OFFICE OF THE
CORRECTIONS
OMBUDS

Monthly Outcome Report
June 2023

UNEXPECTED FATALITY REVIEWS: 1

CASE INVESTIGATIONS: 235

- Assistance Provided - 36
- Information Provided - 112
- DOC Resolved – 15
- Insufficient Evidence to Substantiate - 26
- No Violation of Policy - 46
- Substantiated - 0

INTAKE INVESTIGATIONS: 97

- Administrative Remedies Not Pursued - 64
- Declined - 10
- Lacked Jurisdiction - 9
- Person Declined OCO Involvement - 11
- Person Left DOC Custody Prior to OCO Action - 3

Resolved Investigations: **333**

Assistance or Information Provided in
OVER 63%
of Case Investigations

OCO CASEWORK HIGHLIGHTS

June 2023

Assistance Provided

Reported Concerns

Person reported that the DOC had not updated their Custody Facility Plan for more than two years, preventing him from having a good conduct time (GCT) restoration plan finalized. He requested OCO assist in restoring almost three years of GCT.

OCO Actions

1. Substantiated the person had not had his custody facility plan updated for more than two years and requested DOC finalize the plan.
2. Provided oversight by continuing to communicate with DOC staff the ensure DOC 300.380 was followed and that the GCT was restored**.**

Negotiated Outcomes

1. DOC agreed to finalize the GCT restoration plan.
2. The OCO confirmed that the DOC restored the person's GCT. Person's earned release date moved up almost three years.

Assistance Provided

Reported Concerns

Patient and family reported ongoing concerns: (1) medical access related to multiple approved surgeries; (2) issues with the DOC not following specialized transport orders; (3) medical staff conduct issues; and (4) delayed DOC responses to several Extraordinary Medical Placement (EMP) applications.

OCO Actions

1. Contacted health services at the facility and headquarters and requested an extensive medical records review and follow up with the patient.
2. Provided oversight by monitoring care pathway for an extended amount of time.

Negotiated Outcomes

1. DOC completed an extensive records review and found several missed medical consult referrals. DOC then scheduled the patient for updated care.
2. The Health Services Manager agreed to: (1) continue monitoring the patient's access to care and access to appropriate transportation to/from offsite medical appointments and (2) meet with the patient directly to discuss current concerns and medical requests.
3. The OCO confirmed the patient received a medically necessary vision procedure and follow ups.
4. The OCO confirmed that the DOC recently reviewed the patient's EMP requests. While the patient does not meet EMP criteria, the DOC agreed to follow up with patient to confirm receipt of EMP decision.

Assistance Provided

Reported Concern

Incarcerated individual requests the OCO's support to promote multiple proposals from the population to improve the quality of life and programming for incarcerated people in WA state prisons.

OCO Actions

1. Worked with the DOC Engagement & Outreach at HQ to build a pathway for proposals from incarcerated individuals to be reviewed and responded to by the appropriate DOC staff.

Negotiated Outcomes

1. Proposals sent to Headquarters will be reviewed by the DOC Correspondence Unit and assigned to the appropriate Headquarters staff for review and response. Mailing Address is:

   DOC Correspondence Unit
   PO BOX 41100
   Olympia, WA 98504-1100

Unexpected Fatality Review

RCW 72.09.770

The Department of Corrections is required 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-23-004

The Unexpected Fatality Review Committee met on May 20, 2023, and reviewed the unexpected death of a 57-year-old person in February of 2023.

The Unexpected Fatality Review Committee Report dated June 20, 2023, and the Unexpected Fatality Review Correction Action Plan (CAP) dated June 30, 2023, are publicly available documents.

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

MONTHLY OUTCOME REPORT
June 2023

	COMPLAINT SUMMARY	OUTCOME SUMMARY	CASE CLOSURE REASON
	UNEXPECTED FATALITY REVIEWS		
	Monroe Correctional Complex - SOU		
1.	Per RCW 72.09.770, the OCO formally requested that the incarcerated individual's death be referred for an unexpected fatality review.	This case was reviewed by the unexpected fatality review team. 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 report for UFR-23-004 was delivered to the Governor and legislature and is publicly available on the DOC website.	Unexpected Fatality Review
	CASE INVESTIGATIONS		
	Airway Heights Corrections Center - Camp		
2.	Person reports DOC is not giving them information regarding their graduated reentry status.	The OCO provided information regarding the individual's reentry screening status. At the time the individual submitted their complaint the reentry screening was not complete. The OCO was able to verify the screening process has been completed and the individual is eligible for graduated reentry.	Information Provided
	Airway Heights Corrections Center		
3.	Person reported that when he arrived at SCCC he did not receive all his boxes of property, and that he thinks it never arrived at the facility. Person stated that he was moved multiple times this year.	The OCO provided assistance. The OCO reviewed DOC records regarding the shipment of his property and contacted the SCCC property sergeant. The sergeant confirmed that they received his property and that he will get it when he leaves solitary confinement. The OCO requested that DOC provide him with this information, which they agreed to do.	Assistance Provided
4.	Person reports they were moved to a cell that is not compatible with their ADA needs.	The OCO provided assistance by contacting DOC regarding the individual's ADA needs. Through correspondence with DOC health services, the OCO was able to inform staff of the individual's needs. DOC staff took action and moved the individual to a compatible cell and documented the need for the accommodation.	Assistance Provided
5.	Incarcerated individual expressed concerns about their infraction appeal not being responded to.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO contacted DOC regarding the status of the appeal. DOC responded to the OCO sharing that the	DOC Resolved

		infraction appeal has been responded to. DOC informed the OCO that the infraction was dismissed after the appeal was reviewed.	
6.	Outside person was concerned that an incarcerated individual did not receive two pieces of legal mail.	The OCO was able to provide information regarding the pieces of legal mail. The OCO was able to verify through the legal liaison, the individual did receive the two pieces of mail.	Information Provided
7.	Person reports issues with administrative segregation placement and DOC restricting access to the law library.	The OCO provided information regarding the individual's concerns. The individual will need to appeal their custody facility plan once it is complete. At the time of the OCO's investigation, the plan was not complete. DOC responded to the individual's resolution response regarding their legal paperwork and law library access. DOC is working with the individual to ensure the individual has access to their legal paperwork and law library.	Information Provided
8.	Person reported issues with getting a job and reported that he has been on several referral lists for over a year. Person stated that people who have not been on the lists as long as he has been on the list are getting hired before him and he does not understand why. Person reported that the resolutions program is giving him inaccurate responses to his resolution requests.	The OCO provided information. The OCO contacted the individual's counselor and the job coordinator, who shared that he was not hired for certain jobs because of infraction behavior and stated that he has been hired for a different job, which the OCO confirmed in DOC records. The OCO verified that the counselor shared this information with the individual. The OCO reviewed the individual's resolutions requests and substantiated that the responses given were different than the information the counselor and job coordinator provided.	Information Provided
9.	Person reports there are leaks in the roof over the gym deck at the facility, causing weight deck closures.	The OCO was able to provide information regarding the weight deck closure. There is currently a capital project in the works to perform repairs on the weight deck roof.	Information Provided
10.	Person reports the OCO was able to help them on a previous housing issue. Person reports they are having the same issue again.	The OCO was able to provide the individual with information regarding housing issues. The individual can request to be transferred to another facility during their next custody facility plan review. If safety is a concern, the individual will need to report what is going on to an officer or their counselor.	Information Provided
11.	The individual reports that his tablet has been broken for the past several weeks. He reports that he has been writing kiosk messages but has not been able to send a message to Securus.	The OCO provided information regarding how the individual may contact Securus. Family members can call (972) 734-1111 or (800) 844-6591 to report any issues or problems they are experiencing. If an individual has submitted a ticket and is unable to resolve the issue to their satisfaction, they also have the option to write	Information Provided

		them at: Securus Contact Center, PO Box 1109, Dallas, Texas 75001.	
12.	Incarcerated individual expressed concerns about missing books after they were to be returned to the sender.	The OCO verified that DOC mailed his books out according to the incarcerated individual's preference. What happened after they entered the mail carrier's possession would be outside of DOC jurisdiction.	Information Provided
13.	The individual reports that the facility said they would negotiate a new cable contract during a tier representative meeting, but reports individuals were told that the old contract was renewed, and nothing can be done.	The OCO provided information regarding the facility's cable contract. This office spoke with DOC staff who confirmed the facility recently signed a new cable contract with Buford Satellite, which is also used at other DOC facilities.	Information Provided
14.	Person reports they need an ADA accommodation for medical issue.	The OCO provided information regarding how to request an ADA accommodation. The individual will need to send a kite or kiosk message to the ADA coordinator at their facility.	Information Provided
15.	Person reported that his cell has been very hot, and that there was a power outage that turned off the air conditioning.	The OCO provided information. OCO staff visited the facility to monitor the situation and speak with DOC staff and confirmed that the air conditioning was brought offline by a power outage. DOC staff stated that they are actively working to fix the issue, and that it takes several days for the air conditioner to begin working properly again.	Information Provided
16.	Individual reports he had a Classification review and declined SOTP because he has graduated twice and was a TA in the program. DOC is claiming he refused the program again. DOC is now sending him to mainline.	The OCO reviewed this individual's SOTP records and confirmed he did complete the program 5 years ago, however the ISRB is requesting that he take the program again. This individual was not transferred to mainline and is now in the Residential Treatment Unit.	Information Provided
17.	Person reports issues with receiving their property and legal paperwork.	The OCO provided information regarding the individual's property. DOC responded to the individual's resolution request by stating they will receive their property once they are returned to their unit. The OCO is unable to investigate the individual's concern regarding legal paperwork until they have received a level II resolution response from DOC. The individual is advised to contact the OCO if the level II response does not resolve the concern.	Information Provided
18.	Person reports a cell search was conducted, and legal documents were taken out of one of their boxes during this search.	The OCO was able to provide information regarding the cell search. The OCO contacted DOC regarding this concern and found a cell search was not conducted, however a compliance check was conducted. DOC staff shared no items were	Information Provided

		removed from the individual's cell during the compliance check and no search report is required in cell compliance checks. The OCO was unable to verify the legal documents were removed from the cell. DOC explained if property was removed; a cell search report would have been supplied to the individual.	
19.	External person reports that her loved one was handcuffed and beaten by the guards. He wants medical attention and has a large gash on his face. He is being refused medical attention for the injuries.	This office reviewed all video from this incident and the Use of Force report. At the time, the individual was refusing to cell in. The officers attempted to negotiate with the individual, then the individual attempted to push past the officers which resulted in the use of force. There is no video evidence to substantiate the individual was beaten while handcuffed. He did have a scratch on his face; however, it was not a gash which was reported in the concern. The incident reports written by DOC staff allege this individual was assaulting staff during the use of force; however, after reviewing video evidence, the OCO could not substantiate that this individual assaulted staff. He did see medical after the incident and the OCO asked for an additional medical check-up after receipt of this concern.	Information Provided
20.	Incarcerated individual reports DOC did not provide him with his funds after transferring to another facility and requests assistance receiving the funds.	The OCO provided information regarding the funds. The OCO verified that the DOC has correctly deducted and refunded the funds and the money transferred to his account was accurate. The OCO provided the individual with a full breakdown of the funds transfer that resulted in the amount he transferred with.	Information Provided
21.	The individual reports that the DOC is no longer allowing the Asian Pacific Islander (API) cultural group to have cultural food at events.	The OCO provided information. After outreach and conversations with the OCO and external stakeholders, the DOC reconsidered their initial action to not allow food at cultural events. Currently cultural events may serve food per DOC 240.100 Food Services Program section D.	Information Provided
22.	Person reported that he was gassed in the middle of the night in his unit months ago, and that DOC never explained what happened. Person reported that he was made to wait for medical treatment and has suffered complications since the incident.	The OCO provided information about this incident and provided information about filing a tort claim. The OCO is aware of this incident, which was a mistake made during a DOC training that DOC has investigated and has waived co-pays for medical treatment. The OCO contacted the Health Services Manager, who confirmed that this individual has received respiratory health care and that his condition has improved. DOC 120.500 states "All incarcerated individual tort claims alleging personal property damage/loss must be filed by	Information Provided

		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."	
23.	The individual reports that his property was taken during a cell search. He reports the item was given to him by a Chaplain, so if it was not on his property matrix it is not his fault because it was received through the proper process.	The OCO provided self-advocacy information regarding filing a tort claim through the Department of Enterprise Service (DES) Office of Risk Management if his property has not been recovered through filing a resolution request.	Information Provided
24.	Person reported concerns with art books that were rejected by the mailroom. Person stated that two art books were rejected for sexually explicit material, and that books that have artistic value and are not obscene by community standards are supposed to be allowed. Person appealed the decision from the Publication Review Committee, but they upheld the rejection from the facility.	The OCO provided information. The OCO has been working with DOC Headquarters on revising the interpretation of the Sexually Explicit Material WAC, under which these books would be approved. DOC Headquarters has stated that the new policy and interpretation is awaiting DOC leadership approval and will roll out soon, and that all the mailrooms across the state will be trained in the new policy. The OCO provided information about options for having the book reconsidered in the future.	Information Provided
25.	Person reports DOC is not releasing information on how to keep facility cool in warmer months.	The OCO was able to provide information regarding heat mitigation at the facility. The Department of Corrections released an updated heat mitigation effort memo on May 15, 2023. DOC has procedures in place to handle warmer weather. Facilities will supply the population with sunscreen, extra movements, and cooling stations. There will be changes to dress code to allow the population to wear shorts and shower shoes in most areas of the facilities.	Information Provided
26.	Person reported issues with his classification and custody points and states he should have been placed in a camp, but that he is classified as medium. Person reported that he has not had a classification review since arriving at the facility and does not know how to contact classification.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed DOC records and found that this individual has had multiple classification reviews since arriving at the facility, in accordance with DOC 300.380, and is currently classified as minimum custody. This office provided information about his right to attend his next custody facility plan review	Insufficient Evidence to Substantiate

	Person stated he is concerned that these issues will impact his eligibility for Graduated Re-entry (GRE).	meeting and how to appeal the classification decision.	
27.	Incarcerated individual reports staff alleged a threat that did not occur. The individual was infracted, and a keep separate was issued. The individual was transferred to another facility before the facility responded to the infraction appeal. The individual reports the infraction was dismissed and requests the OCO assist him in getting the keep separate lifted. The individual also reports that it was inappropriate to transfer him before the infraction was heard.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the infraction and spoke with DOC staff who explained that while there was insufficient evidence to uphold an infraction due to inaccuracies with the dates of incident, the threats reported by the staff member were severe enough for DOC staff to approve the keep separate regardless of the infraction appeal outcome. The OCO verified that these concerns were ongoing and have documentation to support the need for a separation in compliance with DOC 320.180 Separation and Facility Prohibition Management. The OCO also confirmed the infraction was dismissed in compliance with DOC 460.140 Hearings and Appeals as the date entered on the infraction was not correct.	No Violation of Policy
28.	Person reports they should be eligible for work release after being revoked from graduated reentry.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Per DOC 300.500 Reentry Center Screening II Eligibility A. An individual is prohibited from Reentry Center placement and should not be considered if the individual: 12. Has been terminated from Reentry Center placement and/or Graduated Reentry during the current incarceration due to disciplinary action(s).	No Violation of Policy
29.	The individual reports that he is several months past his Earned Release Date (ERD) and says that the DOC continues to deny his addresses. The individual does not feel that the reasons for the denials are legitimate.	The OCO was unable to substantiate there was a violation of policy by the DOC. This office found that the DOC has been working on a release plan per DOC 350.200 Transition and Release. Per policy, if a release plan is denied, the case manager will notify the individual of the denial reason and work with the individual to develop on alternative release address. The individual has had several addresses denied, however, the OCO verified that DOC staff continue to work with the individual to find a suitable address for him to release to.	No Violation of Policy
30.	Person reports issues with county they will be released to.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Per DOC 350.200 Transition and Release, Section IV (Release Plan Development): At 6 months before the ERD, the case manager will develop release plan in the electronic file and	No Violation of Policy

		verify proposed address(es). The individual is not within six months of their ERD.	
31.	Incarcerated individual reports concerns with the time DOC is taking to complete a Prison Rape Elimination Act (PREA) violation investigation. The individual also reports the accused is at the job they share, and that the accused has friends in the unit she is in that are harassing her.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the actions taken by DOC staff and verified that the accused was moved out of the unit right after the report was made per DOC 490.850 Prison Rape Elimination Act (PREA) Response. The OCO also verified the individuals work in different buildings and should not be near each other while working. The investigation is still underway, and DOC will communicate with the individual with the findings of the investigation.	No Violation of Policy
32.	A loved one reported a complaint about facility policy and procedures regarding mail rejections. The loved one also reported being suspended from video visits and was not informed why.	The OCO was unable to substantiate a violation of policy by DOC. The OCO contacted the mailroom Sergeant, who stated that multiple books, packages, and photographs were rejected because of not having a return address, including too many photographs per mailing, being from an unapproved vendor, or containing an unknown substance. Two of the rejected books were overturned by Headquarters, and one of the rejected books was upheld. The OCO found that these rejections were in compliance with DOC 450.100 Mail for Individuals in Prison. The OCO could not find any evidence that video visits were suspended.	No Violation of Policy
Cedar Creek Corrections Center			
33.	Person reported that he has not been told if he has been screened for Electronic Home Monitoring (EHM) or Graduated Reentry (GRE). Person stated that his counselor told him he cannot provide him with information about whether he has been screened.	The OCO provided assistance. The OCO contacted DOC Headquarters asking if this individual has been screened for EHM or GRE and if the individual has been provided with this information. After OCO outreach, DOC Headquarters instructed the counselor to provide that information to the individual, which the OCO verified in DOC records.	Assistance Provided
34.	Person reports issues with DOC assigning jobs due to DOC being short staffed.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO was able to verify through the DOC database the individual has been assigned a job at the facility.	DOC Resolved
35.	Person reports their legal paperwork was lost by DOC officers during a facility transfer.	The OCO was able to provide the individual with information on how to obtain their lost documents. The OCO was in correspondence with DOC in an attempt to locate the individual's legal paperwork. The OCO was unable to substantiate if the documents arrived with the individual and DOC was unable to locate them. The OCO was able	Information Provided

