	The OCO provided information about GRE requirements. This office also explained how Reentry Center screenings and approvals can occur outside of the GRE program, which would allow an individual transfer to a Reentry Center without GRE participation. The OCO spoke with DOC staff regarding the individual's GRE placement and DOC staff explained that per RCW 9.94A.733 and Senate Bill 5502 GRE requires participants to be assessed and program or have access to programming to be accepted. In this individual's situation, the GRE program is willing to accept him once the programming is complete. Also, the individual has been screened and approved to transfer to a Reentry Center outside of the GRE program. Transfer to a Reentry Center	Information Provided

		does not require an assessment and is not governed by the RCW and Senate Bill.	
143.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction narrative as well as the accompanying evidence and found no violation of DOC Policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
Other - Community Custody			
144.	Individual reports staff misconduct on Community Custody.	The OCO reached out to the Assistant Secretary of Community Corrections and asked for a review of this concern. The Supervisor of this unit will ensure the individual understands his court ordered conditions and will work with him to get mental health treatment set up.	Assistance Provided
145.	Incarcerated person wrote to the OCO asking for help with Community Custody time calculation as the individual is incarcerated in a non-DOC facility waiting for a trial for a new charge unrelated to DOC Community Custody violations.	The OCO provided information regarding the current status of the individual's stay in the non-DOC facility including information publicly available from the non-DOC facility.	Information Provided
146.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials 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
Other - Jail/County/City			
147.	Loved one expressed concerns about inhumane jail conditions.	Per WAC 138-10-040(3)(a) the ombuds lacks jurisdiction over the complaint as it relates to conduct in a jail facility, but provided the individual with several resources.	Information Provided
148.	Incarcerated individual relayed concerns regarding inability to access medical care in jail.	Per WAC 138-10-040(3)(a) the ombuds lacks jurisdiction over the complaint as it relates to conduct in a jail facility, but provided the individual with several resources.	Information Provided
149.	Incarcerated individual requests information regarding how DOC and Immigration Customs Enforcement (ICE) communicate. The individual requests DOC's protocol for providing information to ICE.	The OCO provided information regarding the DOC policies and protocol's for communicating with ICE. The OCO found per DOC 350.750 Warrants, Detainers, and Holds, "Employees may only engage in or assist with civil immigration enforcement if the information is available to the public." DOC shared with this office that DOC notifies ICE of every admission into their prisons, whether they have a detainer or not and it is the responsibility of ICE to act on their own detainers. This may mean that ICE will come to the prison on a person's release date.	Information Provided
Other - Unknown			
150.	Incarcerated individual expressed desires about changing the pain management prescription policy.	The OCO noted the desired changes to the policy and will consider said suggestions when the policy is up for review.	Information Provided

151.	Individual relayed concerns regarding the ongoing financial problems with the DOC work release program including potential for retaliation against participants who speak out about these problems.	The OCO noted these concerns for ongoing DOC policy feedback. The OCO informed the individual that the work release policy is not currently up for review, but once it is, they are able to make policy recommendations directly to DOC regarding these concerns.	Information Provided
152.	Individual relayed concerns regarding the mismanagement of inmate trust accounts.	The OCO noted the concerns for ongoing DOC policy feedback. The OCO informed the individual that the inmate banking policy is not currently up for review, but once it is, they are able to make policy recommendations directly to DOC regarding these concerns.	Information Provided
Stafford Creek Corrections Center			
153.	Person reported he has been trying to get a brace reissued for some time, but his request is being blocked by custody.	The OCO provided assistance by contacting Health Services management and requested management advocate to custody for the patient to be able to have the brace. Health Services management agreed and worked with the patient's provider and custody to provide a brace that would sufficiently support the patient.	Assistance Provided
154.	Person reported that he was removed from a religious band and alleged that DOC committed criminal offenses in doing so.	The OCO provided assistance. The OCO reviewed DOC records and reached out to the Recreation Specialist, who said that this individual was removed from the band because he was trying to move the band away from playing religious music, and that he could rejoin the band if he spoke to the chaplain. The OCO asked if the Recreation Specialist was willing to place him in a different band. The Recreation Specialist then reached out to him, and set him up with tryouts for a new band, and confirmed that he has multiple options for musical groups for this individual.	Assistance Provided
155.	Patient reports he is having difficulty understanding the care that DOC is giving him. He has an access assistant that he trusts, but the assistant is not allowed to attend his medical appointments with him. He is requesting his access assistant be allowed in his medical appointments.	The OCO provided assistance by contacting the Health Services Manager (HSM) with the patient's request. The HSM flagged the concern for the patient's care team to make sure the patient understands the treatment plan. The OCO provided information to the patient about the Patient Care Navigator, a newer position within DOC created to offer patients with an additional source of information about their medical care..	Assistance Provided
156.	Person reports he has been trying to get a specialist appointment for a sleep study. The person is concerned he may be transferred before he can attend the consult appointment.	The OCO provided assistance. OCO staff contacted Health Services management about the patient's consult. OCO staff verified a medical hold had been placed after the outreach.	Assistance Provided
157.	Person reports DOC staff are refusing to provide her a properly fitted support bra.	The OCO provided assistance by contacting DOC leadership. After OCO outreach, this office confirmed the person was fitted and a new	Assistance Provided

		support bra was ordered. The OCO also provided the individual with related policy information and process.	
158.	Person reports he needs to see a specialist for a severe chronic issue. The patient reports he is supposed to be on a special diet but DOC does not have a special diet established for his needs.	The OCO provided assistance by contacting Health Services management and requesting the nutritional breakdown of the DOC menu be provided to the patient. OCO staff reviewed the specialist consult notes and determined a nutritionist and specialist did review the menu and found it met the medical need with the additional treatment being provided. Certain special dietary needs can be met by the person self-selecting items that meet the recommendations placed by the specialist. OCO staff also verified the patient is scheduled to receive recurring diagnostics to continuously determine the need for repeat treatment.	Assistance Provided
159.	Person reported that he has been in solitary confinement for months, and that he is waiting for his Custody Facility Plan to be finished. Person said that the infractions that put him in solitary confinement have been reduced or dismissed, and he is concerned that his Custody Unit Supervisor recommended him for maximum custody.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed this individual's Custody Facility Plan and found that it was completed and that DOC Headquarters recommended this individual be promoted to medium custody, and that he has now been moved out of solitary confinement into medium custody.	DOC Resolved
160.	Person reported that he is past his Earned Release Date and is waiting for his final review. Person said his classification counselor has made outreach to assist in his release plan being finalized.	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 has been approved, and this individual was released.	DOC Resolved
161.	The individual reported having issues getting a job. He has spoken with DOC staff at the facility and was told that because he received several infractions, he is not on any job list. The individual says that he has not received recent infractions and believes DOC staff mistook him for someone else. The individual wants to be employed.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO verified that the individual was hired for job after this concern was reported. This office encouraged the individual to work with his classification counselor should he have any concerns about his job or want additional job referrals.	DOC Resolved
162.	The individual reported concerns that all legal mailboxes have been removed from his unit.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO spoke with unit staff who verified that all legal mailboxes in the unit were reinstalled shortly after the removal.	DOC Resolved
163.	Person reported concerns about being harassed by another	DOC staff resolved this concern prior to the OCO taking action on this complaint. This individual	DOC Resolved

	individual. Person said that he got a rejected message that allegedly had that individual's name and wants to know who sent that message.	called the OCO and said that the rejected message was overturned. The OCO shared self-advocacy information and how he can work with his Custody Unit Supervisor (CUS) about being harassed.	
164.	A loved one said that an incarcerated individual is having issues logging into his Securus tablet.	The OCO provided information about how to request a meeting with a Securus representative. 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
165.	The individual reported concerns with the business office at the facility. The person says that the DOC violated policy by not processing his VA check within the allotted timeframe.	The OCO provided information. This office reviewed the investigation of the resolution request and found that the DOC did substantiate that the individual's VA check was processed one business day late due to staff shortages in the business office. The facility verified that they have since taken steps to correct the shortage of staff in the business office to ensure checks are processed per policy. This office did not find evidence that the individual's checks were not processed per policy following this incident.	Information Provided
166.	The individual reported safety concerns at the facility he is supposed to transfer to.	The OCO provided information. The OCO confirmed that individual was since transferred to the facility he reported concerns about. This office encouraged the individual to contact Intelligence and Investigations (I&I) if he still has concerns, but will need to provide specific and verifiable details of the concerns for I&I to investigate.	Information Provided
167.	Individual reports he has been held in involuntary protective custody in solitary confinement for two years. He states he does not have protection concerns and will not move to a safe harbor.	The OCO reviewed this concern and contacted DOC Classifications. The DOC maintains that he does have protection concerns and would be willing to move him to a safe harbor lower level of custody. The OCO traveled to the facility to discuss this concern with the individual. He said that DOC is not being truthful about his situation and he will not move to a safe harbor. This individual is scheduled to release next year and the DOC currently plans on releasing him from solitary confinement into the community. The DOC is within policy to hold him in solitary confinement, however the OCO has not seen evidence from the DOC to substantiate that there are valid safety concerns.	Information Provided
168.	Person reported that the legal liaison position has been eliminated from Stafford Creek Corrections Center, and that there is no pathway to grieve the issue.	The OCO provided information. The OCO reached out to the Correctional Program Manager, who confirmed that there is still a legal liaison working at Stafford Creek Corrections Center and connected the OCO with the current legal liaison.	Information Provided