		to gather information on how the individual can access copies of the documents lost during transfer. The legal liaison suggests, depending on the type of documents, the individual should contact his attorney for copies. Any other documents can be requested through the records department. The OCO inquired if the individual would be charged for replacing the lost documents and the legal liaison was unsure if they would incur charges.	
36.	The individual reports that the facility is referring him to the Therapeutic Community (TC) program. The individual reports that at his substance use disorder assessment, he was told he would only need outpatient treatment. The individual reports that he wants to gain skills for employment, but being in the TC program would not allow him to enter other programs. He reports that he is willing to take classes but does not want to be in a full-time residential program for substance use disorder.	The OCO reviewed the individual's Substance Use Disorder Assessment, and found that it was completed per DOC 580.000, Substance Use Disorder Treatment. This office verified that the individual meets the criteria for a full-time program.	No Violation of Policy
37.	Person reports that he was found guilty of an infraction for failure to provide a UA for drug testing. The person also reports he was not able to be seen by mental health to discuss a Health Status Report (HSR) for oral swab testing until after the infraction hearing. The person states he was unaware of the process to get the HSR prior to the UA and was unaware that the process of giving a specimen would be a trigger for his mental health condition. DOC told him in his appeal that he should have been more proactive in getting the HSR before he received a UA.	The OCO was unable to substantiate there was a violation of policy by DOC. The OCO reviewed the infraction packet and requested the situation be reviewed by the superintendent. The superintendent agreed to review the situation; however, declined to overturn the infraction decision. The health status report was not obtained until after the infraction hearing was completed. Per DOC 460.000 Disciplinary Process III.E, the Disciplinary Hearing Officer will only consider the evidence presented at the hearing.	No Violation of Policy
Clallam Bay Corrections Center			
38.	A loved one reported multiple issues with an incarcerated individual's clothing and laundry,	The OCO provided assistance. The OCO contacted the Correctional Program Manager and discussed the issue. After our outreach, OCO verified that his	Assistance Provided

	stating that he has received the wrong sizes of clothing and that every time he has turned in clothes to be washed his laundry had been lost. This person washed his clothes in his cell, received an infraction, and put on cell confinement.	infractions and negative behavioral observation entries (BOE) relating to laundry were removed from his record. The OCO spoke with this individual months later and he reported continued issues with his laundry, including clothes being lost or torn. The OCO contacted property and to the laundry manager, who could not verify this individual's continued issues with laundry. This office also reviewed DOC records and saw no new BOEs or infractions regarding laundry. The OCO shared how to report concerns with laundry and receive replacements for lost or missing items.	
39.	Person reports they were transferred and did not receive all their property, including dental partials.	The OCO provided assistance regarding locating all of the individual's property. The OCO was able to confirm the individual did receive their property per correspondence with the property room. The OCO also verified through correspondence with the health services manager the individual had their teeth on their person before closing the case.	Assistance Provided
40.	Person reports the box for medical kites should be available to individuals in intensive management units in order to ensure privacy.	The OCO provided information regarding the medical kite process in the intensive management unit (IMU) setting. Individuals housed in the IMU can give medical kites to corrections officers or the nurse in the unit. Individuals can request an envelope from any officer in order to protect privacy.	Information Provided
41.	Incarcerated individual expressed concerns about not being able to access the recreation areas due to not being able to clear the scanners.	The OCO provided information. The OCO contacted DOC about this concern and confirmed that the situation is currently being investigated and other options are being reviewed to change the type of material he is using that is activating the scanner.	Information Provided
42.	The individual reports that he has been in the Restrictive Housing Unit, has remained infraction free, completed multiple classes, and maintained a level 3 in the Intensive Management Unit (IMU). He reports that HQ continues to deny a custody promotion based on old infractions. The individual is concerned that with his Earned Release Date (ERD) in less than 12 months he will not have enough time to go to general population and prepare for successful reentry.	The OCO provided information regarding the individual's Custody Facility Plan (CFP). This office spoke with DOC staff and reviewed the individual's CFP. This office verified that the individual has been in MAX Custody and has an Earned Release Date (ERD) in less than 12 months. The OCO verified that the individual's CFP is still in review and provided information on appealing his CFP. Per DOC 300.380, "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
43.	Person states they would like to be transferred to another facility.	The OCO provided information regarding custody facility plans. The individual's custody facility plan	Information Provided

		has not been completed. The individual is advised to appeal the custody facility plan once complete if they disagree with the outcome.	
44.	Individual is in max custody even though he has close custody points. He said he has safety concerns and needs safe harbor but was denied.	The OCO reviewed the current max placement and the individual's custody facility plans. He is currently classified for close custody due to infractions and has refused housing at both facilities that have close custody units. Due to the refusal, he was placed on max custody. Once he agrees to be housed in general population he can be moved. The DOC HQ investigated his safety concerns and decided he did not qualify for safe harbor. This office could not find a violation of classifications policy 300.380 related to this concern.	No Violation of Policy
Coyote Ridge Corrections Center			
45.	Patient reports he tested positive for Tuberculosis (TB) and had x-rays done. The patient is concerned that he still needs further testing and treatment. He is requesting an appointment to follow up on the results of the tests he has had.	The OCO provided assistance. OCO staff contacted Health Services management at the patient's facility and requested an appointment to follow up on his lab results. DOC staff confirmed the patient attended the appointment.	Assistance Provided
46.	Person reported that songs that he purchased have not transferred to his new Securus tablet, and that he has filed a help ticket with Securus requesting a refund. Person also stated that Securus has not yet sent his refurbished old JPay tablet to his family.	The OCO provided assistance and information. The OCO contacted the Securus liaison, who stated that the facility is aware of these issues and is working with Securus to resolve them. The Securus liaison put this individual on a list to speak with a Securus representative about his issues, upon the OCO's request. The OCO shared with the individual that this office has confirmed with DOC Headquarters that Securus has begun the process to send refurbished tablets to individuals' families, and that they have until late 2023 to complete that process.	Assistance Provided
47.	Person reported that he had many songs that he purchased on his JPay tablet that have not transferred over to his new Securus tablet. Person stated that he filed a help ticket with Securus and has not gotten a response.	The OCO provided assistance. The OCO contacted the Securus liaison, who stated that the facility is aware of these issues and is working with Securus to resolve them. The Securus liaison put this individual on a list to speak with a Securus representative about his issues, upon the OCO's request. The OCO is continuing to monitor the transition from JPay to Securus.	Assistance Provided
48.	Person reported that he submitted a clothing exchange request to replace his worn-out shoes and	The OCO provided assistance. The OCO contacted the resolutions specialist who responded to his request and said that this individual had to wait	Assistance Provided

	was told he had to wait and resubmit the request at the end of April. Person stated that he has holes in his shoes and his feet are getting wet.	because of when he would be eligible for new medical-issued shoes. After the OCO reached out, the specialist contacted this individual asking for his shoe size so they can get him new shoes. Once this individual responds to the specialist, he will get new shoes.	
49.	The individual reports that their Extended Family Visits (EFVs) were denied, but the reason DOC staff gave for the denial was incorrect. The individual reports that they appealed the denial, but it was upheld.	The OCO provided assistance. This office reviewed the individual's EFV application and spoke with DOC HQ staff, who verified that the reason for denial was in error. DOC staff agreed to review their application at the next EFV Review Committee Meeting.	Assistance Provided
50.	Patient reports that it was recommended to him to try music therapy for his mental health. He is requesting a ukulele, but this request was denied at the facility level.	The OCO provided assistance. The OCO contacted the Correctional Manager of the Correctional Services Unit and the Union Supply Group Program Manager. Currently, only keyboards and guitars (electric or acoustic) are approved to be purchased. While the ukulele is not currently authorized, the OCO involvement created a conversation with property administration about what musical instruments could be allowed. The OCO encouraged the individual to reach out to Correctional Manager to speak with her directly about accessing more musical instruments as allowable property per her request. The OCO provided contact information for the Correctional Manager to this person so they may contact her.	Assistance Provided
51.	Anonymous caller reports that three staff members purposely leave the count lights on at night.	The OCO has received numerous complaints regarding this issue and has shared the information with the facility leadership.	Information Provided
52.	Incarcerated individual expressed concerns about DOC not letting their grievance go through about a particular issue they are having.	The OCO contacted DOC Headquarters about the resolution concern and verified that the individual asked to withdraw one grievance about this concern and the other grievance was denied because it did not include enough information about what the individual was experiencing, and instead contained speculations. The OCO provided the individual with information on how to properly write a grievance.	Information Provided
53.	Incarcerated individual expressed concerns about an infraction they received and the impact of it on their housing voucher.	The OCO previously investigated the infraction concerns in a separate case. As a result, this office did not further investigate the infraction concern for a second time. Regarding the housing voucher concern, the OCO verified with DOC that the individual is still approved for housing assistance.	Information Provided

54.	The individual reports concerns with a new operational memo redefining Correctional Industries (CI) programming areas. This change will cause him and other CI employees to lose their jobs due to limitations on work programs per policy. The individual states that although their current job is in the same building as their previous position, the work areas are clearly defined as separate work sites. The individual believes this is a gross misuse of policy. The individual reports that mattress, textiles, and laundry are in one building, and an individual can only work there for 7 years, and then they must change jobs.	The OCO provided information regarding time limitations for Correctional Industries (CI). This office spoke with leadership at the facility and found that CI compound jobs do have a limitation of seven years. Once an individual reaches seven years, they will have to wait two years to reapply to the CI compound. Individuals may apply to the CI Kitchen for those two years, because it is in a different building than the other CI jobs.	Information Provided
55.	Person reports that a nurse at the facility did a procedure that eventually needed to be redone at an emergency room, and that the facility's initial procedure left him a scar. Person reported that the hospital stated that this procedure should not have been done at the prison and that he may need further treatment. Person requested compensation for this incident.	The OCO provided information about filing a tort claim to receive compensation for this incident. 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." The OCO also reviewed DOC records and found that DOC is conducting an administrative investigation of this incident.	Information Provided
56.	Person transferred facilities and has not received his property. Person stated that DOC packed the property in his cell, and that he has not received any of that property. Person stated that a sergeant said he received an email from his old facility acknowledging they lost his property and do not know where it is.	The OCO provided information about filing a tort claim. The OCO reviewed DOC records and found a pack-out checklist that showed multiple items of his property were missing after his transfer. 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

57.	Person states that he had a crown fall out. He was told that DOC would not replace the crown and states that the tooth is now dead because DOC refused to replace the crown they had previously put in his mouth. He is requesting his tooth be fixed and that he be given partial dentures so he can eat regularly again.	The OCO provided information to the patient regarding the DOC Health Plan. The DOC does not cover crowns or implants; they are considered level 3 in the Health Plan and if desired must be accessed through Patient Paid Healthcare. The OCO contacted Health Services management and were informed that the patient had declined care at the last dental appointment and had not requested care since that refusal. The patient cannot be fitted for partials until that tooth is extracted, the patient will need to kite dental to get scheduled for treatment.	Information Provided
58.	The individual reports that he has 90 days before his release and feels as though his classification needs are being ignored. The individual says that he thought DOC would be better preparing him for release, but he feels they are not. He reports this is causing him stress. The individual also filed a resolution request, but it was not accepted because he previously filed one about the same concern.	The OCO provided information regarding the individual's release planning. This office found that the individual was denied Graduated Reentry (GRE), as he does not or did not have three months or more left on his sentence at the time of eligible transfer date. The OCO found that the individual was transferred to Work Release, has an approved Offender Release Plan (ORP), and has a planned release date.	Information Provided
59.	Person reports their incarcerated loved one has been in administrative segregation since being transferred. Person reports they would like their loved one transferred to facility close to family.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Per DOC 300.380 Classification and Custody Facility Plan Review D. Overrides 1.) Overrides may be requested when documented behavior, medical, dental, mental health, program needs, or detainers indicate it is appropriate to: a. Assign a custody level other than what is indicated by the CRS, or b. Promote/demote custody. The individual's custody level was demoted due to infraction behavior, which required the individual to be transferred to another facility.	No Violation of Policy
60.	Incarcerated individual expressed concerns about an infraction they received.	The OCO was unable to substantiate there was a violation of policy by DOC. The OCO reviewed the infraction and appeal narrative and found the individual's actions met the "some evidence" standard. DOC utilizes a "some evidence" standard based on a Supreme Court of the United States ruling holding that it is only required that there be "some evidence to support the findings made in the [prison] disciplinary hearing." (Superintendent, Massachusetts Corr. Inst. Walpole v. Hill). Thus, in order to substantiate an infraction, DOC only needs to show there is "some evidence" of the	No Violation of Policy

		infraction behavior which includes just a staff's statement or recollection of the events.	
Larch Corrections Center			
61.	A loved one of the incarcerated individual reports that she and her husband received conflicting information regarding approval of their Extended Family Visits (EFVs) but were ultimately denied.	The OCO provided assistance. This office spoke with DOC HQ staff regarding the individual's EFV application and DOC staff agreed to review their application again at the next EFV Review Committee Meeting. After the EFV Review Committee Meeting, the OCO verified that the individual's EFVs were approved.	Assistance Provided
Monroe Correctional Complex			
62.	Incarcerated individual reports they are being charged Legal Financial Obligations (LFO) that they have already paid.	The OCO provided assistance. This office spoke with DOC staff who were unaware of the concern. DOC staff agreed to speak with the individual about the LFO concerns and resolve the issue if possible.	Assistance Provided
63.	The individual reports he was sent a letter from the ISRB but does not think it is legitimate because he compared it to another letter he was sent from ISRB looks completely different and it does not look official and feels that his counselor or someone else wrote it pretending to be the ISRB.	The OCO met with this individual earlier in the year regarding this same concern. This office was able to identify that it was a legitimate letter from the ISRB. The OCO was unable to identify sufficient evidence to substantiate that he is receiving fake ISRB letters.	Insufficient Evidence to Substantiate
Monroe Correctional Complex – MSU (Camp)			
64.	Person reports they have not received their property after transferring facilities.	The OCO provided information regarding how to file a tort claim. The individual was advised to submit a tort claim for their lost property. The individual can request a tort claim packet from any corrections officer or their counselor.	Information Provided
65.	Person reported an infestation of rabbits at the facility. Person reported that it has caused an unhealthy and unsanitary environment that is affecting his health. Person filed a resolution request regarding the issue, was seen by medical, but does not feel the resolution was responded to adequately.	The OCO provided information. The OCO has communicated with the facility superintendent and confirmed that the facility is working with the USDA to have the rabbits removed.	Information Provided
Monroe Correctional Complex - SOU			
66.	Person reported issues with his time calculation. Person said he grieved the issue and was told by Headquarters that the issue is with the courts.	The OCO provided assistance. The OCO contacted the Headquarters Records Director who explained this individual's sentence calculation in detail. At the OCO's request, the Records Director worked	Assistance Provided

		with facility staff to get this information to the individual.	
67.	The individual reports that he has been in administrative segregation and does not get enough time in the yard.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO verified that the individual has been released from administrative segregation and has remained in his living unit.	DOC Resolved
68.	Person reports they applied for a work assignment and has not received a response after interviewing.	The OCO was able to provide information regarding the individual's requested work assignment. A referral was submitted on the individual's behalf, and they were placed on a waiting list for the desired position.	Information Provided
69.	Person reported that they need a larger covered area around the sweat lodge to protect participants from extreme weather conditions.	The OCO provided information. The OCO is in conversation with facility leadership about this concern. This office encourages this individual to continue to work with the internal resolutions process.	Information Provided
70.	Person reported that he cannot call his family, and states that he lost the ability to call his family after talking to them in his native language. Person reports that he filed a grievance and kited the Intelligence and Investigations Unit (IIU), who stated that his family blocked his calls, not DOC.	The OCO provided information. The OCO contacted IIU, who verified that this individual's family's phone numbers were not blocked by DOC or his family. IIU stated that they advised the individual to file a help ticket with Securus. The OCO reached out with the facility Securus Liaison, who stated that there are phone connection issues facility wide that are being addressed by DOC Headquarters and Securus, and that if he still has issues, he can sign up to talk with a Securus representative.	Information Provided
71.	Incarcerated individual reported an unexpected fatality and asked the OCO to investigate.	Per RCW 72.09.770, the Department of Corrections (DOC) shall conduct an Unexpected Fatality Review (UFR) Committee in any case in which the death of an incarcerated individual is unexpected, or any case identified by the Office of the Corrections Ombuds for review. The UFR reports can be viewed in the Secures tablets and law libraries.	Information Provided
72.	The individual reports that he has bruises from medical negligence that DOC medical staff are ignoring.	The OCO provided information regarding how the individual may see medical if he would like to have his medical concerns addressed. This office spoke with DOC staff who confirmed the individual was seen by medical and the marks were examined. DOC medical staff attempted to schedule a follow up appointment with the individual, but he declined the appointment. This office encouraged the individual to kite medical if he continues to have medical concerns.	Information Provided

73.	Incarcerated individual requests access to a tablet as others have received one. Person also reports units in their facility do not have Wi-Fi.	The OCO was able to provide information regarding the individual's issues. The OCO was able to verify the individual did receive a tablet. The OCO was in correspondence with the correctional program manager at the facility and was able to verify the unit's listed in the individual's concern now have Wi-Fi access	Information Provided
74.	Person reports they need their medical records from outside facilities in order to be properly diagnosed by DOC medical staff.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO was able to verify through correspondence with DOC health services manager, DOC staff have attempted to assist the incarcerated individual with medical records requests from outside facilities. DOC staff confirmed the individual has been able to receive a diagnosis without the outside medical records.	Insufficient Evidence to Substantiate
75.	Incarcerated individual reports DOC is giving him hormone medication involuntarily.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the individual's file and found no indication that the individual was given involuntary medications.	Insufficient Evidence to Substantiate
76.	Person reported that he is being transferred to WSP and has safety concerns, which are documented in his Custody Facility Plan.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed this individual's Custody Facility Plan that recommended transfer due to infraction behavior and could not find any documented prohibitive placement or facility-wide separation orders at WSP or any violation of DOC 300.380. The OCO verified that there is a Custody Facility Plan currently in review regarding his housing.	No Violation of Policy
Monroe Correctional Complex - TRU			
77.	Patient who self-catheterizes reports being denied a Health Status Report (HSR) for cleaning wipes, which he previously had been approved for and accessed for years.	The OCO provided assistance by elevating the concern to the facility and headquarters health services leadership. DOC agreed to re-review the HSR request through the Care Review Committee (CRC), however, there was no change in outcome. DOC discontinued the use of disposable cleaning wipes due to septic issues and replaced with peri bottle and washcloths. This office confirmed the individual was provided the alternative HSR cleaning items and reviewed the catheterization protocols which lists disinfectant soap and gauze sponges for cleaning purposes. In general, HSRs for disposable cleaning wipes will now be reviewed on an individual basis by the CRC and considered specifically for functional limitations when the alternative peri bottle and washcloths would not be accessible to the patient. The OCO provided the individual with self-advocacy information	Assistance Provided

		regarding pathway for HSR access if functional limitations develop.	
78.	Person reports that medical records staff are mixing up records due to similar patient names. The individual reports medical staff have mixed up their medication and given the wrong medication to the wrong person, and they keep doing audits of medical records which are mixing the records up.	The OCO provided assistance by contacting Health Services management and requesting a review of the three patient's charts to ensure there were no misfiled documents. The OCO also requested DOC place name alert stickers on the patient's charts and medication administration records.	Assistance Provided
79.	Person reported that the Facility Risk Management Team is not following DOC 300.380 Classification and Custody Facility Plan Review and DOC 350.100 Earned Release Time, and that policy is not being followed regarding his Restoration of Good Conduct Time.	The OCO provided assistance. The OCO reviewed DOC records and substantiated that this individual did not have custody facility plan reviews within the timeframes per DOC 300.380 and that there were discrepancies with his restoration of good conduct time. The OCO has provided oversight for this issue over multiple cases. The OCO contacted the Correctional Program Manager and provided continued follow-up to ensure that good conduct time was restored. After OCO outreach, she informed this office that this individual's good conduct time was being restored, which this office verified in DOC records.	Assistance Provided
80.	Person reports issues with access to their records and scores from assessments.	The OCO provided information regarding public records request. The individual can access their central file by going to the law library. They can also submit a public records request through the department of corrections.	Information Provided
81.	Person reported multiple issues with his Securus tablet, including dropped calls, not being able to take photos, Wi-Fi issues, and issues submitting help tickets. Person also stated that the OCO phone number and hours are not available on the tablet. Person also reported that hats are a part of their state-issued uniform, but they are not allowed to wear hats indoors, even though staff is allowed to wear hats indoors.	The OCO provided information. The OCO is aware of the multiple issues with the Securus tablets. DOC is also aware of these issues, particularly the issues with the help ticket function, and working with Securus to address them. The OCO has verified that the OCO phone number and hotline hours are posted in the units and are continuing to work with DOC to get OCO information available on the tablets. The OCO requested and reviewed the facility handbook and verified that hats are not allowed to be worn indoors, except for certain religious headwear, per DOC 560.200 Religious Programs.	Information Provided
82.	The individual reports that OCO reports are available on the new tablets, but they all have the same name and date of creation so looking for a specific report is not possible.	The OCO provided information regarding the OCO reports on the new tablets. This office is aware of this concern and is working with the DOC to ensure there are no issues with individuals accessing OCO reports. The OCO is aware there may still be some issues with OCO reports on the	Information Provided

		tablets but continues to work with the DOC to resolve issues as they arise.	
83.	Person reported that the mailroom is removing picture attachments from emails he is getting on his Securus tablet. Person stated that he is not getting rejection numbers or reasons for rejection. Person said that the OCO informed him in a previous case that this policy is going to be amended, but it has not happened yet.	The OCO provided information. The OCO contacted DOC Headquarters who confirmed that the updated mail policy with a new interpretation of the sexually explicit material WAC is waiting for approval from the Assistant Secretary. DOC Headquarters reviewed his rejected messages and showed the OCO identification numbers on the message that the individual can use to appeal the rejections. DOC also shared that the individual can also use the date of the rejection in appeals. DOC Headquarters stated they are working on new rejection language to align with the updated policy, and that it will be up to Securus to provide a text box for stating the reason for message rejection.	Information Provided
84.	Incarcerated individuals report concerns with making calls on their Securus tablets in their cells. The individuals report that calls cannot be made while in their cells if they are housed in a cell far away from the dayroom, and they are discouraged from making calls in the day room.	The OCO provided information. The OCO spoke with DOC staff who are aware of the concern and are addressing it with Securus and MCC facilities staff.	Information Provided
85.	Person reported that he is being blocked from calling or emailing people by Securus and is having trouble downloading music. Person stated that the Corrections Program Manager (CPM) is not doing anything to resolve the issue and that he is worried about retaliation from her.	The OCO provided information. The OCO has been monitoring the transition from JPay to Securus and is aware of widespread issues with communication and media and has verified that DOC is also aware of these issues. The OCO has contacted the CPM about this individual's issues with Securus in the past and knows that she is aware and has verified that he has access to speak with Securus representatives. The OCO encourages this individual to continue working with Securus to resolve these issues.	Information Provided
86.	Incarcerated individuals report concerns with yard closures and staffing shortage that affect recreation and visitation.	The OCO spoke with facility leadership regarding staffing shortages resulting in closing yard/recreation and visiting. DOC facility leadership confirmed they are actively hiring. DOC is understaffed statewide, and recreation/yard are often the first closures when staff are required in areas that need staffing due to health and/or safety.	Information Provided
87.	Person reports they broke their leg at Stafford Creek. Person went to medical and was given an x-ray.	The OCO provided the patient with information regarding tort claims. The OCO reviewed medical records, resolution responses, and confirmed	Information Provided

	DOC staff said their leg was broken and they were given walking boot and cane. They report they were not given any details about the broken leg. Person was told they have an appointment with an orthopedic surgeon and was told he might need his leg to be re-broken and may require surgery. Person is requesting that his leg get fixed and is seeking monetary compensation.	medical and specialist appointments occurred. There was insufficient evidence to confirm a delay or denial of care by DOC. 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.	
88.	Person reports needing a facility transfer due to staff conduct issues. Person reports they have been infracted for their clothing.	The OCO was able to provide information regarding facility transfer. The individual can request a facility transfer during their next custody facility plan review. The OCO was able to verify the individual has received general infractions related to their clothing, however the OCO does not investigate general infractions. General infractions do not carry restrictive sanctions and the OCO was able to verify the individual only received written warnings. The individual is advised if they disagree with an infraction to appeal the decision.	Information Provided
89.	The incarcerated individual reports that there are only pork options for meat in the commissary packages. Previously there were packages that included beef meat sticks and turkey meat sticks, but this has changed recently, and currently, only meat sticks with pork are available for order. The individual does not eat pork and is requesting that someone work with CI to add beef sticks as an option. Beef sticks are available on commissary, so the DOC has them in stock.	The OCO provided information to the person regarding the availability of non-pork meat snacks. The OCO contacted staff at Union Supply and Correctional industries. There was an issue with the catalog for this season's packages, the pork-free options were not included in the catalog listing. It was communicated by kiosk to the population after the catalog was published that the beef snacks were still available for ordering, but not listed in the catalog.	Information Provided
90.	The individual reports that he has learning disabilities and is forced to go to school. He reports that people under 65 without a GED are required to go to school. The individual reports that he has been threatened with an infraction for failure to program if he does not go to school.	The OCO provided information regarding how the individual may request accommodations or exemption from programming. This office spoke with DOC staff who confirmed that the individual was removed from educational programming. If he were to be required to enroll again, per DOC 500.000, Education and Vocational Programs in Prison, "Individuals with physical, mental, medical, or health issues may be exempted from mandatory basic skills enrollment by the case manager and education employees/contract staff,	Information Provided

		with input from mental health/health services, as appropriate. Exemptions will be documented in the Case Management Plan." The individual is on the waitlist for required programming, and DOC staff confirmed that he may work with the instructor for accommodations. If the individual's needs are not met though working with the instructor, he may see mental health staff to document his education and programming needs so that he may have appropriate accommodations for his learning disability.	
91.	Incarcerated individual anonymously reported concerns with bias Washington ONE assessments at the facility when conducted by a specific staff member. The individual requested the OCO review assessments to verify bias.	The OCO notified facility administration about this concern. Facility administration reported that they had not been informed of this previously. The OCO encourages individuals to call or write with specific concerns about their own assessment if they wish to have it reviewed for policy compliance.	Information Provided
92.	Person reports OCO reports are not available on the tablets.	The OCO was able to provide information on the missing reports. The OCO is working with DOC to ensure all the OCO reports are available on the tablets and working properly. OCO reports are available in the law library for review until the issue is resolved.	Information Provided
93.	Patient reports that DOC will not prescribe him the medications that work best for his mental health issues. He is asking that his medication request be reviewed further.	The OCO provided information to the patient about the Care Review Committee (CRC) decision to decline his request. The OCO also provided information to the patient about the CRC appeal process. The OCO noted that the timeline to appeal a CRC decision is too narrow for this office to offer that as a suggestion to a patient before they are outside of timeframes. This concern is being discussed with DOC Health Services leadership as it would require a change in policy to extend the timeline. The current timeline for appealing a CRC decision is only 5 days.	Information Provided
94.	The individual reports concerns regarding individuals with wheelchairs and walkers accessing the dayroom. He reports that there are many people in the unit who have wheelchairs and walkers, and the dayroom can only accommodate a few at a time due to the layout. The individual reports that when people are not able to fit in the dayroom, they sit	The OCO provided information regarding the individual's concerns with accessibility. This office met with DOC staff who report that individuals loitering in the corridor creates safety and security risks for medical and other emergencies and could delay response times. The facility is reviewing access for individuals in wheelchairs and walkers and are also looking at opportunities for prosocial engagement for all individuals. Remodeling the dayrooms would be a capital project which the facility may look to in the future. DOC staff also	Information Provided

	in the corridor to socialize, but DOC staff generally does not allow this. The individual also reports concerns with the number of accessible showers in the unit.	confirmed that maintenance staff are going through all units at the facility and updating showers to be ADA compliant.	
95.	Patient reports he has been dealing with a shoulder injury for some time and DOC medical keeps returning him to conservative treatment measures instead of ordering an MRI. The DOC orthopedic consultant has already been contacted for input on his care. The patient also reports that he is not able to take the medication his provider offered due to the potential side effects.	The OCO provided information to the patient on medications with multiple functions and the determination made by the provider and DOC orthopedic consultant. DOC medical determined that the results of completed imaging indicated that an MRI is not the most appropriate next step. Per DOC 600.000 clinical decisions are the sole province of the responsible health care practitioner and are not countermanded by non-clinicians.	Information Provided
96.	Person contacted the OCO requesting information on DOC's medical provider.	The OCO provided information on how the individual could access information regarding DOC's medical provider. The individual was advised to kite medical to request the name of the provider.	Information Provided
97.	Person reports they have filed multiple records requests through DOC and minimal records have been produced. Person reports one request was closed without explanation.	The OCO was able to provide information regarding DOC records request. The OCO contacted DOC regarding the individual's concern per DOC Policy, 280.510 VII Appeal Process A. If the requestor disagrees with how a request is processed, the requestor may appeal to the Department Appeals Officer for review. The appeal will be reviewed and affirmed, or the handling of the request will be reversed with a communication regarding the decision sent to the assigned employee and the requestor. B. Appeals will not be considered if submitted 12 months or more after the Department's last response or production of records. If the individual feels they did not receive all the records they requested they are advised to utilize the appeals process for records request.	Information Provided
98.	Incarcerated person reports he was suspended from the DOC Resolution Program, and since then he is not receiving responses to his medical kites. Patient states that he had an ultrasound on his hip and was sent to an outside specialist for additional medical care. According to the patient his	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed this complaint with facility health services leadership and did not find evidence to support the claim that his kites were not responded to. Further, the OCO confirmed that the patient was approved and sent to an off-site specialist for evaluations, and that there is documentation in	Insufficient Evidence to Substantiate

	medical records were not reviewed by the outside specialist, causing him to be misdiagnosed.	effect that his medical records were available for review.	
99.	Patient reports DOC is refusing to offer medication for managing his chronic pain.	The OCO contacted Health Services management and confirmed access to pain management. DOC confirmed the patient's pain care is being managed by community-based pain management specialists. The OCO encouraged the patient to work with their primary provider and outside specialists to update his care needs. The OCO also verified the patient is scheduled for the next treatment.	Insufficient Evidence to Substantiate
100.	Outside person reports they are being denied visits with incarcerated loved one.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Per DOC 450.300 Attachment 1 Eligibility Requirements for Visitors Ineligible Visitors 1. The following are ineligible to visit incarcerated individuals: A victim of the incarcerated individual's current offense(s) or any previous adjudicated offense.	No Violation of Policy
101.	Person reports that he is experiencing a vascular issue and was told by DOC medical and the specialist that the surgery to correct this is too risky. He also reports that he needs a wheelchair but only has a walker. The patient reports he has tried to ask his provider, but they will not give him one.	The OCO was unable to substantiate there was a violation of policy by DOC. The OCO verified the patient has been evaluated for this issue. The requested procedure and equipment were decided to not be a clinically appropriate intervention. The patient was provided with alternative means of relief from the condition. Per DOC 600.000 Health Services Management, Clinical decisions are the sole province of the responsible health care practitioner and are not countermanded by non-clinicians.	No Violation of Policy
102.	Person reports their health status report (HSR) renewal is every six months and would like one for a year.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The individual currently has a health status report in-effect. Per DOC health status report protocol the maximum permissible term for renewal for the individual's specific health status report type is one year. These types of health status reports are typically renewed six months to a year. The decision to renew for six months is at the provider's discretion and per their medical opinion.	No Violation of Policy
103.	Person reported that he is supposed to be released in the fall and is currently doing a program, but that DOC is now trying to move him to a different facility. Person is	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed DOC records and found that time was added to this individual's sentence by the Indeterminate Sentence Review Board, who required this individual do specific programming that is not available at his current	No Violation of Policy

	concerned about moving to an area where he has no family.	facility. RCW 72.02.210 states that DOC can determine the "confinement and placement in such correctional facility under the supervision of the department as the secretary shall deem appropriate."	
104.	Incarcerated individual expressed concerns about not being able to call their school.	The OCO reviewed the level 1, 2 and 3 resolution request responses and found no violation of policy as DOC Policy 500,100(IV)(D)(3) and student agreement form DOC 20-309 states that an individual cannot call the school directly but can contact them through mail. The policy would need to change for the individual to be able to contact the school via phone. The resolution request response informs the individual that the policy is up for review in 2023 and DOC will consider the concerns he shared with the current policy during that review period.	No Violation of Policy
105.	Person reported that she was denied transfer to WCCW. Person wrote to the DOC Women's Division, and the response was vague and did not say why she was denied transfer to WCCW at this time.	The OCO was unable to substantiate a violation of DOC 490.700 Transgender, Intersex, and/or Non-Binary Housing and Supervision by DOC. This individual will have a Custody Facility Plan review next month where she will have another opportunity to review her housing.	No Violation of Policy
Monroe Correctional Complex - WSR			
106.	Person reports he was scheduled for a surgery, and it was cancelled. He is requesting this office find out why the appointment was cancelled and ask that it be rescheduled.	The OCO provided assistance by contacting Health Services management. The OCO confirmed the appointment was canceled by the surgery center due to needing further medical clearance. The OCO verified the scheduling of that appointment. The surgery will be scheduled after the patient is cleared for it.	Assistance Provided
107.	Incarcerated individual filed an emergency resolution request in September 2022, and it was lost.	The OCO informed DOC leadership that this emergency resolution request was lost and never addressed at the facility.	Information Provided
108.	Person reported a facility issue regarding the infirmary at Washington State Reformatory (WSR). Person stated that the Securus and JPay system is broken, and that patients do not have access to Securus or kiosk, and that the only way to communicate with staff is through kites. Person reported that policy and procedure manuals and OCO information were not available in the infirmary.	The OCO provided information. The OCO contacted the facility Securus liaison, who stated that the entire complex is experiencing issues with the Securus terminals, and that she is working with DOC Headquarters and Securus technicians to determine and fix the problems, including in the infirmary. The Securus liaison also confirmed that some individuals in the infirmary are able to make phone calls and send messages. The OCO also contacted the WSR Correctional Program Manager, who stated that the infirmary has a small number of beds and is not a regular living	Information Provided

	unit, and that there are wraparound staff who are able to filter out questions about policy and procedure and provide OCO information.	
Olympic Corrections Center		
109. Person reports they are unable to sleep due to assigned work hours.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The individual was switched to a work shift that was accommodating to his sleep schedule.	DOC Resolved
110. Person reports issues with their sentence calculation.	The OCO provided information regarding their sentence calculation. The individual is advised to send a kiosk message or write to DOC headquarters for clarity on their time calculation.	Information Provided
111. Incarcerated individual expressed concerns about being infracted for refusing treatment related programming.	The OCO reviewed the infraction and per DOC Policy 580.000(VI)(B) "individuals who refuse admission, do not complete the treatment program due to their refusal to continue treatment, or are out of compliance with program requirements will be subject to disciplinary action."	No Violation of Policy
Stafford Creek Corrections Center		
112. Person reports he is experiencing severe chronic pain. The patient states that he is having issues keeping his medication and durable medical equipment orders active. The patient is requesting that his Health Status Reports and medication orders be rewritten without expiration dates.	The OCO provided assistance by contacting Health Services management and confirming the specialist consult was scheduled. Patient's requests for orders to be written without expiration dates are not supported by policy. The OCO monitored the appointment on the appointment tracker for completion.	Assistance Provided
113. The individual reports that his wife sent him some articles and magazines and when he was given the mail, the magazines were not included. The individual reports that he did not receive a mail rejection, so he filed a resolution request which was not accepted based on hearsay/speculation.	The OCO provided assistance. This office spoke with DOC HQ resolutions who confirmed with the facility that the individual did not receive a mail rejection notice for the magazines. DOC HQ staff agreed to reopen and review the individual's resolution request. This office also provided the individual with information regarding filing a tort claim through the Department of Enterprise Service (DES) Office of Risk Management if the magazines are not found through his resolution request.	Assistance Provided
114. Person called to report a patient in the IMU was having issues accessing mental health care. He requested this office schedule a phone call with the patient.	The OCO provided assistance by scheduling a phone call with the patient. The patient reported that he was no longer having issues accessing mental health after being transferred to a new facility.	Assistance Provided