		The Correctional Program Manager and the legal liaison stated there are no plans to eliminate that position. The OCO provided this individual with information about who the legal liaison is and how he can contact them.	
169.	Person reports concerns about facility placement and classification.	The OCO provided information about the individual's next opportunity for facility review and informed the individual that their next Custody Facility Plan (CFP) should occur in Spring as part of the annual review process.	Information Provided
170.	External person reports staff misconduct that has created a hostile living environment for her loved one.	The OCO contacted the facility and asked for a review of the staff misconduct. The DOC could not substantiate the details related to this incident, however this individual was promoted and moved out of the unit. The OCO traveled to the facility and met with the individual to discuss his suggested resolution. The individual wants staff held accountable for misconduct. While the OCO cannot dictate staff discipline, this office did ask the individual to contact this office if he is experiencing retaliation for his concerns.	Information Provided
171.	Incarcerated individual relayed concerns regarding a desire to get DOC to respond to their public records requests.	The OCO provided the individual with the public records office address to ensure the individual's requests were being received.	Information Provided
172.	Person reports being transferred to restrictive housing when he should have had a medical hold for surgery. Person requested follow up from his provider.	The OCO provided information to the person regarding the facility hold that is in place. OCO staff contacted Health Service management and were informed the hold was not for surgery and confirmed the patient had been seen recently at sick call. OCO staff noted that a medical hold does not prevent transfer to segregation units.	Information Provided
173.	Cancer patient reports a need for additional testing that DOC is not providing.	The OCO contacted health services and confirmed the recommended testing occurred and an additional test was approved, pending scheduling once other test results are reviewed. Related consults were submitted and approved.	Information Provided
174.	Person described multiple security concerns and is concerned about getting transferred to a different facility. Person said that he has kited the Intelligence and Investigation Unit (IIU) multiple times but has not gotten a response.	The OCO provided information. The OCO reviewed DOC records and reached out to Intelligence and Investigations, who said they never received kites from this individual. The OCO also reached out the Resolutions Specialist, who confirmed that they are currently investigating this issue and are not finished with their investigation yet. The OCO encouraged this individual to continue kiting IIU and continue working with Resolutions.	Information Provided
175.	Person reported concerns about his release plan not moving forward and is concerned he will not release on time. Person thought that his 35-day victim's notification was not	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO verified that his 35-day victim's notification was submitted on time, the day his release plan was approved. The	Insufficient Evidence to Substantiate

	submitted on time. Person reported that he struggles to understand what his counselor is explaining to him, and feels he is being discriminated against.	OCO reviewed DOC records and found that he has a planned release date.	
176.	Loved one relayed concerns regarding the denial of extended family visits (EFVs).	The OCO reviewed the EFV denial and appeal that upheld the denial and found no violation of DOC 590.100. The denial was upheld due to several reasons including: being involved in the introduction of contraband with said visitor, having a domestic violence indicator against a person of a like relationship to the individual as a victim, and having a sex offense and not being amenable to SOTAP.	No Violation of Policy
177.	The individual reported concerns regarding access to the courts. The individual reported that the DOC will not facilitate a telephonic hearing with the courts in Oregon.	The OCO was unable to substantiate a violation of policy by the DOC. The OCO reviewed DOC 590.500, Legal Access for Incarcerated Individuals, and found that the telephonic hearing he was requesting access to is not supported by this policy's priority legal access. The DOC is unwilling to set up a telephonic hearing for civil court matters and recommended the individual write the courts and call in via their Securus tablet.	No Violation of Policy
178.	An anonymous caller reported that DOC staff are not changing their gloves between pat searches.	The OCO was unable to substantiate a violation of policy by DOC. Per DOC 420.310 states that employees performing searches will wear appropriate PPE, like gloves. The policy does not indicate that staff must change gloves between each pat search.	No Violation of Policy
Washington Corrections Center			
179.	External person reports concerns about a patient's access to dental care.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO contacted DOC Health Services and confirmed the patient received antibiotics. More information was provided directly to the patient in case they have ongoing or new issues.	DOC Resolved
180.	Incarcerated individual expressed concerns about not getting classified yet.	The OCO confirmed that DOC resolved this concern as the individual was classified and received a custody facility plan prior to OCO involvement.	DOC Resolved
181.	External person expressed concerns about being sexually harassed during a visit.	The OCO declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint as the subject of the complaint is not an incarcerated individual. The OCO informed the person about the OCO's role and abilities.	Information Provided
182.	The individual reported concerns regarding asking an officer to send his legal mail and the officer not confirming that it was logged and sent per policy. The individual	The OCO provided information. This office verified that the resolution requests the individual filed regarding this concern have all been responded to. The DOC did send the individual DOC 05-171, Notification of Time Extension per policy. This	Information Provided

	reports that he filed resolution requests regarding the officer and his legal mail but has been getting notifications of time extensions for the responses. The individual reports that he was sent to the Intensive Management Unit (IMU) and feels the officer retaliated against him for filing a resolution request regarding staff misconduct in the processing of legal mail.	office reviewed the investigation of the resolution request pertaining to his legal mail and verified that it was logged and processed per DOC 450.100, Mail for Individuals in Prison. The OCO was unable to substantiate whether the officer verbally confirmed that the legal mail was processed. This office also verified that the individual was sent to the IMU after receiving a major infraction. The OCO has reviewed this concern and has not found documented evidence available to verify that DOC staff behavior meets the definition of retaliation. To substantiate retaliation, the OCO must be able to prove that a negative action from a DOC staff member is not only linked close in time to an incarcerated individual's protected action but there must be evidence of a clear relationship between the two acts.	
183.	Incarcerated individual reports his cell was flooded with bio-waste and DOC staff did not take him out of the cell. The individual also reported that his resolution request regarding this incident was not processed per policy.	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. The OCO also reviewed the individual's resolution requests regarding this incident and found that they were not accepted per the Resolution Program Manual (RPM) due to being beyond timeframes to file a complaint about the incident. This office was unable to substantiate or find documentation that the individual submitted an earlier resolution request within the timeframes outlined in the RPM.	Information Provided
184.	Person reported being transferred to WCC receiving units on his way to a county jail for court. Person reported that he had legal paperwork he was bringing with him that he was not allowed to have while in receiving, but on the day of transport, no one could find his paperwork. Person requested help getting his legal paperwork before his court date.	The OCO provided information. The OCO reached out to the Law Library and Legal Liaison at the facility, who confirmed that they have this individual's legal paperwork. The OCO requested that they inform the individual that they have this paperwork, but they declined and said that DOC does not initiate contact with individuals when they are out to court. They told the OCO that this individual can write to the facility superintendent and request the facility to send him his legal paperwork, and the OCO shared this information with the individual.	Information Provided

185.	Incarcerated individual expressed concerns about not receiving a response to an infraction appeal.	The OCO reviewed the infraction and confirmed that the appeal had been responded to. The OCO informed the individual that they may need to kite records or the hearing department to obtain a secondary copy of the appeal decision.	Information Provided
186.	Person reports he was transferred when he should have had a medical hold for surgery. He is requesting an explanation as to how he got transferred.	The OCO provided information to the patient. OCO staff reviewed the patient consults and determined the transfer did not negatively impact the scheduling of the consult. The patient's referral to establish care for a surgical consult was still valid and the appointment was scheduled after he arrived at the new facility. No significant delay in scheduling was noted.	Information Provided
187.	The individual reported that he did not receive items ordered through commissary on two occasions, but he was still charged for the items and did not receive a refund.	The OCO provided information. This office reviewed the investigation of the individual's resolution request regarding this concern and found that his Trust Account records were reviewed and the DOC verified that the individual was refunded due to items ordered being out of stock or unavailable. The individual had also placed orders for items when he did not have funds available, and sales cannot be made unless the item can incur a debt. The OCO advised the individual that he may contact banking should he want an itemized list of charges to his account.	Information Provided
188.	Incarcerated individual expressed concerns about a delayed transfer.	The OCO reached out to DOC regarding the delayed transfer and informed the individual that the reason for the delay was due to both an infraction hold and a lack of bed space availability at their next facility.	Information Provided
189.	The individual reports staff conduct concerns. The individual requested to speak with an officer after yelling from his cell and the officer threatened to spray him with OC spray.	The OCO was unable to substantiate the concern due to insufficient evidence. Video recordings do not have audio so the OCO would not be able to substantiate what was said by the individual or the officer. This office verified that the individual has since transferred to another facility.	Insufficient Evidence to Substantiate
190.	Person reports concerns regarding DOC denying his visitor in person visitation and requests the OCO's assistance in overturning the visitation denial.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the visitation denial and found the visits were denied per DOC 450.300 Visits for Incarcerated Individuals which states, "Persons identified as being involved in attempting/conspiring to introduce, or aiding and abetting another to introduce contraband, in any way, will have their visits suspended or terminated." The OCO confirmed that the DOC has evidence to support this individual's visitor was violating this policy, therefore in person visiting was terminated. The individual and his visitor can video visit, and they may re-apply for in-person visitation annually for reconsideration.	No Violation of Policy