115.	Person reports that they cannot get in contact with the ADA Coordinator, and they need an accommodation for handcuffs due to their disability.	The OCO was able to verify that this individual was issued a health status report (HSR) for double handcuffs after this concern was filed.	DOC Resolved
116.	Patient reported that he has not received infusions since arriving at SCCC and stated that he received the medication in jail and at other DOC facilities. Patient stated that he has been in severe pain without this medication. Patient was seen by a gastrointestinal specialist recently and was told DOC is waiting for him to have another appointment to receive the infusion.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO contacted the Health Services Manager, who substantiated requirements for additional testing and preparation delayed treatment access. Health Services shared records and verified that this individual received his medication and has appointments scheduled for future infusion treatments. The OCO was also able to confirm the patient has a pain management plan in place while awaiting future infusion treatment.	DOC Resolved
117.	Person reports that they are not being given extra clothing or long johns. He has tried to file kites however they are being ripped up.	The OCO was able to verify that this individual was issued a health status report (HSR) for long john bottoms this month.	DOC Resolved
118.	Person reports they declared a medical emergency and was not taken to medical.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The individual reported their concern was resolved. The OCO was able to verify through the DOC database the individual's resolution request was informally resolved. The OCO was able to verify the informal resolution. The individual was seen by medical. If the individual is not satisfied with informal resolution, they are advised to appeal to the next level.	DOC Resolved
119.	Person reports his wheelchair is broken and the DOC will not provide a new one. He is housed in segregation.	The person contacted the OCO to report he received a wheelchair that works.	DOC Resolved
120.	Person reported that he has not been able to get a job, and people who arrived at the facility after him have gotten jobs. Person said he is working with counselor and was told he is low priority.	DOC staff resolved this concern prior to the OCO taking action on this complaint. This person called the OCO and informed this office that he has been hired for a job.	DOC Resolved
121.	Outside loved one is requesting assistance/information on how to get approval to send an outside supplement to their incarcerated loved one.	The OCO was able to provide information regarding the incarcerated individual's treatment options. The OCO contacted the health services manager regarding the supplement the individual is requesting access to. The CI store offers comparable supplements to the one the individual	Information Provided

		is requesting. The health services managers verified the individual has been offered multiple treatment options for their issue and is currently using one the individual has deemed effective.	
122.	External person reported that it was too hot in the visit room on Mother's Day. Temperatures were abnormally hot in Aberdeen.	The OCO contacted facility leadership regarding this concern, the facility was aware and provided a response back to the external person. They have since bought more equipment to keep the facility visit room cool in anticipation of another hot weather event.	Information Provided
123.	An incarcerated person and their loved one reported being denied video visitation while the loved one is on probation.	The OCO provided information. The OCO reviewed the visitation denial and found that there was no violation of DOC 450.300, which states that convicted misdemeanants will not be granted permission to visit until six months after completion of their sentence. The OCO provided information about appealing the visitation denial and applying again once the loved one is no longer on probation.	Information Provided
124.	Incarcerated individual reports he was assaulted after DOC staff placed another individual in the cell with him that was not compatible. The individual attempted to report the concern to staff and DOC staff roomed them together regardless. After they were housed together the individual was assaulted by the new cellmate. The individual is requesting information about options for compensation and requests the OCO investigate the DOC staff action.	The OCO provided the individual with information about filing a tort claim for possible compensation and shared the investigative findings. The OCO was unable to substantiate that DOC staff were informed of the safety concern before housing the two individuals together. However, we were able to substantiate that due to Health Status Reports (HSRs) not transferring with an individual to a new facility, the placement without the HSRs created hardship for both individuals which resulted in the assault. The OCO shared information about how to file a tort claim to have this investigated for potential compensation.	Information Provided
125.	Incarcerated individual expressed concerns about DOC not following the recommendations of Amend.	The OCO elevated this concern to the OCO director who will share the concerns with the Amend team. The OCO advised the individual that they should bring up the concerns with Amend directly.	Information Provided
126.	Person reported that his old JPay tablet was confiscated and replaced with a Securus tablet, which does not work. Person stated that he has been waiting months for a replacement tablet and submitted multiple help tickets. Person reported that people who are new to the facility	The OCO provided information. The OCO has contacted the facility Securus liaison, who is aware that there are many individuals who have broken tablets and are waiting for replacement and stated that they are working to provide tablets to individuals who have not received one at all before providing replacement tablets. The liaison described multiple issues that have delayed the distribution of tablets, including supply issues and receiving a shipment of tablets from Securus that	Information Provided

	are getting tablets, but his broken one has not been replaced.	did not work. This individual will need to wait for a replacement tablet.	
127.	The incarcerated individual reports that he witnessed a staff member being disrespectful to another incarcerated person and another staff member. The individual feels that staff misconduct and behavior affects him and everyone in the unit because the staff are there to protect the individuals and their safety.	The OCO shared this information with facility leadership, and they were aware of the concerns. The DOC was conducting their own investigation and this staff member was moved to a different location. The individual who reported this concern has now moved to a different facility.	Information Provided
128.	The individual reports that the DOC is preventing his access to the courts. He reports that he has had multiple delayed hearings for the same cause number. The individual reports the hearings had to be rescheduled because the DOC was not allowing him to attend.	The OCO provided information regarding how the individual can obtain information regarding his court case. Individuals may obtain the last three entries on the docket for their case from the law librarian, and they may also call and write to the contract attorney for information regarding their case. Contact information for the contract attorney may be posted in the units or can be obtained through the law librarian. The individual did not provide any specific information regarding his court case. The OCO spoke with DOC HQ staff who confirmed that specific information (which court, case number, and dates) is needed to verify if there have been any delayed hearings.	Information Provided
129.	Person reports there are no religious services for their particular religion.	The OCO provided the individual with information regarding the policy for religious programs. The individual received a resolution request response and DOC provided a form to be sent to the Chaplin to establish religious services. Per DOC policy 560.200 Religious programs 1 (C) 2. Assist in developing and reviewing religious programs. If the person has any further issues, they are advised to appeal the concern to a level I.	Information Provided
130.	Person reports DOC has not scheduled follow-up outside medical appointments. Person states DOC is not following specialist recommendations.	The OCO was able to provide information regarding the individual's medical care. The OCO was able to confirm the individual has been scheduled for follow-up medical appointments at outside facilities. The OCO was able to verify through correspondence with DOC the medical staff is following the recommendations given by the specialist.	Information Provided
131.	Incarcerated individual reports concerns with others in the unit. The individual reports others are treating him poorly and requests the OCO ensure staff intervene.	The OCO provided information about how to report concerns to staff. The OCO spoke with DOC facility staff and verified that the concerns were reported to unit management, and they addressed the concerns informally. The unit manager told the	Information Provided

		OCO they have open door hours frequently and appreciate when individuals utilize that time to share concerns going on in the unit. The OCO recommends the individual utilize the open-door time to share concerns as they arise.	
132.	The individual reports that his legal mail was taken. He reports that there is no record of his legal mail in the logbook and the facility never charged him for the outgoing mail.	The OCO provided information regarding the individual's outgoing legal mail. The business office did not initially receive the individual's postage transfer and he was not charged for the outgoing mail; however, this was soon corrected. This office spoke with DOC staff and found that there was a slight error on the address on the postage transfer, but the mail was logged, documented, and sent out. The OCO verified that despite this error, the facility does not have any record of it being returned due to an incomplete address.	Information Provided
133.	Incarcerated individual expressed concerns about an infraction that is impacting their ability to go to GRE.	The OCO provided information to the individual regarding the infraction.	Information Provided
134.	Person reports they were told by medical they could have contacts in prison. When his contacts arrived property staff rejected the mail because they weren't ordered through DOC. He states he has issues wearing glasses and needs contacts.	The OCO provided information to the person regarding the department approved pathway to have contacts sent to his facility. Per DOC 450.100 Mail for Incarcerated Individuals, Attachment 1: #40 property from a third party that is not an approved vendor is not authorized.	Information Provided
135.	Person reports issues with the resolution program requesting a rewrite on his medical grievance.	The OCO was able to provide information regarding the individuals resolution request. The OCO was able to confirm the individual received a resolution response and a rewrite was requested. The individual did not complete the rewrite, however their issues with their medical care were addressed by DOC medical staff. The individual is advised to request a meeting with a resolution specialist if they have issues with what information to include in a rewrite.	Information Provided
136.	Individual reports medical issues that the DOC is not treating.	The OCO contacted the facility medical services regarding this issue. The individual refuses to speak with medical or go to the clinic and due to this medical is unable to access him properly. The OCO has met with HQ medical leadership to discuss a resolution for this patient, however the patient is still unwilling to see medical. The OCO has been onsite at the facility to support the patient during their scheduled appointments, however they have still refused.	Insufficient Evidence to Substantiate

137.	Individual reports he does not have access to dental and he needs an oral surgeon.	The OCO contacted the facility medical services regarding this issue. The individual refuses to speak with medical or go to the clinic and due to this medical is unable to access him properly. The OCO has met with HQ medical leadership to discuss a resolution for this patient, however the patient is still unwilling to see medical. The OCO has been onsite at the facility to support the patient during their scheduled appointments, however they have still refused.	Insufficient Evidence to Substantiate
138.	Individual reports 45 pieces of mail are missing, and he has filed resolutions. The individual states the DOC is blocking his mail to keep him in prison. He claims two of our OCO staff members have attacked him, and the Director is not doing her job.	The OCO could find no evidence to substantiate that any employee at this office has attacked this individual. The OCO has only met with this individual in person at cell front. The OCO also finds no evidence to substantiate his mail is missing. He has filed resolutions; however, this is not the correct process for mail concerns. he will need to appeal his mail rejections.	Insufficient Evidence to Substantiate
139.	Person reports they are being transferred to a new facility and believes a conspiracy is taking place.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the individual's custody facility plan in the DOC database. The individual is not scheduled to be transferred to a new facility and is currently at the same custody level.	Insufficient Evidence to Substantiate
140.	Incarcerated individual reports retaliation after DOC completed a protected investigation due to staff denying him access to go to work.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO verified a communication issue blocked the individual access to work for one shift and was resolved for the next workday.	Insufficient Evidence to Substantiate
141.	External individual reports DOC blocked her contact from an incarcerated individual and requests the OCO assistance in recommending DOC amend their decision.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The OCO reviewed the decision from DOC and found it to be following DOC 450.300 Visits for Incarcerated individuals which states, "Providing false/misleading information or failure to list all previous criminal history on the visit application may result in denial of visit privileges." The OCO verified the external person did not provide DOC with her identity when signing up for video visiting.	No Violation of Policy
142.	Individual reports he was attacked by another incarcerated individual and the DOC staff did not respond, in addition he was placed in segregation for mutual fighting, even though he did not fight back.	The OCO requested the video evidence from the incident reported. Video showed that this individual was attacked, and the DOC staff member can be seen on video calling for assistance on their radio. At the time they were the only DOC staff member in the pod. Initially, the individual was taken to administrative segregation for three days, after the video was reviewed, he	No Violation of Policy

		was released back to general population. The other individual was infracted for assault. The OCO could not find a violation of DOC policy or procedure.	
143.	Incarcerated individual requests the OCO review an investigation to verify DOC thoroughly completed it and conducted the investigation per policy. The individual reports DOC did not complete a just investigation.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the completed investigation and verified that the DOC conducted the investigation following DOC 490.860.	No Violation of Policy
144.	Incarcerated individual expressed several concerns related to an infraction they received. First, the infraction narrative was copied from an infraction another individual received. Second, incarcerated individuals are not able to use video evidence to support their statements. Third, important information about their medical condition was omitted from the infraction narrative.	The OCO reviewed each of the individual's concerns while reviewing the infraction and appeal packet. First, the individual expressed concerns about the infraction narrative being copied from an infraction another individual received. In reviewing the infraction packet, the narrative includes all the pertinent details that are applicable to the situation in which the infraction transpired and only includes information for their personal situation. As most infractions are a simple application of the elements, the stock language of infraction narratives are likely copied and pasted and then filled in with the applicable details for each individual. Second, the incarcerated individual expressed concerns about incarcerated individuals not being able to use video evidence to support their statements. Per DOC form 05-093 and DOC policy 460.000 an incarcerated individual does not have a right to other supplemental tests or examine physical evidence. This includes video evidence. Third, the incarcerated individual expressed concerns about the infraction narrative leaving out information about their medical condition. The OCO verified that there is no violation of policy in relation to the infraction and the individual's medical concern.	No Violation of Policy
145.	Individual had a false PREA filed on them then they were moved to a different unit. They attempted suicide and went on a hunger strike to move back to their original unit.	The OCO contacted the facility for a welfare check and to gather more information. Facility staff were working with this individual to end the hunger strike and move back to general population. This individual is now back in their unit. There was no violation of DOC policy in this concern and the DOC staff responded appropriately per protocol.	No Violation of Policy
146.	Person reported that he is trying to get married, and that DOC is trying to use a domestic violence charge on his sealed juvenile case to deny	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The OCO could not verify that he was denied due to a domestic violence charge and could not	No Violation of Policy

	the marriage application.	find that DOC violated DOC 590.200 Marriages and State Registered Domestic Partnerships.	
147.	Person reports they should be eligible for good conduct time restoration.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Per DOC 350.100 Earned Release Time IV Good Conduct Time Restoration A. (3) Time will not be restored: (b) for individuals found guilty of a serious infraction within the last year. The individual is also not eligible for a restoration pathway due to being close to their earned release date.	No Violation of Policy
148.	Incarcerated individual reports concerns about the outcome of a resolution request investigation because DOC was unwilling to review video to verify harassment. The individual requests the OCO review the investigation and request DOC provide him with a proper investigation response and acknowledge their behavior. The individual requests information about how to file an ethics complaint.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The OCO reviewed the resolution investigation and found it to be in compliance with the DOC Resolution Program Manual (RPM). DOC was unwilling to review the video because the timeframe to review was over 10 hours, and the nature of the complaint did not threaten the individual's health or safety. The OCO also provided the individual with information about how to file an ethics complaint.	No Violation of Policy
149.	Incarcerated individual expressed concerns about their unlawful imprisonment.	The OCO reviewed the individual's concern and verified the individual is currently in prison for a valid and legal reason. This is not a violation of DOC Policy 390.590.	No Violation of Policy
150.	Person reports issues with medical staff not providing a medication they need.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Per DOC 650.040 Over the Counter Commissary Items V. OTC Items in the Outpatient Setting A. If a health care practitioner recommends the use of a listed OTC item, the health care practitioner may suggest that the individual submit an order using the commissary order form. The medication the individual is requesting is only prescribed for short periods of time. If the individual would like the medication, they will need to purchase from commissary.	No Violation of Policy
Washington Corrections Center			
151.	External person reports that their loved one is housed in segregation for no reason and is being mistreated by the DOC staff.	The OCO reviewed this placement and disagreed with the DOC decision to place this individual in solitary confinement upon arrival at the facility. This office contacted the facility and the DOC Classifications unit and requested the individual be	Assistance Provided

		moved to the receiving units for their initial classification. The DOC agreed and he was moved.	
152.	Individual reports that an incident occurred in the visitation room with his loved one and now his visits have been terminated.	The OCO reviewed the incident that occurred in the visit room. This individual did have an altercation with their loved one while visiting, which resulted in the DOC using a Use of force to remove him from the visitation room. The Superintendent terminated visits with this person due to the incident. The individual is now at another facility and the Superintendent said he would re-review the termination. The OCO will provide information to the individual on how to request the review.	Assistance Provided
153.	External person reports their incarcerated loved was trying to contact their case holder.	The OCO provided assistance. The individual was trying to arrange a phone call with their case-holder, the call was arranged, and the individual was able to discuss their case. The OCO did not close this case until it was verified the individual had spoken with their case holder.	Assistance Provided
154.	Incarcerated individual expressed concerns about an infraction they received.	The OCO contacted DOC about this concern and verified that the incorrect information had been entered into the database which led to the individual being infracted. As a result, the OCO requested DOC dismiss the infraction to which the DOC agreed.	Assistance Provided
155.	Patient reports DOC will not honor Durable Medical Equipment (DME) that was prescribed by an outside provider prior to entering custody. Since he has been in DOC custody, he has not received medical care and was issued a cane that does not meet his needs.	The OCO provided assistance by contacting facility health services and requesting the individual been scheduled with medical for DME assessment and access. DOC agreed to schedule the patient and discuss DME concerns as well as assess the fit of the provided cane.	Assistance Provided
156.	Person reports DOC is not providing translation services.	The OCO provided assistance with the individual's complaint. The OCO was able to provide assistance by contacting DOC headquarters to ensure the individual was receiving translation services. While DOC is unable to translate every document available to the population for the individual, headquarters has ensured the individual's kites and written correspondence from staff is being translated to the individual's native tongue.	Assistance Provided
157.	External person reports their loved one has arrived in DOC custody but has not received the medications he needs.	The OCO provided information to the patient regarding self-advocacy steps to resolve issues within DOC. The OCO also contacted Health Services to verify he was receiving the medication	DOC Resolved

		requested and received confirmation that the medication had been approved and ordered.	
158.	Patient reports he has not been able to receive his pain medication after he took the blame for medication being found in his cell that is shared with another person. Patient is requesting to be placed back on the medication.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO contacted Health Services management and confirmed the patient was placed back on the medication.	DOC Resolved
159.	Person reports they have not been able to access dental care. They have submitted multiple emergency grievances and was told that it's not a life-threatening emergency by the dentist. He has been dealing with this pain for more than three months.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO confirmed the patient was scheduled for extraction prior to outreach and verified the completion of the appointment.	DOC Resolved
160.	Person reports DOC is refusing to pull his tooth after filing multiple medical emergencies.	DOC resolved this concern prior to OCO action. The OCO reviewed related resolution requests and found the tooth was removed. The individual can kite dental if they have issues during healing period (4-6 weeks) to request follow up.	DOC Resolved
161.	External person reports their loved one was taken off the Medication-assisted treatment (MAT) program and needs treatment for pain management.	The OCO provided information to the patient regarding the process to request the treatment he wants. The patient has been moved from reception to his home facility and will need to request the intervention from his primary care provider. The OCO confirmed the patient was taken off the MAT program per protocol.	Information Provided
162.	Incarcerated individual reports Securus tablets shut off access to call out after 10 pm. The individual expressed concerns about being able to report Prison Rape Elimination Act (PREA) related concerns to the PREA hotline.	The OCO provided the individual with information about the phone access protocol in Washington DOC. The OCO verified that this practice is not limited to WCC and is a statewide protocol. The OCO shared with the individual how to report PREA related concerns to a staff member, as this is the pathway to report PREA concerns when phones are not on.	Information Provided
163.	Person reports he was sent shoes by family directly from the store they were purchased from. He asked the superintendent for authorization and was told they were not authorizing shoes in that way anymore.	The OCO provided information to the person regarding DOC policy for Packages, mail rejections, and allowable personal property. DOC 450.120 Packages for Incarcerated Individuals states All packages must comply with 450.100 mail for offenders and DOC 440.000 personal property for offenders. DOC 450.100 States that unauthorized mail includes (#40) property from a third party. DOC 440.000 personal property for offenders states: Allowable property, C. Offenders may only	Information Provided

		acquire personal property through the following sources: 1. offender commissaries 2. Department approved vendors. The OCO also provided information to the person regarding how to request a shoe fitting appointment through property.	
164.	External reporter states that the patient had arrived at DOC and did not receive medication or CPAP for 5 days.	The OCO provided self-advocacy information to the patient. The OCO contacted Health Services management at the patient's current facility and were informed the patient had received his CPAP machine and his medications were reviewed to make sure they were up to date.	Information Provided
165.	Person reported that he is being held illegally on a Community Custody revoke and that his supervision had already ended.	The OCO provided information. The OCO reviewed DOC documents and found that this individual's maximum expiration of sentence date has not occurred yet, and that date is his current release date. The OCO has communicated with DOC Records, who stated the maximum expiration of sentence date is an individual's release date when they are revoked from Community Custody. Per RCW 9.94A.728, DOC can confine an incarcerated individual up to the expiration of their sentence. The OCO lacks jurisdiction over sentencing and convictions.	Information Provided
166.	The individual reports that he was taken to administrative segregation for an investigation regarding the introduction of contraband. The individual was not infracted, but the DOC removed his family and partner from his visiting list. The individual reports that there was no reason to remove his family from his visiting list other than retaliation.	The OCO provided information regarding the individual's visitation list. This office spoke with DOC HQ staff who confirmed that his partner was removed per DOC 450.300, "persons identified as being involved in attempting/conspiring to introduce, or aiding and abetting another to introduce contraband, in any way, will have their visit privileges suspended or terminated." This office verified that the individual's other family members were not removed from his visitation list. This office confirmed with DOC staff that the individual's partner may reapply for visitation after one year of the incident. Generally, the pathway to have visitation privileges reinstated includes the individual remaining serious infraction free, and often video visits will be approved before approving regular visits.	Information Provided
167.	The individual reports that the facility does not have a third shift porter for the education building and individuals have to clean up after themselves during programming. The individual reports that he was told that	The OCO provided information regarding why there is not a third shift porter. This office spoke with DOC staff and confirmed that due to the movement schedule, a porter would only have one and half hours to clean the education building. This office verified with DOC staff that individuals are not required to clean up after themselves but	Information Provided

	cleaning supplies are provided during class, but he reports that individual should not have to work for free and there should be a third shift porter for the education building.	may do so as a courtesy in the classroom if they would like to wipe down the tables and chairs. DOC staff also verified that the current cleaning schedule meets a level satisfactory enough to pass the safety and sanitation inspections, and if there was an issue such as a biohazard or extreme mess, a porter would be sent to the building.	
168.	External person included the OCO in a copy of an email sent to a Superintendent at a facility.	The OCO was able to verify that the Superintendent responded to the external person.	Information Provided
169.	Person reports that they do not have access to the Medication-assisted treatment (MAT) program where they are located and wants to be in the program before they release.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The patient was transferred to a different facility that offers induction to the MAT program. The OCO contacted Health Services management and confirmed the patient has been evaluated for eligibility and will be started on the program closer to their release per MAT program protocol. This information was provided to the patient.	Information Provided
170.	Person reports they were given a negative behavior observation entry (BOE) and was then told it was removed. Person requested the OCO's help to ensure the entry was removed.	The OCO was able to provide information regarding the individual's behavior observation entry (BOE). The OCO was able to verify through the DOC database the negative BOE had been removed from the individual's record.	Information Provided
171.	Person reports they need access to their records.	The OCO was able to provide information regarding how the individual could access his records. The individual can sign up to go to the law library and ask to view his records. The person is also able to submit a records request through the Department of Corrections.	Information Provided
172.	Outside loved one reports their incarcerated loved one was transported out of the facility without being given information as to why.	The OCO was able to provide information regarding the individual's transport. The DOC database shows the individual was informed they would be transported to attend a hearing. For safety and security reasons DOC cannot release information to prevent security risk. The OCO understands this was a hardship; however, DOC has an obligation to bring him to court when he is summoned. Evidence suggests he was made aware of the transfer before it happened. The OCO suggest if the individual is unclear on delays they can reach out to an officer at the facility for more information.	Information Provided
173.	Person reported that a DOC memo stated that every Intensive Management Unit (IMU) statewide	The OCO contacted the facility Securus liaison and spoke with DOC Headquarters, who confirmed that they are working with Securus to get charging	Information Provided

	would be provided with Securus tablets by February 2023, but that the IMU at Washington Corrections Center (WCC) has not received tablets yet. Person reported that DOC says that the delay is because the unit is not adequately equipped with power. Person said that each cell does have power to run individual's TVs.	stations installed in the living units in IMU and that tablets will not be issued until that happens. DOC stated that there not a set date for Securus to complete this, or a timeline for the individuals in IMU to receive tablets.	
174.	Person reported that DOC is refusing him access to his central file and medical records.	The OCO provided information about filing a public records request for his central file. The OCO reviewed DOC records and found that this person has released, and DOC should have provided him his medical records.	Information Provided
175.	Individual reports he filed a PREA and after that he experienced retaliation from staff. He said he had a seizure and staff held him down and almost dislocated his shoulder.	The OCO requested and reviewed all PREA investigations, video evidence, Use of Force Reports, and medical records from the facility related to the incidents reported in this concern. There was a delay in the OCO investigation process, due to an active investigation by the Washington State Patrol. After the review, the OCO determined there was no evidence to substantiate that staff dislocated his shoulder, or that staff retaliated against him for filing PREAs. The PREA reports were determined to be unfounded by the DOC and the Washington State Patrol.	Insufficient Evidence to Substantiate
176.	The incarcerated individual reports that she was sexually assaulted, and her housing did not change. She is being harassed by other incarcerated individuals for reporting the person that sexually assaulted her.	The OCO verified at the time the concern was placed that this individual was no longer housed with the individual that they filed a PREA report on. After that initial contact, the OCO had to wait for the DOC to finish their investigation before the OCO could review. This caused a delay in the OCO investigation process. After reviewing all the evidence in the PREA investigation which included witness statements and statements from all parties involved, the OCO could not substantiate that a sexual assault occurred. There was no video evidence due to the location of the alleged incident. This individual has since transferred to a different facility. In addition, law enforcement has declined to pursue an investigation.	Insufficient Evidence to Substantiate
177.	External individual reports their incarcerated loved one is being harassed by staff while being housed in segregation. The individual reports their loved one	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the investigative records and verified the appropriate staff investigated the concerns. The records including video did not have evidence to	Insufficient Evidence to Substantiate

	filed a resolution request and is concerned that the investigator may have a conflict of interest.	substantiate the harassment claims. The incarcerated witness was not interviewed and the OCO spoke with DOC staff about interviewing that witness and they were not willing to at the time due to the time that has passed since the reported harassment occurred.	
178.	Incarcerated individual expressed concerns about a UA infraction where the temperature was not registering on the cup and the sample not being sent to the lab.	The OCO contacted DOC regarding this concern and confirmed that the UA was sent out to the lab for further confirmation.	Insufficient Evidence to Substantiate
179.	External person reported that an incarcerated individual was held in a dry cell on vague intel information and no contraband was found.	The OCO reviewed the concern and compared the time in dry cell with DOC 420.311. The Department has the authority to extend dry cell watch if they have reasonable suspicion to believe an individual re-ingested contraband. There is video evidence to suggest this individual received contraband during an in-person visit.	No Violation of Policy
180.	External person reported that an incarcerated individual was held in a dry cell on vague intel information and no contraband was found.	The OCO reviewed the concern and compared the time in dry cell with DOC 420.311. The Department has the authority to extend dry cell watch if they have reasonable suspicion to believe an individual re-ingested contraband. There is video evidence to suggest this individual received contraband during an in-person visit.	No Violation of Policy
181.	Person reports concerns with their time calculation and denial for work release.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Per DOC 300.500 Reentry Center Screening II Eligibility A. An individual is prohibited from Reentry Center placement and should not be considered if the individual: 1) will not be assigned Minimum 1 custody within 12 months of the Earned Release Date (ERD) or has had a custody demotion after approval. and (12) Has refused assessment or has not completed mandatory programming and was found guilty of the refusal during incarceration. Based on the individual's convictions an override is based on headquarters and has been determined the individual is not eligible for a lower custody level at this time.	No Violation of Policy
182.	Incarcerated individual expressed concerns about a delayed infraction appeal response.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC as the OCO substantiated that the appeal response was seriously delayed; however, 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	No Violation of Policy

		proceeding." Thus, there is no violation of DOC policy.	
183.	Person reported concerns with an investigation by the Intelligence and Investigations Unit (IIU) regarding a possible violation of the Prison Rape Elimination Act. Person reported that his Extended Family Visits (EFV) with his wife were cancelled as a result of this investigation and is concerned he is being retaliated against.	The OCO was unable to substantiate a violation of policy by DOC. The OCO found that this investigation is still pending, and that EFVs were cancelled until the investigation is finished, and that this individual's wife currently does not meet the eligibility requirements outlined in DOC 450.300 Visits for Incarcerated Individuals.	No Violation of Policy
184.	The individual reports that he was on Work Release but was returned to the facility. He reports he was on medications while incarcerated before and while on Work Release. He was told when he got to WCC they are tapering off everything and will discontinue it. He reports the DOC Chief Medical Officer had previously overridden his medication.	The OCO was unable to substantiate a violation of policy by DOC. Per DOC 600.000 Clinical decisions are the sole province of the responsible health care practitioner and are not countermanded by non-clinicians. Potential conflicts between clinical decisions and administrative/security needs will be resolved jointly by the Superintendent/ designee, Health Authority, and Facility Medical Director (FMD) and/or appropriate clinician. The OCO verified the patient's access to medications for the reported and confirmed the patient was seen recently to discuss medication management. The OCO was also informed that the patient's medications and requests had been reviewed by the facility's FMD.	No Violation of Policy
Washington Corrections Center for Women			
185.	Patient reports concerns about custody staff involvement in transport to medical appointment.	The OCO provided assistance by discussing the issue with the Health Services Manager. DOC agreed to reschedule the appointment and is planning around transport concerns with patient.	Assistance Provided
186.	Patient and family reports ongoing concerns about medical access related to multiple approved surgeries. Person and family also reports issues with DOC not following specialized transport orders, medical staff conduct issues, and provided updated details and concerns to the OCO. They also reported delayed DOC response to several Extraordinary Medical Placement (EMP) applications.	The OCO provided assistance by contacting health services at the facility, elevating the concerns to headquarters, requesting a medical records review and follow up with the patient. The office kept this case open for an extended amount of time due to limited details provided by DOC and delayed responses. The OCO recently met with the Health Services Manager after an extensive records review. Several medical consult referrals were found, identified for follow up, and the patient was scheduled for updated care. The office also confirmed the patient has now received medically necessary vision procedure and follow ups. The Health Services Manager agreed to continue monitoring the patient's access to care, multiple	Assistance Provided

		consult referrals, and access to appropriate transportation to/from offsite medical appointments; they also agreed to meet with the patient directly to discuss her updated concerns and medical wishes for moving forward. The OCO confirmed DOC review of EMP requests, found patient does not meet criteria, and DOC agreed to follow up with patient to confirm receipt of EMP decision. This office discussed updates with the patient via phone several times and provided information about how to follow up if they experience new or ongoing issues.	
187.	Individual reports they were demoted from minimum to close custody without cause and has no access to get around in their wheelchair.	The OCO reviewed this individual's custody facility plan and verified they were demoted two custody levels without a history of serious infractions. This office contacted HQ Classifications and asked for a review. HQ Classifications stated the individual could appeal the classification. This office gave the individual information on how to kite or kiosk the ADA coordinator to ask for a wheelchair pusher.	Assistance Provided
188.	The individual reports that her Extended Family Visits (EFVs) have been terminated and her regular visits are paused. The individual reports she does not have an infraction on her record that would result in EFVs, or regular visits being paused or suspended.	The OCO provided information regarding the individual's current allowed visitation. The OCO reviewed the individual's infraction history and verified per DOC 590.100, Extended Family Visiting, one of the infractions the individual received makes her ineligible for EFV privileges for three years. The OCO was unable to find evidence that the individual's regular or video visits will be impacted, and she may reapply for EFVs after three years.	Information Provided
189.	Individual reports they were terminated from Graduated Re-entry and placed in a higher custody classification.	The OCO reviewed the GRE termination, related infractions, and current custody facility plan. Due to unaccounted time in the community, she was placed on escape status, this is why her custody level changed. DOC is acting within policy 300.380.	Information Provided
190.	Individual requests that the person she filed a PREA report about be moved from her unit.	DOC resolved this concern prior to OCO action. The OCO found the accused individual is no longer housed in the same unit. The OCO scheduled and completed a phone call with the individual to see if there were any ongoing concerns and provided information about following up with the OCO if new concerns arise.	Information Provided
191.	Person reports issues with the resolution program.	The OCO provided information on how to file a resolution request. The OCO advises the individual to include all pertinent information when submitting a request. They will need to have information regarding what was said, who said it and where an incident took place. When an	Information Provided

		individual is infracted, they should always file an appeal if they disagree with the reason behind the infraction. In the appeal the individual should include information on why the individual disagrees with the infraction.	
192.	Patient reports she is not receiving proper medical care for her chronic pain and other medical issues. The patient states that she is being retaliated against for filing a lawsuit against the provider.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed several hundred pages of medical records and did not find evidence of inappropriate care. The provider has declined certain specific interventions, that is a clinical decision that cannot be countermanded by non-clinicians. The OCO verified the patient's care is managed by the facility medical director, the care management nurse, and another doctor is overseeing the patient's pain treatment plan.	Insufficient Evidence to Substantiate
193.	Individual reports that a staff member hit them with a door.	The OCO reviewed the resolution request that was filed regarding this incident and called to speak with facility leadership. The video was pulled and reviewed from the date and time that the incident was reported and there was no evidence to substantiate that a staff member hit this individual purposefully with a door.	Insufficient Evidence to Substantiate
194.	Patient reports that she had a medical emergency, and the medical staff did not take her concerns seriously and turned her away. The patient reports that she missed dinner, and no one would let her get food after the emergency.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed medical records from the medical emergency and found that the patient was ordered follow-up vitals check. The patient declined the vitals check and no changes could be made to her care plan. In regard to the missed meal, the patient was requesting the meal be delivered to the living unit. There is not an active health status report (HSR) for that request, the patient had access to meals in the kitchen.	Insufficient Evidence to Substantiate
195.	Person reports someone in their unit has lice and wants the individual moved.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. The OCO reviewed the DOC protocol for handling head lice. DOC has followed procedure.	No Violation of Policy
196.	Person reported that she was demoted custody and has not had a hearing or been served a major infraction. DOC said she was moved based on a pending infraction. She does not think she should be demoted without having a hearing first.	The OCO reviewed the infraction packet, the hearing, the appeal, and her custody facility plan. She was found guilty of multiple infractions in a short period of time which caused a demotion in custody. She was not moved to close custody until after her hearing. She did appeal the infraction, however that does not stop the process of a demotion. This office could not find a violation of DOC 300.380 or 460.000	No Violation of Policy