191.	Person reported that dental services is requiring COVID-19 testing for routine dental work. Person stated that he thinks this is a violation of his religious rights.	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 was informed of the Washington State DOC COVID-19 Screening, Testing, and Infection Control Guideline states in the Routine Pre-Procedure COVID-19 section, "Health care providers may require routine COVID-19 testing of asymptomatic patients prior to surgical, dental, or other aerosolizing procedures." The response also explained that when performing aerosolizing procedures like teeth cleaning, the possibility of spreading COVID increases in a small, shared space. Until that protocol is rescinded by DOC it is valid, regardless of the community infection mitigation efforts changing.	No Violation of Policy
Washington Corrections Center for Women			
192.	Person reports her medical equipment was switched with that of another individual. The person also reports that she is not being allowed to cover her cell for privacy while using the medical equipment and is being forced to clean the medical equipment in the bathroom sink.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO contacted Health Service management and were informed of the steps taken by DOC staff to prevent the incident from reoccurring. Health Services management also informed this office of the negotiations health services staff had with custody staff to make it possible for people to wash their medical equipment in an alternative location.	DOC Resolved
193.	The individual reported that she submitted a resolution request which was substantiated regarding her legal mail not being processed per policy. The individual reported that she had a previous case with the OCO regarding this concern and did not understand the closure reason.	The OCO provided information. This office reviewed the individual's previous OCO case regarding this concern and found that the individual's case was closed due the individual not pursuing internal resolution of this concern, per RCW 43.06C(2)(b). The individual then filed an emergency resolution request which did not meet the criteria for an emergency, which the OCO verified, but it was reviewed via the regular resolution request process. The OCO reviewed this and found that the individual's resolution request was substantiated regarding a letter from the OCO being opened by mistake and scanned for safety and security, but it was not read. The individual was informed that this occurred due to a sticker placed by the post office covering the addressed portion of the envelope.	Information Provided
194.	Person reports experiencing complications during a surgery that resulted in the surgery being ended. This person is requesting extraordinary medical placement.	The OCO provided information to the person regarding the Extraordinary Medical Placement policy. OCO staff verified the patient's request was reviewed per DOC 350.270.	Information Provided
195.	Person reports she is being told she cannot keep her wheelchair	The OCO provided information to the patient Regarding the rationale behind keeping the	Information Provided

	outside of her cell. She has mobility issues and does not want to walk to the end of the hallway to get to her chair.	wheelchair out of the hallway. OCO staff contacted Health Services management and were informed the patient has another mobility aid to assist in getting down the hallway. The OCO verified the patient has been assessed for ability to transfer between mobility aids safely. Health Services staff confirmed the hallway is too narrow to store wheelchairs without impeding traffic.	
196.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the individual's infraction history and was unable to locate an infraction that met the description given. Thus, the OCO was unable to further investigate this concern.	Insufficient Evidence to Substantiate
197.	Person reports she is being placed in restraints over a chronic injury. The patient states she is getting reinjured every time she has to go on a DOC transport and does not feel safe with the transport team. The patient is requesting to not have upper body restraints used when she goes on transports.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff contacted Health Services management and the Facility Medical Director (FMD) to discuss this patient's care. OCO staff verified the patient has been evaluated by the FMD for any necessary health status reports. The use of restraints during outside trips is required by policy.	Insufficient Evidence to Substantiate
198.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials 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 State Penitentiary			
199.	Individual reports retaliation by DOC staff after they filed a Resolution Request regarding staff misconduct.	The OCO reviewed this concern and confirmed that this individual was infracted multiple times for allegedly falsifying information in their Resolution Requests and the individual was placed in IMU. Following an in-person visit, the OCO requested that the facility review all of the infractions, as filing a Resolution Request is considered a legally protected act. The DOC did not dismiss the first infraction the individual received; however, DOC agreed to dismiss the subsequent infractions and the individual was returned to general population. The OCO has issued a public recommendation to the DOC regarding the Prison-Initiated Disciplinary Process that the DOC has declined to incorporate.	Assistance Provided
200.	Patient reports DOC did not follow through on negotiated outcomes from a previous OCO case as the patient's case was not submitted to the Care Review Committee (CRC).	The OCO provided assistance by following up with DOC facility and headquarters health services leadership. DOC agreed to submit the case to CRC and OCO confirmed the case was reviewed. The CRC found contacts level 3 under the Health Plan and an alternative option to trial cotton padded sleeve on the eyeglass arms provided.	Assistance Provided
201.	Individual expressed concerns about the housing voucher program. He said that not many	The OCO reviewed his re-entry plan and had concerns about his release. The DOC notated in his file that they would provide him a tent and a	Assistance Provided

	places accept the vouchers and this makes it tough to release.	sleeping bag for his release to Eastern Washington in the winter. This office contacted DOC re-entry and asked if the department could find him housing before release. The DOC will schedule a meeting with him to find a more sustainable re-entry plan.	
202.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reached out to DOC regarding the infraction as this office saw that included in the infraction packet there is a statement from the cellmate who claims responsibility for the contraband that was the basis of the infraction. This office requested that DOC dismiss the infraction since 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 individuals 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, DOC agreed to dismiss the infraction.	Assistance Provided
203.	The individual reported that people in the Intensive Management Unit (IMU) are only getting toilet paper on certain days and if someone runs out before a toilet roll exchange day, staff will not give individuals more. The individual says that this is a sanitary issue.	The OCO provided assistance. This office contacted the facility and asked that staff be reminded to provide toilet roll when requested. DOC agreed to meet with IMU staff to ensure they are accommodating requests for more toilet paper outside of the scheduled toilet roll exchange days. DOC staff also agreed to check on the individual who reported this concern to ensure he had toilet paper.	Assistance Provided
204.	Person reports he needs treatment for two separate injuries. The patient believes he is supposed to have surgery and has gotten information about one issue, but his other injury has not been addressed.	The OCO provided assistance. The OCO contacted Health Services management and were informed that the patient was scheduled for follow up. OCO staff monitored the appointment for completion and followed up with the facility. The OCO was informed that one surgery was scheduled while the other's status was not currently indicated. OCO staff requested that the patient be seen to discuss the plan for the other injury. DOC agreed to schedule the patient in the clinic. OCO staff verified the appointment was scheduled within the month.	Assistance Provided
205.	Person reports he has not been placed on a medical hold for an upcoming surgery. The person is worried that his surgery could be missed if a hold is not placed.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff verified the patient has a hold in place. OCO staff contacted Health Services management and verified that the surgery is scheduled.	DOC Resolved

206.	Incarcerated individual expressed concerns about an infraction they received.	The OCO monitored the infraction as the hearing had not yet happened when the individual contacted this office, upon reviewing the individual's records the infraction was no longer visible in their infraction history as it had been dismissed.	DOC Resolved
207.	Person reported safety concerns in his current unit and is in solitary confinement for protective custody. Person wants to transfer to a different facility.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed this individual's Custody Facility Plan and found that DOC acknowledged his safety concerns and transferred him to a different facility.	DOC Resolved
208.	Incarcerated individual relayed concerns regarding placement in segregation.	This case was resolved by DOC prior to OCO involvement. The OCO verified with DOC that the individual has been taken off administrative segregation status and is waiting for an available bed.	DOC Resolved
209.	Individual reports concerns about staff conduct during visitation.	The OCO provided information after reviewing related resolutions and discussion with DOC facility leadership. This office confirmed follow up occurred with the staff and verified the staff member is no longer assigned to that post.	Information Provided
210.	External person reports their loved one was promoted, however they are keeping him housed in solitary confinement.	The OCO verified that this individual has been promoted, however due to the ongoing construction at the facility, they cannot place him until the construction is complete. This office verified that multiple individuals are waiting for this unit to become available and will continue to monitor the process.	Information Provided
211.	Individual reports staff misconduct that is creating a hostile living environment.	The OCO contacted the facility to speak with the facility leadership regarding this concern and verified that the facility recently made staffing changes to the unit reported in this concern. The OCO cannot dictate staff discipline, however this office continues to monitor the number of concerns received regarding this specific staff member.	Information Provided
212.	The individual reported concerns regarding his facility placement. The person said that he has safety concerns at a particular facility.	The OCO provided information. This office verified that the DOC is currently reviewing placement options for the individual. If the individual has concerns once he receives his new Custody Facility Plan (CFP) in the near future, he may appeal per DOC 300.380, Classification and Custody Facility Plan Review. Per policy, individuals may appeal by submitting DOC 07-037, Classification Appeal, within 72 hours of being notified of the decision to the Superintendent at the facility where the classification decision was made.	Information Provided
213.	Incarcerated individual reports concerns regarding a DOC employee. The individual reports	The OCO provided information regarding the staff conduct and how to access appeal documentation and other documents. The OCO reviewed the	Information Provided