197.	Incarcerated individual expressed concerns about an infraction for not being able to provide a UA.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC as the OCO reviewed the infraction and appeal packet and found that as the individual does have any HSRs or documented medical conditions that prevent them from providing a UA, there is no violation of DOC policy 460.000 as an individual will be infracted if they cannot provide a sample within one hour.	No Violation of Policy
Washington State Penitentiary			
198.	Incarcerated individual reports DOC is painting the pods in the unit he is housed in, and the paint fumes are making him feel sick. The individual requests the OCO assist in having the ventilation improved in the unit.	The OCO provided assistance. The OCO verified that the unit is being painted and DOC is ventilating the unit with the resources available and is providing individuals with surgical masks upon request. The OCO spoke with medical staff at the facility who verified that the individual has not requested medical care yet. DOC medical staff agreed to waive medical copays if the individual requires care to address the symptoms from paint fumes.	Assistance Provided
199.	The individual reports that he was served a sanction notice under DOC 470.540, Group Violence Reduction Strategy (GVRS). The individual reports that he received GVRS sanctions due to his race. He says that there was an altercation involving multiple races that he was not involved in nor witness to. The individual believes that staff affiliated him as a Security Threat Group (STG) member due to his race but says that this is racial discrimination.	The OCO provided assistance. This office reviewed DOC 470.540, Group Violence Reduction Strategy, and all associated forms. The OCO identified a discrepancy between the language in the updated policy and the forms used to identify associates of the individuals involved in an altercation. Per policy, “restrictions will only be applied to incarcerated individuals identified as perpetrators and their identified negative close associates.” The forms given to DOC staff to identify negative close associates have not been changed and asks for a list of “close associates.” Due to this discrepancy, the individuals identified to receive sanctions under DOC 470.540 may or may not be negative close associates to the perpetrator(s). During the investigation of this concern, the individual completed the sanctions under GVRS. However, the OCO is reviewing the policy and related forms with DOC Headquarters staff to ensure the forms match the policy. DOC staff at the facility also confirmed that they would train staff in the correct way to fill out the forms to match the policy.	Assistance Provided
200.	Incarcerated individual reports concerns at the facility they recently transferred to and were unable to share their security concerns with DOC staff. The	The OCO provided assistance. The OCO made outreach to the facility and requested investigative staff speak to him to discuss the safety concerns he shared. DOC staff confirmed that they spoke	Assistance Provided

	individual requests assistance in accessing safe housing.	with him about the concerns. The individual agreed to move to a unit that felt safe to him.	
201.	Person reports two individuals in the Close Observation Area (COA) of WSP are in active psychosis and are not receiving support.	The OCO provided assistance by contacting health services at the facility and requesting follow up with the individuals as well as more information about general conditions in the unit. This office confirmed the individuals are no longer in COA.	Assistance Provided
202.	Person reported that he was moved cells in solitary confinement and has not received all his property. Person reported that he filed a resolutions request and was told that he did receive all his property, but he is still missing his commissary items.	The OCO provided assistance. The OCO contacted the Custody Unit Supervisor asking if this individual was allowed to have his commissary items, and if not, where were his commissary items placed. The Custody Unit Supervisor stated that his commissary items were placed in storage with the rest of his property, and that he will receive them when he promotes Restrictive Housing levels and is allowed to have commissary. The OCO requested that the Custody Unit Supervisor communicate this information to the individual, and he agreed to do so.	Assistance Provided
203.	Incarcerated individual is requesting the OCO's support to promote multiple proposals from the population to improve the quality of life and programming for incarcerated people in WA state prisons.	The OCO provided assistance. The OCO worked with DOC engagement staff to build a pathway for proposals from incarcerated individuals to be reviewed and responded to by DOC staff. The OCO shared the pathway to have DOC headquarters review and respond to the proposals which is to write to the DOC Correspondence unit at DOC Headquarters.	Assistance Provided
204.	External individual reports concerns with the rules being enforced in the visiting room.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO verified DOC responded to the external person and explained the reasons the concerns occurred and shared they have since stopped enforcing the rules they have concerns with.	DOC Resolved
205.	External person reported that their loved one is experiencing mental and medical abuse from long term segregation.	The OCO does not have a signed Release of Information on file for the external contact; however, this office did reach out to the facility for a welfare check and was able to verify that this external person has been in contact with DOC staff and was able to get a release of information to talk to the facility about this individual's needs and care.	Information Provided
206.	Person reported that when he received his tablet, none of his previously purchased media was on it. Person has filed multiple help tickets and spoken to the Securus	The OCO provided information and has been monitoring the transition from JPay to Securus. The OCO has spoken to DOC Headquarters, who confirmed they are aware of widespread issues with media transferring to the new tablets and working to resolve this issue with Securus. The	Information Provided

	liaison, and the issue has not been resolved.	OCO encourages this individual to continue working with Securus to resolve his issue.	
207.	Incarcerated Individual reported he has concerns that he received an override to close custody.	The OCO contacted classifications regarding this concern to discuss the current plan. DOC will not change the override currently due to infraction behavior and are within DOC Classifications policy 300.380 to determine the override. However, he will be eligible for a new custody facility plan in 6 months.	Information Provided
208.	The individual reports that he purchased a book through Amazon, and it was rejected because Amazon sent the book through a third-party vendor. The individual says this raises the issue that incarcerated people do not have access to a list of approved vendors for purchasing books.	The OCO provided information regarding ordering from Amazon and how to obtain a list of approved vendors. This office informed the individual that while books may be purchased directly through Amazon, the website also may present other buying options through a third party. The OCO advised the individual to avoid purchasing used or other buying options through Amazon which may be sent through a third party. This office also spoke with DOC staff who confirmed that individuals may kite the mailroom at the facility to obtain a list of approved vendors for purchasing books.	Information Provided
209.	Person reports he is supposed to have surgery on his throat. It is getting hard for him to breathe and talk and swallow. The patient has been dealing with this for 6 months. It is also very painful. He has had outside consults and diagnostics. Both specialists have recommended surgery. Medical staff tell him he just needs to wait.	The OCO provided information to the patient regarding the process needed to move his care forward and receive the surgery he is requesting. The OCO contacted Health Services management and verified that the surgery is not a confirmed treatment yet and cannot be scheduled until further clearance from another medical discipline is obtained. The OCO verified the patient is scheduled with the specialists that need to clear the patient and make the final decision on the need and type of surgery to be performed.	Information Provided
210.	Person reported being brought back to Washington DOC for resentencing after being on an out of state transfer. Person expressed concern that he will be in solitary confinement for years and wants OCO oversight to ensure he is transferred in a reasonable timeframe.	The OCO provided information. The OCO reviewed DOC records and verified that they are working on a transfer plan and do not anticipate this individual staying in Washington longer than necessary. The OCO encouraged this individual to work with his classification counselor to get updates on his transfer.	Information Provided
211.	Person reports DOC staff has not explained his sentence and release options.	The OCO provided information regarding the individual's sentence. The individual has been resentenced and his earned release date now reflects his new sentence date. While their previous sentence was vacated the court required the individual be kept in custody during the	Information Provided

		resentencing which has now completed. The individual remains in DOC custody on the new sentence.	
212.	Person reports they were denied graduated reentry. Person states DOC is holding them past their release date.	The OCO was able to provide information regarding the individual's release plan. Per correspondence with DOC the OCO was able to confirm the individual's release plan has been approved. The person's custody level has not been changed due to refusal to speak to investigators regarding safety concerns, which affected their eligibility for graduated reentry.	Information Provided
213.	Person reports issues scheduling an eye appointment and states they have not received glasses from previous facility.	The OCO was able to provide information regarding the individual's eye appointment and glasses. Per communication with DOC the individual was seen for an eye appointment and acknowledges the delays in the individual receiving their glasses. The individual was transferred, and the previous facility could not locate the glasses ordered while they were there. Since arriving at the new facility, the individual has picked out their frames and their glasses have been ordered. The OCO informed the person it will be four to six weeks until they receive the glasses.	Information Provided
214.	Person reported that he is being racially discriminated against and verbally harassed by another incarcerated individual in his unit, and that DOC staff are not taking action to stop it.	The OCO provided information. The OCO contacted the Custody Unit Supervisor, who shared documentation of her resolution request investigation. The Custody Unit Supervisor confirmed that she spoke to the individual who was verbally harassing the person who filed this complaint about the inappropriateness of his behavior and moved him to an area where they are far away enough to avoid this happening again in the future. The OCO encouraged this individual to continue reporting these issues to the unit staff and utilizing the resolutions process to resolve issues in the unit.	Information Provided
215.	Person reports he is hearing voices bouncing off walls that are threatening to him. The person states he is about to be transferred.	The OCO provided information to the person regarding the pathway to appeal classification decisions. The OCO contacted Health Services management and confirmed the patient was evaluated by Mental Health staff upon arrival to his new facility.	Information Provided
216.	Incarcerated individual reports concerns about their facility placement. The individual reports they have safety concerns in general population and DOC did not verify the concerns. The	The OCO provided information about his current classification. The OCO was unable to confirm that DOC has created a plan to transfer the individual to general population in the near future. The OCO shared information about how to report safety concerns that DOC can verify and recommended	Information Provided

	individual is concerned that DOC will place him in general population therefore endangering his life.	they stay in contact with their classification counselor to be an active part of their custody facility planning.	
217.	Person reports they were told they cannot file a resolution request regarding the misapplication of policy, practice, or procedure. Person states the resolution program manual states they can.	The OCO provided information regarding what concerns are accepted by the resolution program. If the individual has an issue with policy or procedure regarding an infraction, the information should be included in their infraction appeal. Incarcerated individuals can file resolution request policy regarding procedure; however, they cannot file a resolution request regarding a policy or procedure that has its own appellate process.	Information Provided
218.	Person reported that his Social Security number was locked after his identity was stolen. Person requested help getting DOC to contact Social Security and unlock his Social Security number.	The OCO provided information. The OCO contacted the legal liaison requesting DOC write to Social Security verifying this individual's identity to begin the process of unlocking his Social Security number but were unable to negotiate that outcome. DOC shared that they have communicated with this individual that per their Memorandum of Understanding with the Social Security Administration, DOC is only able to request replacement Social Security Cards and can only do so within six months of an individual's release or entry into partial confinement. The OCO provided information about options for unlocking his Social Security number and getting a new Social Security Card upon release or partial confinement.	Information Provided
219.	Incarcerated individual reports staff shortages result in cancelled yard time and delays in his programming.	The OCO provided information related to staff hiring. The OCO is aware of the concerns related to staffing and DOC is actively hiring to fill vacant positions.	Information Provided
220.	The individual reports concerns for his safety at the facility he is housed in. The individual reports that he believes that he may be killed by being housed at the facility. He reports he is put in situations which get him in trouble for reacting to threats. The individual also reports mental health issues not being addressed.	The OCO provided information regarding the individual's recently completed Custody Facility Plan (CFP). This office reviewed the individual's CFP and spoke with DOC staff who confirmed he will transfer to a facility on the west side of the state per his request. The individual has a pathway to general population if he completes programming at the facility and remains infraction free. The OCO also confirmed that the individual has had regular appointments with mental health staff.	Information Provided
221.	Person reported issues with the clothing exchange program and stated that he has not gotten back the appropriate clothing items from the program.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed DOC records and found that the Superintendent responded to this concern before this individual wrote to the OCO. This office contacted this	Insufficient Evidence to Substantiate

		individual's counselor and the unit sergeant, who had unit staff ask the individual if he was still having clothing issues, and he said no.	
222.	Person reported that he is supposed to have a Health Status Report for a snack to take with medication, but DOC is not helping him. Person also reported that he asked to be switched to kosher meals, but that has not happened yet.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed DOC records and found that this individual is currently approved for kosher meals and for snacks to be taken with medication, and recently requested to be on the regular mainline diet. The OCO could not find a resolution request regarding the Health Status Report. 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.	Insufficient Evidence to Substantiate
223.	Person reports staff misconduct issues.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO is unable to pull video from the incident due to timeframes. There is no evidence to substantiate the complaint of staff misconduct.	Insufficient Evidence to Substantiate
224.	Incarcerated individual expressed concerns about misapplication of certain RCWs in the disciplinary hearing.	The OCO reviewed the RCWs that the individual provided but neither apply to the DOC disciplinary hearing process. As the individual did not provide further information about how these RCWs apply to the infraction they expressed concerns about, the OCO was unable to further investigate this concern. The OCO informed the individual in order to investigate the concern further the individual would need to provide more details.	Insufficient Evidence to Substantiate
225.	Patient states that DOC staff lied to the OCO about assigning him a different therapist. The patient states he has not been seen by a therapist since he received the closing letter from his last case.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff reviewed the patient's medical records and appointment history and confirmed the patient was assigned a different therapist. The OCO provided information to the patient about mental health appointment scheduling protocol. Per DOC 630.500 Mental Health Services: the frequency of appointments scheduled by DOC mental health providers is determined by the patient's S code.	Insufficient Evidence to Substantiate
226.	The individual reports that his cellmate filed a resolution request about a program and after that, things became difficult for him. He reports there was a sudden cell search, and he was infracted for items found in the common area. The individual reports he lost his job due to this. He also reports that	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the individual's infractions and spoke with DOC staff and found that the infractions were dismissed upon appeal. DOC staff also reported that anytime individuals receive a major infraction, they are suspended from their jobs pending the outcome of their hearing. DOC staff report that before the infractions were dismissed, the individual went to	Insufficient Evidence to Substantiate

	he was never given a drug test and was not told the results of the test for the residue on the items found in the cell. The individual feels it is retaliation for a resolution request his cellmate filed.	medical and asked for an exemption from being required to work, which medical staff agreed to. Once this information was given to the individual's counselor, he was removed from the waitlist to return to work at his previous position. This office verified that the individual's good time conduct related to the infraction has been restored. 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.	
227.	Incarcerated individual requests an OCO investigation of a reported PREA concern regardless of moving from the location of incident.	The OCO was unable to substantiate the concern due to insufficient evidence. This office requested and reviewed the related PREA report and investigation, which found the actions unsubstantiated due to a lack of identifiable information. The PREA investigation was conducted according to DOC 490.860.	Insufficient Evidence to Substantiate
228.	Incarcerated individual expressed concerns about a falsified mail rejection.	The OCO verified with DOC that the rejection was legitimate and for valid reasons, but DOC overturned the rejection upon appeal and the items were sent to property.	Insufficient Evidence to Substantiate
229.	Patient reports a condition that leaves him immunocompromised and increases risks when exposed to other illnesses. The person requested single cell placement.	The OCO was unable to substantiate there was a violation of the Health Plan or policy 420.140 Cell/Room Assignment by DOC. Medical reports the condition is currently benign and individual's assessment did not find single cell placement medically indicated.	No Violation of Policy
230.	The individual reports that he filed a resolution request regarding staff misconduct and was told that the Resolution Program that they don't handle staff misconduct concerns.	The OCO was unable to substantiate a violation of policy by DOC. This office reviewed the individual's resolution request and found that he referenced something he was told by another person related to staff conduct. Per page 8 of the Resolution Program Manual, concerns based on speculation or hearsay information (third-party information or what someone reportedly heard).	No Violation of Policy
231.	The individual reports that the DOC miscalculated his good time conduct (GTC).	The OCO was unable to substantiate there was a violation of policy by the DOC. This office spoke with DOC HQ Records staff who verified that the individual was convicted of a crime where the underlying offence is a 10% earned release time (ERT) eligible offence per RCW 9.94A.729(3)(c). The jail made an error in calculating the	No Violation of Policy

		individual's good time for his conviction. The DOC requested clarification from the jail and the information was subsequently updated along with the jail certificate, which resulted in the accurate amount of 10% being applied. The individual is still under jurisdiction of the DOC, and the DOC regularly conducts audits to ensure accurate release dates.	
232.	Person reports they want to be transferred to another facility due to safety concerns.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Per DOC 300.380 Classification and Custody Facility Plan Review A. Determining facility placement will be consistent with Department needs and: 1. Address safety and security issues, including separation and facility prohibitions. If the individual has safety concerns, they will need to be interviewed by DOC staff to relay the concerns in detail.	No Violation of Policy
233.	Person reports they are being denied the opportunity for graduated reentry due to refusing programming.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. Per DOC 390.590 Graduated Reentry I. General Requirements A. Individuals must participate in programming and treatment as determined by the Department and based on assessed needs.	No Violation of Policy
234.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction and appeal narrative and found the individual's actions met the some evidence standard. DOC utilizes a "some evidence" standard based on a US Supreme Court ruling holding that it is only required that there be "some evidence to support the findings made in the [prison] disciplinary hearing." (Superintendent, Massachusetts Corr. Inst. Walpole v. Hill). Thus, in order to substantiate an infraction, DOC only needs to show there is "some evidence" of the infraction behavior which includes just a staff's statement or recollection of the events.	No Violation of Policy
235.	Incarcerated individual expressed concerns about an infraction they received.	The OCO already reviewed this infraction for a previous related case for this individual and found the infraction elements were met.	No Violation of Policy
236.	Incarcerated individual expressed concerns about sanctions they received for an infraction.	The OCO reviewed the individual's sanctions and found no violation of DOC Policy 460.050 attachment 2.	No Violation of Policy

Intake Investigations			
Airway Heights Corrections Center			
237.	Outside person reports incarcerated loved one is facing discriminatory treatment from DOC staff.	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 individual was advised to contact the OCO after they have received a level two response to their grievance and an infraction appeal decision.	Administrative Remedies Not Pursued
238.	Person reports facility is restricting the amount of property they can have.	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 individual is advised to contact the OCO after they have received a level II resolution response from DOC.	Administrative Remedies Not Pursued
239.	Person reports they would like an infraction removed.	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 individual is advised to contact the OCO after their appeal hearing.	Administrative Remedies Not Pursued
240.	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
241.	Person reported that staff mishandled his property and lost multiple items.	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.	Person reported multiple concerns regarding cell searches and urine analysis tests.	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.	Person reported multiple medical concerns and stated that his health provider was taking a long time responding to kites or scheduling 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
244.	External person reports an incarcerated individual shared concerns about another incarcerated person coming into their personal space inappropriately.	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 individual will need to report this incident to DOC staff prior to OCO involvement.	Administrative Remedies Not Pursued
245.	Incarcerated individual expressed concerns about being harassed by a staff member which resulted in an infraction and their inability to return to work.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
246.	Person reports DOC is refusing to provide salt and pepper shakers on tables after the actions of someone else.	The OCO has declined to review this concern. The OCO is required to establish priorities based on the limited resources available to the office. Per WAC 138-10-040 (3) The ombuds may decline to investigate any complaint or may close any investigation of any complaint for any of the following reasons: (g) Any other reasons the ombuds deems relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors	Declined
247.	Incarcerated individual expressed concerns about two infractions they received.	The OCO has declined to investigate this concern per RCW 43.06.040(2)(c) due to the nature and quality of the evidence as no identifying information was provided regarding the concern.	Declined
248.	A loved one of the incarcerated individual reports issues regarding the individual's counselor and being told he does not qualify for Graduated Reentry (GRE).	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 Involvement
249.	Outside person reports DOC has failed to send their incarcerated loved one's property home.	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 Involvement
250.	A loved one of the incarcerated individual reports that the DOC is	The incarcerated individual did not respond to the OCO's request to provide additional information	Person Declined OCO Involvement

	trying to prevent the individual from going to work release by not assigning classes and programming to him.	within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	
251.	Person reports their Health Status Report (HSR) for disposable cleaning wipes was discontinued.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint. Patient called the hotline to report the case can be closed now. DOC told him he has been permanently qualified to receive wet wipes again and he knows that many other patients have had concerns about this same thing. He wanted to pass along that DOC has come up with criteria in order to approve the wipes in some situations moving forward. The OCO has been in active conversations with Health Services leadership to encourage this outcome.	Person Declined OCO Involvement
Cedar Creek Corrections Center			
252.	Patient reports unsightly bumps on his body are causing him discomfort and making him self-conscious. He has quit his job because he feels like people are staring at him. He is requesting this office ask DOC to give him surgery.	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 provided information to the patient regarding how to get his request reviewed by the Care Review Committee.	Administrative Remedies Not Pursued
Clallam Bay Corrections Center			
253.	Outside person reports their incarcerated loved one was transferred and has not received their 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
254.	Person reports DOC is not following an operational memorandum.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process	Administrative Remedies Not Pursued
255.	Person reported being harassed by staff while at his 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
256.	A loved one of an incarcerated individual reports that she had	The OCO has declined to review this concern. Per WAC 138-10-040 (e), the ombuds may decline to	Declined

	her car searched before visiting the individual.	investigate any complaint or may close any investigation of any complaint for any of the following reasons: "(a) Lack jurisdiction over the complaint. At a minimum, complaints should meet the requirements in RCW 43.06C.040 and be: (i) About an incarcerated individual."	
Coyote Ridge Corrections Center			
257.	Person reports a fight occurred and everyone in the facility was punished.	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. A rewrite was requested for the resolution request submitted. The individual did not submit the rewrite.	Administrative Remedies Not Pursued
258.	Person reported that there are beehives next to one of the buildings and that they are highly allergic to bees.	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 their property was destroyed by a DOC officer.	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 advised the individual to utilize the resolution program and to participate in interviews with DOC staff to resolve the issue.	Administrative Remedies Not Pursued
260.	Person reports their access to law library has been restricted.	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 individual is advised to contact the OCO when they have received a level II response from DOC.	Administrative Remedies Not Pursued
261.	Person reports their tort claim was denied.	The OCO lacks jurisdiction to investigate this complaint because the complaint relates to an action taken by an agency other than the Washington State Department of Corrections.	Lacked Jurisdiction
Larch Corrections Center			
262.	A loved one reported that an incarcerated individual has not been assigned a counselor yet	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the	Administrative Remedies Not Pursued

	and was woken up to go to a job he was never assigned to.	incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	
263.	Person reported issues with the records department not responding to kiosk messages and taking weeks to provide notary services.	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.	Person reported that he is being told he must serve a sanction for a charge that was vacated.	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.	Outside person reports issues with their incarcerated loved one's time calculation.	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 Involvement
Mission Creek Corrections Center for Women			
266.	Person reports DOC staff are trying to block communication with their loved one on the outside.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
Monroe Correctional Complex			
267.	Person reports that he was given the wrong type of CPAP mask and machine.	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
268.	The individual sent the OCO a copy of a DOC memorandum regarding the distribution of Securus tablets.	As described in WAC 138-10-040(3), the OCO declined to investigate the complaint beyond the intake investigation phase because the complaint did not allege violation of policy, procedure, or law.	Declined
Monroe Correctional Complex - SOU			
269.	Person reported being infracted after making a comment to DOC staff.	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.	Person reported a corrections officer cursed at him and stated that multiple DOC staff are targeting him.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
Monroe Correctional Complex - TRU			
271.	Person reported that he is being retaliated against and harassed by being pat searched.	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.	Person reported concerns about being passed up for jobs. Person stated that he has talked with his counselor and Custody Unit Supervisor about needing a job and feels discriminated against.	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.	Person reports they were told they would not be screened for graduated reentry based on infraction history.	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 their incarcerated loved one received 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. The individual is advised to appeal the infraction and to contact the OCO after they have received a decision from DOC.	Administrative Remedies Not Pursued
275.	The individual reports that a book was taken during a cell search, and he wants it returned to him.	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.	Person reports they are not being supplied with correct undergarments.	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.	Person reported that staff are shutting his lights off at night and not letting him turn them back on.	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.	Person reports issues with dental aftercare.	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.	Person reports they are being prevented from filing paperwork regarding an injury.	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 person's resolution request was informally resolved. If the individual is not satisfied with the informal resolution, they are advised to appeal the concern to level II and contact the OCO when they have received a level II response from DOC.	Administrative Remedies Not Pursued
280.	Incarcerated person reports he disagrees with the outcome of a previous complaint with the OCO related to accessing public records (DOC policies). He states that because he was suspended from the DOC Resolution Program and because the DOC is no longer allowing him to make copies of DOC policies in the law library, due to a court ordered permanent injunction, the DOC is denying him access to the courts.	The OCO declined to advance this complaint beyond the intake investigation phase. The OCO reviewed the permanent injunction barring this person from submitting more than two public records requests to the DOC per calendar year. Per WAC 138-10-040 (3), the ombuds may decline to investigate any complaint or may close any investigation of any complaint for the following reason "(e) the requested resolution is not within the ombuds' statutory power and authority."	Declined
281.	Incarcerated person reports that because he was suspended from the DOC Resolution Program, he is not allowed to file resolution requests related to photocopies of seven boxes of legal work that he had sent to him.	The OCO has declined to advance this complaint beyond the intake investigation phase. Per WAC 138-10-040 (3), the ombuds may decline to investigate any complaint or may close any investigation of any complaint for any of the following reasons: "(d) because the complaint does not allege a violation of policy, procedure, or law."	Declined

282.	Incarcerated person requests OCO assistance because he was assigned a group therapy treatment and his preference is for individual treatment. He states that he will not participate in group treatment because he is concerned that he will be required to waive his right to keep his health information protected. He also states that he has a current lawsuit alleging the DOC mishandled his protected health information and he suggests that forcing him to participate in group treatment is a violation of DOC policy.	The OCO declined to advance this complaint beyond the intake investigation phase because there is record of this individual participating in this specific voluntary psychoeducational group during the month of June 2023. Per WAC 138-10-040 (3), the ombuds may decline to investigate any complaint or may close any investigation of any complaint for any of the following reasons: "(c) the nature and quality of evidence."	Declined
283.	Incarcerated person reports he was suspended from the DOC Resolution Program and appealed the suspension. He states that he wrote the Secretary and the Resolution Program Manager asking for clarification and has not received a response in more than 30 days.	The OCO has declined to advance this complaint beyond the intake investigation phase. Per WAC 138-10-040 (3), the ombuds may decline to investigate any complaint or may close any investigation of any complaint for any of the following reasons: "(d) because the complaint does not allege a violation of policy, procedure, or law."	Declined
284.	Person reports DOC is abusing their incarcerated loved one's 8th amendment right.	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 Involvement
Monroe Correctional Complex – MSU (Camp)			
285.	Person reported that he was placed in solitary confinement pending an investigation involving a different facility, which he has not been housed at for many years.	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
Other – Community Custody, Jails, Statewide, Out of State			
286.	Person reported being assaulted in 2021 in a DOC facility and is no longer in DOC custody.	The OCO has declined to review this concern. The OCO is required to establish priorities based on the limited resources available to the office. This incident occurred in 2021 and the individual is no longer under the custody of DOC. As WAC 138-10-040(3)(a)(f), states, "the ombuds may decline to investigate any complaint or may close any investigation of any complaint for any of the	Declined

		following reasons: the DOC took action to resolve any alleged violations. The DOC did a PREA investigation into this incident and it was found to be unsubstantiated.	
287.	Outside person reports their incarcerated loved one needs another attorney for a hearing. Person reports current attorney is not handling the case well.	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
288.	A loved one reported issue with Community Custody and paperwork about a release address not being received.	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
289.	Person reports they were released and have not received their property.	The OCO lacks jurisdiction to investigate the concern. 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
290.	Person reports they were terminated from work release due to false allegations.	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 advises the individual should be advised to appeal their hearing outcome if they disagree with the decision.	Administrative Remedies Not Pursued
Stafford Creek Corrections Center			
291.	Outside loved one reports their incarcerated loved one has not received their 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
292.	Person reported multiple issues with an institutional debt because of DOC incorrectly debiting funds and being fined multiple times for the same debt.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
293.	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

294.	Person reports they were charged a copay for medical visit and wants a refund.	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.	Person reports they have prescriptions for medication and DOC will not give them the medications.	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 individual is advised to contact the OCO if the issue is not addressed after they have received a level I resolution response from DOC.	Administrative Remedies Not Pursued
296.	The individual reports that he did not receive his art curio box when he transferred to a new facility. The individual says that he contacted property staff who told him that it was sent, but he has not received 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
297.	Person reported needing a wrist brace and to be seen by medical.	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.	Person reports staff conduct issues at their facility.	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 individual is advised to contact the OCO after a level II grievance response has been received.	Administrative Remedies Not Pursued
299.	Person reports having issues logging into the kiosk in their 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
300.	Individual is requesting the OCO provide him with phone numbers of people in the community.	The OCO cannot assist this individual with this request.	Declined

301.	Person reports misconduct concern from their community custody officer. The person reports they were revoked from community custody as a result of the misconduct.	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
302.	Person reports another incarcerated individual should be released.	The OCO lacks jurisdiction to investigate this concern. Per RCW 43.06C.040(2)(e), the OCO lacks jurisdiction to investigate this complaint because the complaint relates to the person's underlying criminal conviction	Lacked Jurisdiction
Washington Corrections Center			
303.	A loved one reported that an incarcerated individual's identification badge was confiscated and that it has not been returned.	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.	Incarcerated individual expressed concerns about being targeted at their facility and being infracted.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
305.	Person reports they were found guilty of an infraction and there is no evidence.	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
306.	Person reports they want DOC to provide surgery.	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.	Person reports they would like an override to stay at their current facility.	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 advises the individual to submit a classification appeal.	Administrative Remedies Not Pursued
308.	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	Administrative Remedies Not Pursued

		incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	
309.	Person reports issue with their time calculation. The person reports they should not have to serve any community custody and DOC reports he does.	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
310.	The individual reports multiple concerns with the Resolution Program and often not following timeframes given in the Resolution Program Manual.	The individual advised the OCO they did not want the OCO to investigate the complaint. The individual requested this case be closed regarding their own concerns but would like it to be considered for systemic review. The OCO is currently in conversation with the DOC about concerns with the Resolution Program and this office is reviewing this case for systemic issues.	Person Declined OCO Involvement
311.	Person reported difficulty with getting the facility to allow him access to cultural food items and seasonings. Person wants the Superintendent to provide a process by which gifts can sent quarterly from outside Correctional Industries and Union Supply per WAC 137-48-040.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint. This individual called and stated that the Superintendent is working with him on this issue.	Person Declined OCO Involvement
312.	Person reported issues with his Earned Released Date and DOC records saying that he has a detainer.	This person was released prior to the OCO taking action on the complaint.	Person Left DOC Custody Prior to OCO Action
313.	Person would like information regarding if they will be under probation upon release.	This person was released prior to the OCO taking action on the complaint. The individual was released before outreach was attempted.	Person Left DOC Custody Prior to OCO Action
314.	Person reports it has been five months since he has gotten his mental health medications. He also reports lack of DOC response after filing a mental health emergency.	This person was released prior to the OCO taking action on the complaint.	Person Left DOC Custody Prior to OCO Action
Washington Corrections Center for Women			
315.	Person reported that the unit has not installed privacy barriers between all of the showers and bathrooms in the unit, and people can be seen showering.	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.	Loved one reports DOC has restricted communication between them and incarcerated loved one.	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 Involvement
Washington State Penitentiary			
317.	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
318.	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
319.	The individual has concerns about how the Therapeutic Community is operated at Washington State Penitentiary.	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.	Person reported concerns with an infraction and being moved to close custody.	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
321.	Person reported concerns about a facility transfer and specific programming requirements.	The OCO informed this individual that they must appeal their Custody Facility Plan regarding the transfer before the OCO can get involved. 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 is investigating other aspects of this individual's concerns in other cases.	Administrative Remedies Not Pursued
322.	Outside person reports their incarcerated loved one did not receive their package.	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 incarcerated individual has not filed a resolution request regarding this issue.	Administrative Remedies Not Pursued

323.	Person reported being unable to purchase certain types of paper for arts and crafts from a DOC approved vendor.	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
324.	Person reported multiple concerns about Securus, indigent mail policy, and diet.	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
325.	Person reports being revoked from community custody, and that he is in longer than his sentence should be. Person reported issues with imposed conditions on his judgement and sentencing and requested his supervision after release to be cut.	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 lacks jurisdiction over community supervision or judgement and sentencing.	Administrative Remedies Not Pursued
326.	Incarcerated individual expressed concerns about their custody facility plans.	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
327.	The individual reports that he was injured last year and has nerve damage and severe back pain. He wants long term pain management but says that nothing has been done to help him, and he is concerned about taking large quantities of Tylenol.	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
328.	Person reports they received an infraction during a medical emergency.	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
329.	Person reported his Earned Released Date (ERD) was pushed out after a sentence recalculation.	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.	
330.	Person reports issues with how RCW was applied to his conviction.	Per RCW 43.06C.040(2)(e), the OCO lacks jurisdiction to investigate this complaint because the complaint relates to the person's underlying criminal conviction.	Lacked Jurisdiction
331.	Person reports issues regarding how RCW was applied to their conviction.	Per RCW 43.06C.040(2)(e) the OCO lacks jurisdiction to investigate this complaint because the complaint relates to the person's underlying criminal conviction.	Lacked Jurisdiction
332.	Patient followed up with the OCO to report DOC had not met the agreed upon resolution from a previously closed OCO case.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint. The person called the OCO hotline to withdraw the complaint because he is pursuing litigation instead. The OCO continues to discuss the issue of Durable Medical Equipment (DME) limitations in IMU settings with headquarters health services generally and did not continue further investigation or resolution of the patient's particular case.	Person Declined OCO Involvement
333.	Patient reports ongoing fungal infection and use of antifungal medication longer than recommended. Patient is requesting podiatry specialist remove all toenails and reports two small toenails are still infected. He wants to be seen before transferring facilities and for DOC to pay for the medical treatment.	The OCO was unable to identify evidence to substantiate a violation of the DOC Health Plan. Podiatry specialist appointment occurred recently, and medication was renewed. Specialist did not recommend removal of all toenails and the individual can go through Patient Paid Health Plan for this request. Nursing did not note any swelling, bleeding, or cellulitis. Fungal nail cosmetic treatment is not a DOC approved option unless there are medical complications. The person later called the OCO hotline and advised this office that they did not want any further investigation of the complaint.	Person Declined OCO Involvement

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-004

Report to the Legislature

As required by RCW 72.09.770

June 20, 2023

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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Unexpected Fatality Review Committee Report

UFR-23-004 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

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

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on May 20, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary Health Services
- Dr. Karie Rainer, Director of Behavioral Health
- Rae Simpson, Quality Systems Director
- Danielle Moe, Chief Nursing Officer
- Paul Clark, Health Services Administrator
- Dr. Zainab Ghazal, Health Services Administrator
- Mary Beth Flygare, Program Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Eric Jackson, Deputy Assistant Secretary
- Melissa Andrewjeski, Superintendent
- Lorne Spooner, Correctional Operations Program Manager

DOC Risk Mitigation

- Michael Pettersen, Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Senior Corrections Ombuds – Policy

Department of Health (DOH)

- Brittany Tybo, Director – Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Sophie Miller, Medical Officer

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

Fatality Summary

Date of Birth: 1965 (57-years-old)

Date of Incarceration: December 2022

Date of Death: February 2023

The incarcerated individual had been involved with the criminal justice system since 1985. He had recently transferred to his home facility and had not yet been referred for any programming. He was appropriately screened per DOC policy upon prison admission and his mental health support needs were appropriately identified. He had a history of suicidal ideation and previous suicide attempts. His health record documented multiple emergency room visits in 2021 and 2022 for ingesting foreign bodies or acts of self-harm. His death was the result of asphyxia due to ligature strangulation. The manner of his death was suicide.