	the employee will not respond to his kites and has not been helpful in accessing documents he is requesting. The individual also reports concerns with his Custody Facility Plan (CFP) and the ability to appeal it.	individual's resolution requests and was unable to locate one filed directly about the staff's actions. The OCO requests the individual utilize the resolution program to resolve staff conduct concerns. The OCO reviewed evidence to substantiate staff conduct and was unable to locate any evidence to support staff blocking the individual's access to documents. The OCO found DOC headquarters responded to a letter addressing this concern and multiple other issues the individual reported. The individual has received the finalized CFP and OCO explained how to appeal the CFP per DOC policy.	
214.	The individual reported concerns regarding being placed in medium custody. The person feels that he should be placed in a safe harbor facility due to trying to drop out of a Security Threat Group(STG).	The OCO provided information. This office verified that the individual was approved placement in a transfer pod, and the DOC is currently reviewing his custody level and facility placement. If the individual has concerns once he receives his new Custody Facility Plan (CFP) in the near future, he may appeal per DOC 300.380, Classification and Custody Facility Plan Review. Per policy, individuals may appeal by submitting DOC 07-037, Classification Appeal, within 72 hours of being notified of the decision to the Superintendent/CCS at the facility where the classification decision was made.	Information Provided
215.	Person reported that the facility said his mail rejection appeal was never received or forwarded to DOC Headquarters.	The OCO provided information. The OCO reached out to the staff that the individual stated did not forward the appeals, but they no longer worked in that position and no longer had access to those records. The OCO communicated with the mailroom sergeant, who provided information about these appeals, and said that they never received a request for his appeal to be sent to DOC Headquarters, and that this could have been an error by mailroom or unit staff. The OCO asked if they would be willing to accept his appeal now, and the sergeant said they cannot accept an appeal because the rejected mail was received a year ago and has already been destroyed.	Information Provided
216.	Incarcerated individual was denied an in-person deathbed visit and requests the OCO review the denial.	The OCO provided information to the individual about the denial and options he has in the near future. DOC was unwilling to approve this visit due to safety and security concerns which the OCO verified were valid. The OCO shared with the individual that staff are willing to set up a virtual visit with this loved one. The OCO shared other options to be connected with family during this time, such as seeking approval to be at funeral services.	Information Provided

217.	The individual reported that he placed a Union Supply order a while ago and it has not yet arrived. The individual filed a resolution request which was not accepted and sent a kite to property staff who said they did not have his order.	The OCO provided information regarding how the individual may contact Union Supply to request a refund. Individuals may write to Union Supply at: Washington Package Program, c/o Union Supply, Direct Dept. 105, P.O. Box 619059, Dallas, TX 75261-9059. The individual's loved ones may also contact Union Supply via email at customerservice@unionsupplydirect.com or via phone at (562) 361-5722.	Information Provided
218.	Incarcerated individual relayed concerns regarding being on the list to get a 752 (positive drug test) infraction expunged and good conduct time restored but not having heard back.	The OCO contacted DOC headquarters and confirmed that everyone who was on the list to have their infractions reviewed and eligible to have good conduct time restored has been notified about a decision. Thus, if an individual has not been notified, it was determined that they were not eligible to have their infraction removed and time restored based on the September 6th Presumptive Drug Testing memo from DOC.	Information Provided
219.	Incarcerated individual relayed concerns regarding lost property and a desire for OCO to record the concern but not investigate.	The OCO confirmed the individual has been given access to a tort claim form to continue the concern regarding the lost property.	Information Provided
220.	Person reports he has been attempting to get surgery and is not getting information from medical about his pending procedure.	The OCO provided the patient information about the status of his healthcare consult. The OCO reviewed patient consults and confirmed the referral is active.	Information Provided
221.	Person reported safety concerns about being sent to general population.	The OCO provided information. The OCO reviewed DOC records and found that this individual requested protective custody because of safety concerns in his new unit, and found that DOC intends to transfer him to a different facility for medical concerns. The OCO provided information about contacting staff about his safety concerns.	Information Provided
222.	The OCO opened a case after reviewing an incident report regarding a use of force in the Close Observation Area.	The OCO met with the patient directly during a facility visit to follow up. OCO staff talked with the person cell front in the medical unit, and he thanked the OCO for checking in with him. The individual said they have no active complaints/concerns for follow up at this time. This office provided a complaint form via mail in case the individual has future concerns they would like to report.	Information Provided
223.	Individual reported they were denied GRE.	The OCO contacted the GRE Administrator and reviewed the GRE denial. The individual was denied GRE based on evidence the DOC collected from their phone calls regarding illegal activities. Due to these phone conversations, the DOC was unwilling to risk placing the individual in the community on partial confinement.	Information Provided

224.	Incarcerated individual expressed concerns about policy not being updated to reflect the agreed upon outcome between OCO and DOC regarding property not being thrown away when someone is in solitary.	The OCO informed the individual that the Washington State Penitentiary updated WSP Operational Memo 440.00 pertaining to how consumable items are managed by staff for individuals in restrictive housing. These updates allow 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
225.	Person states that being in solitary confinement has caused him to develop dysfunctional behaviors and is requesting a single cell screening because he does not want to live with a cellmate.	The OCO provided information to the person regarding the process to get screened for a single cell housing assignment.	Information Provided
226.	The individual reported that he is being denied access to his legal paperwork because he is in the Intensive Management Unit (IMU). The person said that he was promoted and should be released from the IMU when there is bed space for him. The individual said that he has a deadline with the courts, but DOC staff said that they cannot verify that. The individual reported that he filed a resolution request regarding this concern but has not yet received a response.	The OCO provided information. This office spoke to the Resolution Specialist at the facility who reported that they had just completed the response to the individual's resolution request. The OCO reviewed the investigation of the resolution request and found that the individual had confirmed that he was granted an extension on the deadline. This office encouraged the individual to kite the CUS to request the form for priority access, DOC 02-247, Law Library Request for Priority Access, to the law library and mail it to the law library.	Information Provided
227.	Incarcerated individual reports DOC did not calculate his custody points correctly and requests the OCO recommend DOC change his custody facility plan (CFP) to reflect his actual custody points.	The OCO provided information regarding the individuals custody points. The OCO reviewed the individual's most recent CFP and found that during the plan creation, the individual had infractions dismissed which changed his custody score. DOC staff noted the change in the CFP and the individual's custody level is accurate to the points restored. The OCO shared with the individual that the DOC made a clear notation of the classification change and why is was such in his CFP.	Information Provided
228.	Person reported receiving multiple infractions and is now doing a maximum custody program. Person expressed protection concerns about where he will be transferred after his program.	The OCO provided information. DOC will determine this individual's next facility placement at his next Custody Facility Plan. The OCO provided information about working with his counselor when he gets closer to his next review date.	Information Provided
229.	Person reports that he has several medical issues and is requesting to	The OCO provided information to the patient regarding the process to have healthcare services	Information Provided

	be released early so he can receive healthcare from the Veterans' Administration.	paid for by the Veterans' Administration. OCO staff also provided the person information on how to submit and Extraordinary Medical Placement request.	
230.	Incarcerated individual reports safety concerns and reports they cannot be placed in general population.	The OCO provided the individual with information regarding how to report verifiable concerns to DOC. The OCO reviewed the individual's safety concerns and found that they could not be verified due to the lack of information provided to DOC. The OCO shared options with the individual to be released from segregation and report safety concerns as they arise.	Information Provided
231.	Incarcerated individual relayed concerns regarding a use of force.	The OCO reviewed video of the unit the individual was in on the alleged date of the incident and were unable to view any uses of force. This office requested any use of force packets, but no records were available as a use of force investigation was not completed. Without the records related to a use of force this office was unable to investigate this concern further.	Insufficient Evidence to Substantiate
232.	Incarcerated individual relayed concerns regarding being terminated from treatment due to an infraction.	The OCO reviewed the infraction materials, recent custody facility plan and spoke with DOC regarding this and confirmed that due to the individual's behavior as well as infractions, they were terminated, confirming that at this time they are not eligible for treatment. The OCO advised the individual that they can appeal their DOSA revoke decision that is scheduled for later, in the event that it is a termination.	No Violation of Policy
233.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found the infraction elements were met based on the "some evidence" standard utilized by DOC and thus was unable to identify a violation of DOC Policy 460.000.	No Violation of Policy
234.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC Policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
235.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials 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
236.	Person reported that he has a chronic injury that is preventing him from participating in programming. As a result, he lost his TV and tablet privileges. The person is requesting to be promoted back to the level where he can have those items.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed records and found that the person was removed from programming due to attendance issues. OCO staff contacted the person’s medical provider to ask if the patient may qualify for accommodation by a Health Status Report (HSR) to exclude him from programming. OCO staff were unable to substantiate that the patient had requested this HSR from his provider. OCO staff contacted the	No Violation of Policy

		patient's counselor and were informed that the patient had already reentered the necessary programming.	