Below is a brief timeline of events leading up to his death.

Days Prior to Death	Event
5	• The incarcerated individual was transported to the community emergency room (ER) to be evaluated for chest pain. His work-up was unremarkable and he was discharged back to the facility with a diagnosis of stress and pain from his neck that radiated into his chest.
4	• He reported not feeling well after ingesting several foreign objects one week prior that he was not passing naturally. He was again transported to the community ER. It was noted that he had ingested: ○ 2 ea. AAA batteries ○ 2 ea. eyeglasses ○ 9 ea. toothbrushes • The community medical provider recommended continuing to allow the objects to pass naturally without a surgical intervention if possible. ○ He was discharged back to the facility and placed in the close observation area for safety monitoring. ○ Mental health clinician ordered a 15-minute safety watch to be conducted by custody staff which was supplemented by monitoring video feed from the cell.

	○ The conditions of confinement for the incarcerated individual allowed a suicide prevention smock, blanket, mattress, and a soft-covered book.
2	• He was transported to the community ER for an abdominal x-ray to see if the foreign bodies had passed. ○ The x-ray showed some of the items had not yet passed through his system. ○ The community emergency room staff cleared him to be transported back to the facility for continued safety monitoring.
0	• A psychologist conducted a cell-front assessment in the morning and relaxed his conditions of confinement based on a brief conversation with the incarcerated individual who indicated he was not suicidal. ○ After his shower, per the new CONDITIONS OF CONFINEMENT he was provided thermals (long underwear) and a t-shirt to wear. ○ The safety checks were decreased to every 30 minutes. • He appeared to be unresponsive during the custody tier check. • Custody officers entered the cell and found him not breathing with a ligature tied around his neck. • Resuscitation efforts were unsuccessful, and he was pronounced deceased by community Emergency Medical Services.

Committee Discussion

A. The DOC mortality review determined the following topics warranted further discussion and UFR committee consideration:

1. The incarcerated individual had a history of degenerative disc disease in his lower neck that occasionally caused pain to radiate into his chest and arms.

2. He had previously been diagnosed with opioid use disorder and treated with suboxone.

3. His mental health diagnoses included bipolar disorder, borderline personality disorder and antisocial personality disorder. His treatment plan included medication and supportive therapy.

4. He had a history of several self-harm events, expressed suicidal ideation, and reported suicide attempts that included:

    A. Drinking water to the point of water intoxication causing low sodium levels requiring medical treatment;

    B. Repeated episodes of ingesting foreign bodies requiring medical procedures for removal;

C. A left wrist laceration that required hospital treatment;

D. Overdose events and

E. A gunshot wound.

5. The day of his death, the conversations between the incarcerated individual and medical/mental health staff occurred through his closed cell door. Not utilizing a confidential space may have hindered him from communicating his level of mental distress.

6. There was a lack of communication between medical, mental health and custody staff regarding the rationale and safety needs for his placement in the close observation area.

7. The psychological autopsy found:

   A. The incarcerated individual died a middle-aged man whose personality and mood problems, combined with sub-optimal compliance with treatment, kept him cycling back and forth between an itinerant lifestyle of thrill-seeking, drug dependent homelessness and the structure and familiarity of incarceration.

   B. He was readmitted to prison in December 2022 after his Drug Offender Sentencing Alternative was revoked due to non-compliance. He had an Earned Release Date in March of 2024.

   C. He had a long history of mental health concerns. The most concerning being his frequent self-harm behaviors often resulting in emergency medical trips to the community and close observation area placements.

   D. During the 62 days of his final incarceration, he was placed in the close observation area twice and had three medical trips in the community.

   E. The drivers for these self-harm behaviors tended to fall into three main categories:
      i. To regulate emotions and relieve boredom;
      ii. To affect housing and prison placement and
      iii. To "get back" at staff who he felt disrespected him.

   F. He frequently expressed suicidal ideation, but it is uncertain whether they reflected a genuine desire to end his life or were a component of his borderline and antisocial personality.

   G. He had several risk factors for suicide both static and dynamic including:

      i. A history of serious and persistent mental illness with few protective factors;
      ii. Impulsive behaviors;

iii. Poor coping skills;
iv. Limited frustration tolerance;
v. Enduring substance abuse;
vi. Early childhood trauma;
vii. Chronic physical pain;
viii. A lengthy history of suicidal statements and serious self-harm events;
ix. Feelings of helplessness and hopelessness;
x. Depressive symptoms;
xi. Agitation;
xii. Anxiety; and
xiii. Recent substance abuse.

H. He was designated as needing mental health services during this prison admission. After transferring to his home facility, he was unable to meet with his primary therapist due to being sent out to the community emergency room after swallowing foreign objects almost as soon as he arrived. Upon his return to the facility, he was placed in the close observation area for his safety.

I. Due to the short length of time he spent in close observation, starting Friday afternoon during a holiday weekend, he was unable to develop a therapeutic relationship with the mental health team. He died the following Monday.

J. Even though he was placed on a safety watch for self-harm and potential suicidal concerns, a formal suicide risk assessment was not conducted. As a result, the determination of his level of suicidal intent is based on his history, the known stressors in his life, and his pattern of communicating distress through suicidal statements, gestures, and non-suicidal self-injury.

K. Although accidental death cannot be definitively ruled out, the incarcerated individual's death was self-inflicted without any immediate influence on his actions by others. The available evidence supports the conclusion that his death appears to have been a suicide.

8. The mortality review committee members discussed the staff interviews from the critical incident review, which indicated that staff working in the close observation area may have become fatigued and desensitized to the environment.

B. Independent of the mortality review, the DOC conducted a critical incident review to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operational procedures. The Unexpected Fatality Committee reviewed the findings and recommendations of the critical incident review and have considered this information in formulating

the recommendations for corrective action.

C. The Health Care Authority (HCA) representative discussed multiple points where the safety system failed, and they agreed that staff may have become desensitized to the close observation area environment.

D. The Department of Health (DOH) representative confirmed that incarcerated individuals have mental health professionals available on-site during regular business hours, and medical staff on-site 24/7 if they need assistance. There is also a mental health professional on-call and available via phone during non-business hours for consultation and assistance. DOH offered resources for DOC to further support staff who are experiencing symptoms of burnout and compassion fatigue.

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

1. The OCO asked why the incarcerated individual was placed in the close observation area if no suicide risk assessment was performed?

    a) He was released from the community emergency room late in the day. Due to his recent ingestion and retention of foreign material it was determined the safest environment would be the close observation area until a suicide risk assessment could be done. He was not placed in the close observation area to monitor if he passed the material but to protect him from ingesting more. It was also easier to monitor if he was becoming distressed from an ingested object.

2. The OCO asked how often mental health staff take incarcerated individuals to a private area for discussions while they are housed in the close observation area?

    a) During regular business hours incarcerated individuals are taken to an interview room for assessments and mental health appointments.

    b) The mental health team conducts rounds (a brief wellness check) on weekends and holidays. They do not have staffing to support conducting assessments after hours.

3. The OCO asked if mental health staff can change the conditions of confinement over the phone?

    a) The mental health duty officer can change the conditions of confinement over the phone. Usually, the conditions of confinement are increased due to level of risk or behaviors being demonstrated, not decreased unless there is a pre-set plan in place that was previously agreed upon with the primary therapist and the incarcerated individual.

4. The OCO asked if would be too great of a resource drain to make a process that modifying conditions of confinement would only happen after an in-person assessment and meeting with a

senior custody staff member to discuss changes?

   a) There is a multidisciplinary team meeting that happens during regular working hours and shared through shift reports that include the conditions of confinement and a support plan for moving forward. DOC mental health leadership will review and formalize this process.

5. The OCO asked what are the requirements to be a custody officer in the close observation area?

   a) The officer must meet the requirements of the bid criteria to obtain a permanent position. When there is a staff shortage and overtime is required, there is the possibility that the assigned officer may never have worked in that area.

6. The OCO recommends DOC explore the possibility of not utilizing overtime in the close observation area environment and reducing the number of cells that appear on the supplemental video feed being monitored.

   a) Custody posts and duties of the close observation area are covered by a collective bargaining agreement. Any changes related to utilization of overtime and post duties would require labor negotiations.

7. The OCO recommends changing the post order language from tier check to health and wellness check in a close observation area environment.

Committee Findings

1. The incarcerated individual was placed in the close observation area after regular business hours on a holiday weekend when mental health staff were not present. Nursing staff did not conduct a suicide risk assessment per DOC protocol.

2. There was a lack of communication between medical, mental health and custody staff regarding the rationale and safety needs for his placement in the close observation area.

3. The conditions of confinement were decreased without a suicide risk assessment being conducted and the conversation between the mental health staff member and the incarcerated individual did not occur in a confidential manner.

4. DOC does not have an electronic health record and the psychologist who relaxed the conditions of confinement did not have the benefit of having the incarcerated individual's mental health history readily available.

5. The close observation area post orders were not consistently followed by custody staff when conducting tier checks, searching the incarcerated individual's cell, and monitoring the supplemental video.

6. DOC Policy 890.620 Emergency Medical Treatment was not followed during the medical emergency response. A nurse did not immediately respond to the location, and the emergency response kit was not fully stocked.

7. The UFR Committee members raised concerns that staff in COA may be at increased risk for desensitization and fatigue due to the repetitive nature of the duties they are required to perform. Appropriate countermeasures to support staff are warranted.

Committee Recommendations

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

Table 1. ***UFR Committee Recommendations***
1. Conduct a statewide survey of staff who work in or with incarcerated individuals housed in the close observation area (i.e., medical providers, religious coordinators, custody officers, classification counselors, hearings officers, nurses, mental health staff) to identify opportunities to increase staff engagement and promote safety for the incarcerated individuals in their care.
2. Review and recommend updates to the suicide prevention policy and associated forms at the next scheduled mental health leadership meeting.
3. Tier checks should be completed in accordance with post orders and align with the conditions of confinement.
4. Recommend changing the language in the post orders from a tier check to a "health and wellness" check and provide additional training.
5. DOC should resume annual in-person suicide prevention training.
6. DOC should require medical emergency response drills with medical and custody staff.
7. Formalize and standardize onboarding and ensure mental health staff are trained related to conducting close observation area assessments in a confidential manner, and how to utilize and implement conditions of confinement.

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

1. DOC should continue the implementation of the Patient Centered Medical Home care model at their facilities.

Unexpected Fatality Review DOC Corrective Action Plan

Unexpected Fatality UFR-23-004

Report to the Legislature

As required by RCW 72.09.770

June 30, 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 23-004 on June 20, 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-23-004-1
Finding:	There was an opportunity for better communication between medical, mental health and custody staff regarding the rationale and safety needs for the incarcerated individual's placement in the close observation area.
Root Cause:	There is not a process/protocol to guide the interdisciplinary communication and collaboration between health service teams and custody staff.
Recommendation:	A process for formal Multidisciplinary Team (MDT) meeting should be developed when an individual is placed in a close observation area for safety monitoring to include options for after business hours communications.
Corrective Action:	Develop and implement minimum standards for conducting Multidisciplinary Team meetings to discuss care plans and housing of individuals in close observation areas.
Expected Outcome:	Improved communication and support for staff and incarcerated individuals.

CAP ID Number:	UFR-23-004-2a
Finding:	The conditions of confinement for an individual being housed in the close observation area were changed without a formal suicide risk assessment being conducted.
Root Cause:	The mental health staff member who decreased the conditions of confinement had the authority to decrease the conditions of confinement but was not as familiar with the mental health history of the incarcerated individual and chose not to conduct a formal suicide risk assessment.
Recommendation:	Formalize and standardize onboarding to ensure all mental health staff are trained on where, when, and how to conduct close observation area assessments when there are concerns about suicide or self-harm or other sensitive mental health concerns.
Corrective Action:	Provide and document training to custody and health services staff on general suicide prevention and the policy and procedures for incarcerated individuals being housed in a close observation area.
Expected Outcome:	Improved support and safety for incarcerated individuals.

CAP ID Number:	UFR-23-004-2b
Finding:	The conditions of confinement for an individual in the close observation area were decreased without a formal suicide risk assessment being conducted.
Root Cause:	The mental health staff member who decreased the conditions of confinement had completed suicide prevention training per his license requirements, however it was not the DOC in-person version of the training.
Recommendation:	Improve staff awareness that self-harm events may be a suicide attempt and not an attention seeking behavior.
Corrective Action:	Develop a plan to restart annual in-person suicide awareness training and continue to provide and document appropriate onboarding and training for mental health staff.
Expected Outcome:	Improved support and safety for incarcerated individuals.

CAP ID Number:	UFR-23-004-2c
Finding:	The custody officers working in the close observation area did not understand which clothing items were allowable for the incarcerated individual after the conditions of confinement were decreased.
Root Cause:	The custody officers did not understand which items were allowable had not received DOC annual in-person suicide risk training.
Recommendation:	Formalize and standardize onboarding to ensure all custody staff are trained on how to follow the written conditions of confinement and to seek clarification from the mental health staff when they have questions.
Corrective Action:	Provide and document training to custody staff on general suicide prevention and the policy and procedures for incarcerated individuals being housed in a close observation area.
Expected Outcome:	Improved support and safety for incarcerated individuals.

CAP ID Number:	UFR-23-004-3
Finding:	The brief assessment of the incarcerated individual’s self-harm/suicidality between the mental health staff member and the incarcerated individual did not occur in a confidential manner.
Root Cause:	The mental health staff member chose not to utilize a confidential space when assessing the individual’s suicidality.
Recommendation:	Develop guidance for utilizing confidential settings for communications with incarcerated individuals housed in a close observation area.
Corrective Action:	Create and implement a protocol or guideline for assessing suicide risk.
Expected Outcome:	Improved support and safety for incarcerated individuals.

CAP ID Number:	UFR-23-004-4
Finding:	DOC does not have an electronic health record that providers can easily reference to obtain an incarcerated individual’s mental health history.
Root Cause:	DOC does not have an electronic health record and the psychologist who relaxed conditions did not have the benefit of having the incarcerated individual’s mental health history readily available.
Recommendation:	DOC should acquire an electronic health record.
Corrective Action:	Health Services leadership continue the process to acquire an electronic health record when full legislative funding becomes available.
Expected Outcome:	Improved patient safety and improved provider access to medical information.

CAP ID Number:	UFR-23-004-5
Finding:	The close observation area post orders were not consistently followed by custody staff when conducting and documenting tier checks, searching the incarcerated individual’s cell, and monitoring the supplemental video.
Root Cause:	Staff did not follow the standards for the unit post.
Recommendation:	Tier checks, cell searches and supplemental video monitoring should be completed and documented in accordance with post orders and align with the conditions of confinement. DOC should consider adding the language “health and wellness” check to describe the purpose of a tier check during training.
Corrective Action:	DOC leadership should pursue progressive discipline per Article 8 of the Teamsters 117 Collective Bargaining Agreement when there is evidence that appropriately trained custody staff are not following post orders and DOC policy.
Expected Outcome:	DOC leadership will ensure policy and post orders are being followed.

CAP ID Number:	UFR-23-004-6
Finding:	DOC Policy 890.620 Emergency Medical Treatment was not followed during the medical emergency response. The emergency response kit was not fully stocked, and staff were not familiar with the use of equipment.
Root Cause:	There were gaps in knowledge and training for Health Services staff.
Recommendation:	DOC should require medical emergency response drills with medical and custody staff.
Corrective Action:	Health care and custody staff will participate in joint emergency response drills regularly that will include an evaluation and debrief by both a member of custody and health services.
Expected Outcome:	Improved timeliness of emergency response and treatment, and patient outcomes.

CAP ID Number:	UFR-23-004-7
Finding:	DOC Policy 890.620 Emergency Medical Treatment was not followed during the medical emergency response. A nurse did not immediately respond to the location.
Root Cause:	Staff did not follow DOC Policy and nursing protocol standards.
Recommendation:	Nursing staff should immediately respond to a medical emergency.
Corrective Action:	DOC leadership should pursue progressive discipline per Article 8 of the Teamsters 117 Collective Bargaining Agreement when there is evidence that appropriately trained staff are not following DOC policy and protocols.
Expected Outcome:	DOC leadership will ensure timeliness of emergency response, treatment, and patient outcomes.

CAP ID Number:	UFR-23-004-8
Finding:	Staff working in the close observation area may be at increased risk for desensitization and fatigue due to the repetitive nature of the duties, working overtime shifts, and the intensity of working with incarcerated individuals in crisis.
Root Cause:	DOC has not formally evaluated options to mitigate the potential impacts to staff working in a specialized close observation unit environment.
Recommendation:	Recommend DOC conduct a statewide survey of staff who work in or with incarcerated individuals housed in the close observation area (i.e., medical providers, religious coordinators, custody officers, classification counselors, hearings officers, nurses, mental health staff) to identify opportunities to increase staff engagement and promote safety for the incarcerated individuals in their care.
Corrective Action:	Develop and conduct a statewide survey of staff working with individuals in the close observation area to identify opportunities to increase staff engagement and promote safety for the incarcerated individuals.
Expected Outcome:	Developing a deeper understanding of the experience that leads to desensitization and fatigue in the close observation area and identifying opportunities for improvement in engagement and safety of incarcerated individuals.

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