INTAKE INVESTIGATIONS			
Airway Heights Corrections Center			
237.	Incarcerated person contacted the OCO to advise ADA accessible showers were not being reserved for individuals who need ADA accommodations.	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.	Incarcerated individual relayed concerns regarding staff misconduct related to religious books.	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
239.	Incarcerated individual relayed concerns regarding menu suggestions not being complied with.	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
240.	Loved one relayed concerns regarding individuals not getting paid all the hours that are listed on the call out.	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
241.	Person reports he was placed on isolation and have not received their laundry back. They also state that other incarcerated people are refusing to test.	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
242.	Incarcerated individual relayed concerns regarding not getting paid properly.	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
243.	Incarcerated individual expressed concerns about staff conduct related to programming.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued

244.	Incarcerated individual relayed concerns regarding an infraction and housing assignment.	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.	Incarcerated individual relayed concerns regarding someone pushing kites under doors of DOC staff members with their name on it.	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 the desire for OCO to acknowledge that DOC is violating federal and state rights for usage in a lawsuit.	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
247.	Incarcerated individual relayed concerns regarding a desire for OCO assistance getting a tort claim denial overturned.	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
248.	Loved one expressed concerns about an incarcerated individual being sentenced to prison.	This office has declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
249.	Loved one expressed concerns about an individual who believes he is being targeted for breaking rules..	The OCO mailed the incarcerated individual a review request form to ensure this was something the individual wished for this office to investigate, however, the individual did not contact this office within the allotted 30 day timeframe. This case was closed without investigation.	Person Declined OCO Assistance
250.	Family reports concerns about their loved one's access to camp placement and an HSR.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint.	Person Declined OCO Assistance
251.	Incarcerated individual expressed concerns about being removed from camp to go to a medium unit.	The OCO confirmed that the individual has since released from prison, thus, this issue is no longer impacting them.	Person Released from DOC Prior to OCO Action
Clallam Bay Corrections Center			
252.	Loved one relayed concerns regarding staff misconduct.	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 noted that this individual was transferred to another facility after this complaint was filed.	Administrative Remedies Not Pursued
253.	An incarcerated person reports DOC staff behavior complaint related to BOEs.	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	Administrative Remedies Not Pursued

		resolve it through the DOC internal grievance process, administrative, or appellate process.	
254.	Person reported that the facility is not letting him participate in his religious practice, and that the Asatru religious group's meetings have been repeatedly cancelled.	This person was released prior to the OCO taking action on the complaint. The OCO is reviewing this concern in separate cases.	Person Released from DOC Prior to OCO Action
Coyote Ridge Corrections Center			
255.	Loved one relayed concerns regarding staff misconduct related to racial bias.	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
256.	The individual reported that the unit is being locked down earlier than it should be, and this is also when the phones are being turned off.	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
257.	Incarcerated individual relayed concerns regarding particles coming out of the vents in the cells.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
258.	Individual reports not receiving TBI treatment after a fall.	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
259.	Person reports he is receiving placebos instead of his medication.	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
260.	Incarcerated individual expressed a concern about the condition of their wheelchair.	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
261.	Incarcerated individual expressed concerns about scheduling medical appointments.	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

262.	Incarcerated individual requested advice regarding gang activity 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.	Administrative Remedies Not Pursued
263.	An incarcerated person contacted the OCO and reported that they are not receiving enough time in the yard. The person reports they did file a resolution request but had not appealed the outcome to at least a level 2.	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
264.	An incarcerated person contacted the OCO reporting that they are having issues obtaining a tablet.	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
265.	Incarcerated individual relayed concerns regarding time calculation.	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
266.	Incarcerated individual relayed concerns regarding not getting access to recreation or time out of 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.	Administrative Remedies Not Pursued
267.	Incarcerated individual relayed concerns regarding concerns about the mailroom's conduct but no desire for the OCO to take action.	The OCO declined to investigate this concern per WAC 138-10-040(3)(g) as the individual did not request the OCO to take action on the concern.	Declined
268.	A loved one reported that DOC is not notifying an incarcerated individual of hearings being cancelled.	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
Monroe Correctional Complex			
269.	External individual expressed concerns about an incarcerated individual receiving an infraction.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
270.	An incarcerated person reported to the OCO that DOC has not calculated their sentence correctly	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	Administrative Remedies Not Pursued

	per the J&S that was issued by the court.	resolve it through the DOC internal grievance process, administrative, or appellate process.	
271.	Incarcerated individual relayed concerns regarding job placement.	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
272.	Incarcerated individual relayed concerns regarding not being allowed to come out and do their job.	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
273.	Incarcerated individual relayed concerns regarding not receiving food packages.	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
274.	Person reports he has several medical issues that are not being addressed by medical. The patient also reports that he is not being given information about specialist appointments.	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 person reports staff conduct issues related to job assignments.	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
276.	Incarcerated individual expressed concerns about their sentence being incorrectly calculated.	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 staff refusing to transport property boxes unless they work with DOC.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
278.	An incarcerated person reports issues with a maintenance request that is not being worked. No Resolution Request has been filed related to the reported 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

279.	An incarcerated person reported to the OCO an issue with hot water in the unit where they are housed.	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 expressed concerns about an infraction they received.	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
281.	A loved one reported concern about an incident during a phone call with an incarcerated individual.	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.	An external person reports concerns regarding the incarcerated individual's family being denied visitation.	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
283.	Person reports concerns about their facility and cell placement.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint. The person called the hotline and asked that the case be closed.	Person Declined OCO Assistance
284.	Loved one relayed concerns regarding a PREA complaint.	The OCO mailed the incarcerated individual a review request form to ensure this was something the individual wished for this office to investigate, however, the individual did not reply. This case was closed without further investigation.	Person Declined OCO Assistance
285.	An external person reported concerns regarding the incarcerated individual having his prayer oil taken away by DOC 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
286.	Individual is requesting an interview for the Solitary Confinement Project.	The OCO verified that this individual has now released from the DOC custody.	Person Released from DOC Prior to OCO Action
Olympic Corrections Center			
287.	Incarcerated individual relayed concerns regarding staff misconduct related to HSRs.	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
288.	Incarcerated individual relayed concerns regarding dissatisfaction with how the facility is handling mice in the units.	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	Administrative Remedies Not Pursued

		resolve it through the DOC internal grievance process, administrative, or appellate process.	
Other – Community Custody			
289.	A person in the community called in to report that they are on community custody in county jail.	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
Other – Jail/County/City			
290.	Incarcerated individual relayed concerns regarding being released from prison late due to good conduct time not being returned.	The OCO declined to investigate this concern per WAC 138-10-040(3)(f) as the alleged violation is a past rather than ongoing issue.	Declined
291.	Individual relayed concerns regarding the negative impact the conditions of confinement are having on individuals housed in a jail facility.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Declined
292.	Loved one expressed concerns about the placement of an incarcerated individual.	The OCO declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint as the individual is not currently incarcerated in a Washington DOC facility.	Lacked Jurisdiction
Stafford Creek Corrections Center			
293.	An external person reported a complaint on behalf of an incarcerated person related to property.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. The OCO sent information to the incarcerated person regarding how to request assistance from the OCO and included with the letter an OCO review request form.	Administrative Remedies Not Pursued
294.	Loved one relayed concerns regarding an infraction.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
295.	Incarcerated individual expressed concerns about missing religious property.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
296.	Incarcerated person reports they missed a hearing with the court because DOC staff did not open the building that the hearing was supposed to be held in.	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	Administrative Remedies Not Pursued

		resolve it through the DOC internal grievance process, administrative, or appellate process.	
297.	Incarcerated individual relayed concerns regarding not getting legal mail.	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
298.	Incarcerated individual relayed concerns regarding a medical 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
299.	Incarcerated individual relayed concerns regarding being charged a shipping cost for property.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
300.	Incarcerated individual expressed concerns about staff conduct related to records.	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
301.	Incarcerated individual relayed concerns regarding an infraction.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
302.	Incarcerated individual relayed concerns regarding a visitation denial.	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
303.	Incarcerated person reports a complaint regarding quality of food served to incarcerated population.	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
304.	Person reports he had an injury in the summer and was supposed to receive follow up 8 weeks later. The person states he did not understand the grievance response from DOC.	The OCO staff provided self-advocacy information to the 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	Administrative Remedies Not Pursued

		DOC internal grievance process, administrative, or appellate process.	
305.	Incarcerated individual relayed concerns regarding DOC dropping a person off at a hospital during a mental health crisis and leaving said individual there.	The OCO declined to investigate this concern per WAC 138-10-040(3)(g) as there was insufficient identifying information provided to investigate the concern. The OCO informed the complainant that providing identifying information for this individual, if known, would allow the office to investigate further.	Declined
Washington Corrections Center			
306.	An incarcerated person contacted the OCO to report a dispute with infraction sanctions.	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
307.	Incarcerated individual relayed concerns regarding staff misconduct related to meals.	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.	Individual wants evaluation for re-entry placement and suitability to be completed before he releases and states because of the nature of the crime of conviction, the process is taking too much time.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
Washington Corrections Center for Women			
309.	Incarcerated individual relayed concerns regarding DOC neglecting an individual who is not being given medicine by DOC for a bacteria.	The OCO declined to investigate this concern per WAC 138-10-040(3)(g) as there was insufficient identifying information provided to investigate the concern. The OCO informed the complainant that providing identifying information for this individual, if known, would allow the office to investigate further..	Declined
310.	Incarcerated individual relayed concerns regarding being wrongfully convicted.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint. The OCO provided the individual with contact information for the Washington Innocence Project.	Lacked Jurisdiction
Washington State Penitentiary			
311.	Person in the community reached out to the OCO to request assistance for their loved one specifically asking for help clearing infractions.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued

312.	Incarcerated individual expressed concerns about retaliation after filing a lawsuit.	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
313.	Incarcerated individual expressed concerns about losing their job.	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
314.	Incarcerated individual expressed concerns about pay.	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
315.	An incarcerated person reported to the OCO a concern about DOC staff conduct related to treatment of Native Americans.	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
316.	Incarcerated individual relayed concerns regarding their HSR being rescinded without reason.	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
317.	An Incarcerated person reported to the OCO a concern related to property lost at a facility change and an issue with staff behavior.	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
318.	Incarcerated individual relayed concerns regarding not receiving property that was ordered.	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
319.	Incarcerated individual expressed concerns about the therapeutic communities program.	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
320.	Loved one relayed concerns regarding denial of a visitor.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the	Administrative Remedies Not Pursued

		incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	
321.	Incarcerated individual expressed concerns about staff misconduct related to retaliatory infractions.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
322.	Incarcerated individual relayed concerns regarding not being able to get access to kites.	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
323.	Incarcerated individual relayed concerns regarding medical concerns that occurred at WSP many years ago.	The OCO declined to investigate this concern per WAC 138-10-040(3)(f) as the alleged violation is a past rather than ongoing issue. Person is no longer incarcerated.	Declined
324.	Incarcerated individual expressed a desire for OCO assistance getting a tort claim denial overturned.	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
325.	Incarcerated individual relayed concerns regarding the conduct of Disability Rights Washington (DRW) employees.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint. The OCO provided information to the individual about filing a complaint with the Washington State Office of the Attorney General.	Lacked Jurisdiction

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-010

Report to the Legislature

As required by RCW 72.09.770

November 21, 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-23-010 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 October 19, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Brooke Amyx, Health Services Reentry Administrator
- Dawn Williams, Program Administrator, Substance Abuse Recovery Unit
- Tiffany Bibeau, Health Services Credentialing Manager
- Deborah Roberts, Program Manager
- Ashley Ayers, Executive Secretary

DOC Prisons Division

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

DOC Risk Mitigation

- Mick Pettersen, Director

DOC Community Corrections Division

- Dell-Autumn Witten, Community Corrections Administrator
- Kelly Miller, Administrator – Graduated Reentry

DOC Reentry Centers

- Danielle Armbruster, Assistant Secretary - Reentry
- Scott Russell, Deputy Assistant Secretary - Reentry
- Susan Leavell, Senior Administrator
- Carrie Stanley, Administrator

Office of the Corrections Ombuds (OCO)

- 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. Heather Schultz, Associate Medical Director

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

Fatality Summary

Year of Birth: 1989 (34 years-old)

Date of Incarceration: May 2023

Date of Death: July 2023

At the time of his death, this incarcerated individual was housed in a Reentry Center operated by a contracted vendor. The cause of death was the result of acute drug intoxication including fentanyl. The manner of death was accident.

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

Weeks prior to death	Event
11 weeks	• Readmitted to prison.
8 weeks	• Transferred to parent facility.
6 weeks	• Transferred to reentry center.
2 weeks	• Started a job in the community.
Days prior to death	**Event**
1 day prior to death	• Incarcerated individual was showing signs of concerning behavior prior to entering his room at 21:52 hours.
Day of death	• He did not leave the facility for work and contract employees did not verify his status. • At 13:05 hours, he was found deceased.

UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee and the DOC Critical Incident Review. The UFR Committee 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 was diagnosed with methamphetamine, opioid, and alcohol use disorder.

b. He was cared for briefly by DOC Health Services while in the violator unit, which provides problem focused care. Records from the violator units are not part of the

central medical file.

c. He died of a fentanyl overdose while living at a reentry center.

d. He was not in substance use treatment or receiving medications for opioid use disorder.

e. He did not report a need for help to DOC Health Services regarding substance use or mental health.

f. A review of his community hospital admissions after his death showed, he had previous hospital admissions for mental health treatment and a history of substance use.

2. The MRC recommended:

a. Discussing the role of DOC, HCA and DOH for individuals in similar situations during the UFR Committee meeting to determine what additional resources might have helped this individual.

b. DOC continue to pursue an electronic health record (EHR) to interface with community health systems.

c. DOC explore options for obtaining community care information using a health information exchange like One-Health port.

d. DOC explore the possibility of integrating violator health records and assessments into the permanent medical file to support care needs.

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

1. The CIR found:

a. The incarcerated individual was housed in a reentry center, operated by a contracted vendor to provide the daily operations and custody of individuals within facility.

b. He was not referred for substance use disorder (SUD) treatment, as required.

c. There is no documentation that he was pat searched per DOC Reentry Center established procedures.

d. The contractor did not conduct training per DOC Reentry Center established procedures, although contract employees did complete the 40-hour on-the-job training checklist.

e. Contract employees and other incarcerated individuals in the reentry center did not report concerns or attempt to intervene and offer assistance when he began to exhibit unusual behavior.

f. The contracted vendor's staffing issues included not being able to employ enough people to adequately staff the facility. The facility census was reduced to mitigate staffing concerns as well as DOC providing staff to fill vacant shifts identified by the vendor.

g. There were no male contract employees available to conduct urinalysis for drug screening. Due to this concern, DOC provided an alternate drug testing method with oral swabs. Use of the oral swabs did delay results being communicated back to the facility.

h. Facility counts were not conducted per DOC Reentry Center established procedures.

2. The CIR recommended:

a. Ensure contract staff are fully trained prior to assuming independent completion of duties.

b. DOC update Reentry Center procedures for pat searches, room searches, counts, inside security checks, drug testing, and area searches within 90 days.

c. DOC work on statewide reentry center operational memorandum/procedures for counts and security checks and work towards inclusion in DOC Policy 420.150 Counts, which currently applies only to prisons.

C. The Department of Health (DOH) representative supported the recommendations. DOH also asked how we can help foster an environment so incarcerated individuals will report when someone may need support? Is there any way to take away the fear of getting in trouble?

Note: DOC is fostering an environment of support for incarcerated individuals in reentry centers which includes orientation and discussion around the importance of reporting when they have concerns for another resident's safety. Reentry is actively trying to break down these barriers to help people succeed. Additionally, the vendor has returned the contract and at this time all residents have been moved out of the building and transferred to another reentry center.

D. The Health Care Authority (HCA) Representative asked about existing agreements between HCA and DOC regarding Medicaid and Medicare benefits.

Note: DOC would welcome exploring the expansion of partnership with HCA. An electronic health record that has the ability to retrieve community health records could have made a difference in this case.

E. The Office of the Corrections Ombuds (OCO) submitted the following for UFR committee discussion:

1. The OCO asked what is in place to identify patients in need of treatment when they inaccurately self-report.

Note: DOC screens for follow-up care needs. This incarcerated individual declined services. DOC also partners with the assigned managed care organization (MCO) by providing a care report identifying care needs. The MCO case manager offers support and access to care following reentry.

2. The OCO stated that self-reported assessments have limitations and gaps and asked if there was some way to supplement the assessment.

Note: DOC offers services to those who self-report as well as those identified by DOC.

Kiosks are available for the incarcerated individuals in reentry centers and can be used anytime to request care or change an assessment response. Additionally, case managers are a resource and support to incarcerated individuals in reentry.

3. The OCO asked if there are differences in health care between a regular prison unit and a violator unit.

   Note: Violator units are typically a short-term setting which provides problem focused medical care, mental health support and medication assisted treatment. Sanctions for violating community supervision are typically 15 days or less, limiting what care DOC can provide in this timeframe.

4. The OCO asked how DOC is improving overdose education at re-entry centers. Is there regular education or events around Narcan use and signs of overdose for the residents and staff?

   Note: DOC has signage in the facilities and accessible emergency Narcan stations. A Health Care Authority video is played at orientation, pamphlets are provided, and contactors provide a verbal training. Each contract staff member is provided a required training on Narcan and opioid overdose education.

Committee Findings

The manner of the incarcerated individual's death was accident. The cause of death was acute drug intoxication including fentanyl.

Committee Recommendations

1. DOC update statewide Reentry Center procedures for:
   a. searches,
   b. counts,
   c. drug testing,
   d. facility security,
   e. orientation and training, and
   f. substance use assessment referral.

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 DOC explore the possibility of reviewing violator records and assessments to integrate into the central medical file to support care needs.

B. The committee recommended DOC continue to pursue an electronic health record (EHR) to interface with community health systems when funding becomes available.

C. The committee recommended DOC explore options for obtaining community care information using a health information exchange like One-Health port.

Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-23-010

Report to the Legislature

As required by RCW 72.09.770

December 1, 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 23-010 on November 21, 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-23-010-1
Finding:	Contractor failed to follow DOC Reentry Center procedures regarding pat searches, room searches, inside security checks, drug testing and area searches which allowed contraband into the facility.
Root Cause:	Lack of clear direction and oversight.
Recommendations:	• DOC update Reentry Center procedures for pat searches, room searches, counts, inside security checks, drug testing, and area searches within 90 days. • DOC work towards Reentry Center inclusion in DOC Policy 420.150 Counts, which currently applies only to prisons.
Corrective Action:	DOC update reentry center procedures that outline requirements for searches, counts, drug testing, facility security, and substance use assessment referrals.
Expected Outcome:	Clear direction will lead to increased safety and support for staff, contractors, and incarcerated individuals.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-011

Report to the Legislature

As required by RCW 72.09.770

November 27, 2023

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
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Unexpected Fatality Review Committee Report

UFR-23-011 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 September 11, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary
- Dr. Zainab Ghazal, Administrator
- Rae Simpson, Director - Quality Systems
- Patty Paterson, Director of Nursing
- Brooke Amyx, Health Services Reentry Administrator
- Deborah Roberts, Program Manager
- MaryBeth Flygare, Project Manager

DOC Prisons Division

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

DOC Community Corrections Division

- Kelly Miller, Administrator – Graduated Reentry

DOC Reentry Centers

- Danielle Armbruster, Assistant Secretary - Reentry
- Scott Russell, Deputy Assistant Secretary - Reentry
- 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: 1989 (34 years-old)

Date of Incarceration: April 2023

Date of Death: July 2023

At the time of his death, this incarcerated individual was in prison. The cause of death was due to toxic effects of methamphetamine. The manner of death was accident.

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

Day of death	Event
13:10 – 19:53 hours	• Incarcerated individual meets with visitors. • Visitors exit. • Incarcerated individual is searched.
20:01 – 20:23 hours	• Incarcerated individual enters the unit dayroom. • He receives a cup from another incarcerated individual. • He leaves the dayroom and returns to his cell.
20:24 – 21:21 hours	• Several incarcerated individuals visit his cell.
21:29 hours	• Emergency lights flash for his cell.
21:32 hours	• Staff arrive and begin rendering aid, including Narcan administration. • Incarcerated individual was not responsive but had a pulse and was breathing on his own.
21:49 hours	• Community Emergency Medical Services arrive on scene and assume care.
21:56 hours	• Incarcerated Individual becomes pulseless and stops breathing. • CPR is initiated.
22:36 hours	• Emergency medical services call time of death.

UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee and the DOC Critical Incident Review. The UFR Committee 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. This 34-year-old male died after resuscitation attempts by staff and emergency medical services.
    b. The decedent was noted to have altered conscious state in his shared cell. His clinical state worsened, and he became unresponsive, with resuscitative measures unsuccessful.
    c. Restraints were placed to protect staff from being struck when the incarcerated individual was unable to control his movements and were removed as soon as he became unresponsive.
    d. At autopsy, multiple small packages were identified in the small intestine, including one ruptured package.
    e. The cause of death was due to methamphetamine intoxication.
    f. From review of the medical record, the emergency response by the medical staff was appropriate given the limited amount of information.
2. The DOC Mortality Review Committee members did not identify any additional care recommendations to prevent a similar fatality in the future.

B. Independent of the mortality review, the DOC conducted a critical incident review (CIR) to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operational procedures. The CIR found:
    1. The decedent was appropriately classified.
    2. Emergency response was within policy guidelines.
    3. No corrective action items were identified.

C. The Department of Health (DOH) representative offered resources for response to methamphetamine overdose. The DOH representative asked what system gaps were there that allowed him to ingest these objects.

    Note: DOC provided information about contact visits and how when these visits are in place there are opportunities for visitors to pass drugs. Drugs may also be introduced by DOC staff or through physical mail. Maintaining connections through physical mail and contact visitation support successful reentry into the community.

D. The Health Care Authority (HCA) Representative asked if DOC considered using other drugs after the administration of Narcan.

    Note: DOC starts basic life support until community emergency medical services (EMS) arrive to assume care. EMS can initiate advanced life support procedures including medication administration.

E. Office of the Corrections Ombuds (OCO) submitted the following for UFR committee discussion:

1. The OCO asked if the resuscitation attempts may have been impacted by restraints and what the impact might look like.

   Note: DOC indicated that the restraints were initially placed for staff safety to allow treatment without anyone being inadvertently injured by the incarcerated individual when he could not control his movements. The restraints were immediately removed when he became unresponsive.

2. The OCO discussed concerns with emergency red bags and supplies and asked if there were missing items and requested the current status of the red bags.

   Note: DOC nursing has been working on this statewide. DOC Health Services has a request out for a quote on new emergency bags that are smaller and easier to use. Items that are not used are being removed. Updated emergency response training for each facility has been scheduled and includes use of the red bag and its contents. The training will be conducted quarterly instead of annually and new staff will receive the training prior to starting patient care.

Committee Findings

The manner of the incarcerated individual's death was accidental. The cause of death was toxic effects of methamphetamine.

Committee Recommendations

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

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-013

Report to the Legislature

As required by RCW 72.09.770

December 11, 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-23-013 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 November 16, 2023:

DOC Health Services

- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Zain Ghazal, Administrator
- Patty Paterson, Director of Nursing
- Mark Eliason, Deputy Assistant Secretary
- Rae Simpson, Director Quality Systems
- Deborah Roberts, Program Manager
- MaryBeth Flygare, Project Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Lorne Spooner, Director Correctional Services
- Rochelle Stephens, Project Manager
- Deborah Jo Wofford, Deputy Assistant Secretary
- Jeri Boe, Superintendent CBCC
- Eric Jackson, Deputy Assistant Secretary

DOC Risk Mitigation

- Mick Pettersen, Director

DOC Community Corrections Division

- Dell-Autumn Witten, Administrator
- Kelly Miller, Administrator – Graduated Reentry

DOC Reentry Centers

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

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director, Office of the Corrections Ombuds

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

Health Care Authority (HCA)

- Dr. Charissa Fotinos, Medicaid Director

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

Fatality Summary

Year of Birth: 1991

Date of Incarceration: May 2022

Date of Death: August 2023

At the time of his death, this incarcerated individual was housed in a prison facility and was classified as close custody. The cause of death was the result of methamphetamine toxicity. The manner of death was accidental.

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

Hours prior to death	Event
14:16 hours	• Incarcerated individual (I/I) begins visit with approved visitor.
15:12 hours - 15:14 hours	• Visitor approaches game cabinet and reaches into her shirt. • Visitor places balloon in game box. • I/I places balloon into his mouth.
15:45 hours – 15:51 hours	• Visitor leaves. • I/I is strip searched at the end of his visit. • I/I arrives in his cell.
17:56 hours	• Medical emergency called. • I/I found unconscious, not moving, not breathing and had no pulse.
17:57 hours – 18:15 hours	• CPR started. • 911 called. Ambulance enroute. • AED was placed but no shock was advised. • Narcan dosage delivered 5 times. • Pulse returned and shallow breathing noted. • AED advised delivering a shock and shock was delivered. Within seconds he became pulseless again. • Resuscitation efforts continue. • Narcan delivered a sixth time.
18:34 hours	• Ambulance arrives.
18:40 hours	• Emergency Medical services assumes care.
19:21 hours	• Time of death pronounced.

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 was diagnosed with polysubstance use disorder, depression, anxiety, and post-traumatic stress disorder.
        b. He was found unresponsive in his cell and died despite full resuscitation efforts.
        c. Toxicology report showed high levels of methamphetamine which were incompatible with life.
        d. His cause of death was acute methamphetamine toxicity.
        e. There were no meaningful gaps in his primary or psychiatric care.
        f. The emergency response was appropriate.
        g. He needed substance use care that was not available at the facility.
    2. The MRC recommended:
        a. DOC explore the expansion of addiction recovery services via telemedicine.

B. Independent of the mortality review, the DOC conducted a critical incident review (CIR) to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operational procedures.
    1. The CIR root cause analysis found:
        a. During his approved visit he was given a balloon containing illegal drugs.
        b. The approved visitor was able to conceal the illegal narcotics in a manner that defeats contraband detection practices.
        c. Current security practices only allow for pat searches, metal detectors and scanning of allowable items approved for visitors prior to entering the visiting room.
        d. The drugs were carried into the living unit via ingestion by the incarcerated individual.
        e. The incarcerated individual was in his assigned cell when he began showing symptoms of distress and was not observed by staff or reported by the incarcerated individual's cellmate who witnessed the symptoms.
        f. Staff did not observe the contraband exchange.
    2. The CIR root cause analysis recommended:
        a. DOC create a communication to be placed in visiting rooms, sent out via kiosk, and given to visitors prior to visitation which identifies the danger of ingesting drugs,

recent deaths after ingesting drugs, and the likelihood of people involved in the introductions of drugs to be prosecuted for introduction and death of an individual.

C. The Department of Health (DOH) representative supported both the use of telehealth by DOC to expand substance use treatment and creating informational flyers for the incarcerated population and their visitors.

   1. DOH asked what overdose education training DOC provides to staff.

   Note: DOC requires all staff to complete a Fentanyl and Safety Awareness Training and First Aid/CPR, both of which cover signs of overdose and response. Staff in the living units are taught to report any signs of an incarcerated individual being off their baseline and summon immediate assistance. In this case, the cellmate knew the individual had ingested contraband and that he was becoming ill and chose not to report until it was too late.

D. The Health Care Authority (HCA) Representative stated that the medical response was appropriate, and the first response is to give Narcan. The toxicology report showed the incarcerated individual had five times the lethal level of methamphetamine in his system and there was nothing medically that could be done to assist him by the time staff were notified.

   1. HCA concurred with the educational information being distributed and advised that most individuals who have a substance use disorder also have experienced significant trauma during their lifetime. Research demonstrates that providing trauma-informed therapy along with the substance use treatment has better outcomes than substance use treatment alone. They stated there are many telehealth programs that offer this type of treatment approach, and they encourage the Department to offer co-occurring treatment when appropriate.

E. The Office of the Corrections Ombuds (OCO) submitted the following for UFR committee discussion:

   1. The OCO noted that the incarcerated individual had an extensive history of substance use and questions why he was housed in a facility that did not have the treatment resources needed to assist with his addiction.

   Note: The incarcerated individual was transferred to this facility due to his recent custody demotion and DOC concerns for his safety due to his security threat group affiliation and associated threat concerns from other incarcerated individuals. In this case the individual chose to ingest the drugs in an attempt to introduce them into the facility. We cannot know if the individual would have sought treatment if it were available or if he intended to use the drugs himself. Based on the investigation, including recorded phone calls, it appears the reason for the contraband introduction was monetary.

   2. The OCO encourages the Department to continue to explore options to expand substance use treatment services to include requesting additional funding.

Committee Findings

The manner of the incarcerated individual's death was accidental. The cause of death was acute methamphetamine toxicity.

Committee Recommendations

DOC create and distribute an informational flyer highlighting the risk of overdose, recent deaths involving illegal drug use in the facilities and the prosecution risk for visitors introducing drugs into a facility.

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

The UFR Committee recommended DOC explore telehealth options to expand current substance use disorder treatment and seek additional funding to support the expansion of services.

Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-23-013

Report to the Legislature

As required by RCW 72.09.770

December 21, 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 23-013 on December 11, 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-23-013-1
Finding:	The incarcerated individual died of methamphetamine toxicity.
Root Cause:	During his approved visit he was given a balloon containing illegal drugs that he ingested. Signs of overdose were not reported to staff until the individual became non-responsive.
Recommendation:	Provide additional education to incarcerated individuals and their visitors related to the risk of overdose deaths from ingesting illicit substances.
Corrective Action:	Create a statewide communication to be placed in visiting rooms, sent out via kiosk, and given to visitors which identifies dangers of ingesting drugs, recent deaths after ingesting drugs, and the likelihood of people involved in the introduction of drugs to be prosecuted for introduction and death of an individual.
Expected Outcome:	Improved safety for incarcerated individuals.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-014

Report to the Legislature

As required by RCW 72.09.770

December 21, 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-23-014 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 October 19, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Dawn Williams, Program Administrator, Substance Abuse Recovery Unit
- Patty Paterson, Director of Nursing
- Mary Beth Flygare, Project Manager
- Mark Eliason, Deputy Assistant Secretary
- Deborah Roberts, Program Manager
- Rae Simpson, Director, Quality Systems

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- Jason Bennett, Superintendent
- Lorne Spooner, Correctional Operations Program Manager

DOC Women's Prison Division

- Jeannie Darneille, Assistant Secretary
- Deborah Jo Wofford, Deputy Assistant Secretary

DOC Risk Mitigation

- Mick Pettersen, Director

DOC Community Corrections Division

- Kelly Miller, Administrator – Graduated Reentry

DOC Reentry Division (Reentry Centers)

- Danielle Armbruster, Assistant Secretary - Reentry
- Scott Russell, Deputy Assistant Secretary - Reentry
- Susan Leavell, Senior Administrator - Reentry
- Carrie Stanley, Reentry Center Administrator

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

Health Care Authority (HCA)

- Dr. Christopher Chen, Associate Medical Director

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

Fatality Summary

Year of Birth: 1972 (51-years-old)

Date of Incarceration: June 2023

Date of Death: August 2023

At the time of his death, the incarcerated individual was on escape status from a DOC Reentry Center operated by a contracted vendor. Cause of death was the result of acute combined drug intoxication including fentanyl and methamphetamine. Manner of death was accidental.

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

Weeks prior to death	Event
10 weeks	• Readmitted to prison.
5 weeks	• Transferred to parent facility.
2 weeks	• Transferred to reentry center.
1 week	• Escaped from reentry center.
Day prior to death	**Event**
Day of death	• Reentry center employees received phone call from the parent of the incarcerated individual informing them of his death from apparent overdose. • County Medical Examiner was contacted by reentry center staff to confirm his death.

UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee and the DOC Critical Incident Review. The UFR Committee 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 had a known history of methamphetamine use.

b. No significant safety or quality issues were identified with his medical care during his short period of incarceration.

c. He was seen twice for problem focused medical care prior to transferring to the reentry center.

d. He did not report a history of opioid use and as a result DOC Health Services did not have an opportunity to assess and initiate medications for opioid use treatment prior to his transfer.

e. He died of a combined fentanyl and methamphetamine overdose while on escape status from a reentry center.

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

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

1. The CIR found:

a. While the incarcerated individual was housed in a reentry center, he was issued a point-to-point community pass. When he returned to the facility late in the afternoon, he tested positive for methamphetamines. He was placed on total restriction in the facility until his case could be reviewed in the morning with the multidisciplinary team to determine next steps in his case management.

b. The decision was made to return him to full confinement for his safety. Before he could be detained, he exited out of the emergency exit side door of the facility without authorization. He was placed on escape status and a case was opened with the DOC Community Response Unit.

c. One week later, a family member notified the reentry center that the incarcerated individual was found deceased in the community.

2. The CIR recommended:

a. Adding escape response checklist training to the Reentry Center Academy.

b. Update the On-the-Job training checklist which identifies standard actions and response timeframes in the event of an escape from a reentry center.

c. Update DOC Safety Program form 03-474 to include reentry center site specific information indicating primary and secondary arrest and detain locations within their facility for staff orientation purposes.

C. The Department of Health (DOH) representative offered resources for training and asked about reentry center orientation for the residents related to overdose risk after a period of abstinence and the process to return a person to full confinement from a reentry center.

Note: Incarcerated individuals receive an orientation during the first 48 hours after transitioning to the reentry center. Orientation includes a DOH education video on overdose

risk. All residents are offered a Narcan kit and are also able to access emergency Narcan kits throughout the facility without needing staff permission.

Incarcerated individuals may be returned to full confinement if they are not following reentry center participation requirements that place their own or others safety at risk.

D. The Health Care Authority (HCA) representative asked a) if the case managers are notified when a new resident is at risk due to a history of substance use, b) whether Narcan is offered, c) whether it is possible to offer Narcan to incarcerated individuals prior to them leaving the reentry center and d) whether there were indications of mental health concerns for this individual.

Note: DOC indicated that reentry center employees have access to an incarcerated individual's needs assessment which includes past substance use. In this situation, the individual never disclosed he had a history of opiate addiction. Additionally no mental health concerns were identified or disclosed by the individual. All residents are offered a Narcan kit and educated on its use when they transfer to the reentry center. They are allowed to carry the kit with them at all times. There are several dispensing boxes located throughout the facility. Residents are encouraged to take and use Narcan anytime without permission.

E. The Office of the Corrections Ombuds (OCO) asked whether there are standard procedures for a contracted reentry center employee to follow when there is an escape. The OCO also asked about opportunities to respond differently to SUD treatment needs vs return to total confinement, and how to improve systems to address treatment needs not identified via self-reported.

- *Note: DOC provides staff education for responding to an escape. As a general practice, reentry center employees are taught not to pursue an individual who escapes from partial confinement for the safety of the employee, the incarcerated individual, and members of the community.*
- *DOC attempts to conduct a multidisciplinary team meeting prior to any decisions being made about treatment versus return to total confinement. Each individual situation is unique and needs to be reviewed in the moment.*
- *Reentry center staff are working with HS to investigate options to expand SUD treatment services in reentry centers. Currently all individuals receive a substance use disorder assessment prior to transferring to a reentry center. As DOC moves forward with expanding treatment services, the goal is to have a larger presence in the reentry centers to provide support and additional resources for case managers and residents.*

Committee Findings

The manner of the incarcerated individual's death was accidental. His cause of death was acute combined drug intoxication including fentanyl and methamphetamine.

Committee Recommendations

1. DOC Substance Abuse Recovery (SARU) staff should continue to partner with reentry centers to support and expand substance use disorder treatment services as resources permit.

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

1. DOC should look for opportunities to seek alternatives for sobriety support instead of returning the individual to full confinement until appropriate substance use treatment can be arranged.
2. DOC should continue to pursue opportunities and strategies to reduce prohibited substances from entering the facilities as resources permit.

Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-23-014

Report to the Legislature

As required by RCW 72.09.770

December 29, 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.

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Unexpected Fatality Review Committee Report

The department issued the UFR committee report 23-014 on December 21, 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 from the corrective action plan publication.

Corrective Action Plan

CAP ID Number:	UFR-23-014-1
Finding:	Substance use disorder (SUD) treatment services are not currently available on site in DOC reentry centers.
Root Cause:	Resources are not currently funded for on-site SUD services.
Recommendations:	DOC Substance Use Recovery Unit (SARU) staff should continue to partner with reentry center staff to support and expand SUD treatment services in reentry centers as resources permit.
Corrective Action:	Reentry center leadership in partnership with SARU leadership develop a plan to expand SUD services for reentry center participants.
Expected Outcome:	Improved sobriety support for reentry center participants.

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