Office of the Corrections OMBUDS

Monthly Outcome Report

January 2025

Unexpected Fatality Reviews: 2

Case Investigations: 185

Assistance Provided: 46
Information Provided: 76
DOC Resolved: 25
Insufficient Evidence to Substantiate: 9
No Violation of Policy: 27
Substantiated: 2

Intake Investigations: 122

Administrative Remedies Not Pursued: 0
Declined: 1
Lacked Jurisdiction: 6
Person Declined OCO Assistance: 25
Person Released from DOC Prior to OCO Action: 10
Technical Assistance Provided: 80

Resolved Investigations:

309

Assistance Provided, Information Provided, or Technical Assistance Provided in

65%

of Investigations

OCO Casework Highlights

January 2025

Assistance Provided

Reported Concerns: An incarcerated individual reports that he was not provided important lab results about an infection. The person also reported a concern regarding the treatment he received for the infection. When he attempted to use the resolution program, his resolution request went missing. The person requested that this problem be addressed so that it does not happen to another person.
OCO Actions: OCO staff reviewed the patient's records, resolutions, DOC policy, and Washington State Quality Assurance Commission Guidelines. OCO staff did not find a violation of the protocol related to the management of the reported infection. OCO staff substantiated that the person did not receive the lab results through the normal process established by DOC. It is a standard of care that patients be notified of lab results per the Washington State Quality Assurance Commission Guidelines for Communicating Test Result to Patients.
Negotiated Outcomes: OCO staff contacted DOC headquarters staff regarding issues found in the resolution process. DOC staff agreed to address the issue through retraining.

Assistance Provided

Reported Concerns: Person reported that he has multiple food allergies and that he was prescribed a snack by the dietician that contains a food he is allergic to and was instructed to remove the item he is allergic to. Person said he was given this snack by the kitchen and that he removed the item he is allergic to, but still had an allergic reaction and had to be taken to the hospital. Person expressed frustration for not being allowed to have a Health Status Report (HSR) to accommodate all of his allergies, as he is only allowed to have an HSR to accommodate one allergy per DOC policy and has to remove items that he is allergic to.
OCO Actions: The OCO reached out to DOC staff and substantiated that this individual was prescribed a snack that contained an item he is allergic to and was told to remove that item, and that he received this snack from the kitchen, and it caused an allergic reaction that caused him to be hospitalized.
Negotiated Outcomes: The OCO met with DOC staff, who provided more information about the limitations of the special diet process and said they would meet with this individual to discuss diet options. DOC staff informed the OCO that they have discontinued the snack that contained the item the individual is allergic to and have prescribed him an alternative snack. The OCO is

aware of systemic concerns with the special diet process and individuals not being able have more than one HSR to accommodate an allergy and will continue to review these issues.

Assistance Provided

Reported Concerns: Individual reported they were placed on MAX custody and may be discharged from the residential treatment program. They were also involved in a use of force and injured.
OCO Actions: The OCO reviewed the camera footage from the use of force and could not see the incident clearly due to the placement of the video cameras. This office then contacted DOC classifications to ensure this individual could complete their MAX program in the residential treatment unit.
Negotiated Outcomes: The DOC confirmed that they would stay in the residential treatment unit. In addition, the individual was worried about certain staff in their living unit. The OCO confirmed the staff were removed from the unit. The individual has completed the MAX program and is now in a lower custody level.

Assistance Provided

Reported Concerns: Incarcerated individual shared concerns regarding being forced to take a program despite not being provided with needed accommodations.
OCO Actions: The OCO contacted DOC about this concern.
Negotiated Outcomes: At OCO request, DOC staff shared they will work with this individual and provide them with resources to request the accommodations they need to be successful within the program. DOC staff also shared that they will be providing the whole class with information on how to request accommodations.

Assistance Provided

Reported Concerns: Person reported that his resolution requests were getting rejected because DOC said he was under conditions of confinement (COCs), and there was an appeal process.
OCO Actions: The OCO conducted an extensive review of this individual's resolutions requests and documentation surrounding his placement into solitary confinement and conditions of confinement (COC). The OCO substantiated that it was not clearly documented when he was taken off of COCs, and multiple facility staff were unclear of his confinement status. The OCO also substantiated that the length of time he was documented as being on COCs violated the timelines in DOC policy 320.255. Per DOC policy 320.255, his extension of being on COCs required Assistant Secretary approval, and the OCO substantiated that approval was never given. The OCO spoke with unit staff and facility leadership about the discrepancies in the documentation, who were unable to explain the discrepancies.

Negotiated Outcomes: The OCO spoke with DOC headquarters about ways to prevent issues like this in the future, such as putting these notifications in writing, and the head of Mission Housing instructed all restrictive housing unit supervisors to notify individuals when they are taken off of COCs.

Assistance Provided

Reported Concerns: An external person reported that staff targeted their loved one when their room was searched, and they were told their TV did not belong to them. This resulted in the individual being taken to segregation and infracted.
OCO Actions: The OCO reviewed evidence including the infraction and the handheld video from the day of the incident and contacted facility leadership. The OCO could not review the outcome of the infraction because they never appealed the guilty finding. The OCO provided information to the individual that moving forward, if they disagree with the outcome of the infraction hearing, they need to file an appeal and contact this office if the appeal is denied. The OCO did have concerns after reviewing the handheld video recording of the interaction with staff on that day. The OCO found the incident did not meet the criteria listed in DOC policy 410.200 for a use of force because, if a use of force is necessary, resistance must be evident and the amount of force used must be directly related to the level of resistance or perceived threat, and the amount of force used must be reasonably necessary to resolve an incident. The individual was threatened with OC spray at cell front when they were speaking with staff. The individual eventually came out of their cell and were then escorted to restrictive housing.
Negotiated Outcomes: . The OCO contacted the facility to voice concerns that the OC spray was unnecessary. The facility reviewed and agreed it was inappropriate and indicated that it will address the matter with the staff involved.

Assistance Provided

Reported Concerns: Person reported to the OCO in person that she had been involved in a use of force days ago and thought her wrist was broken. She said medical was refusing to x-ray it.
OCO Actions: The OCO could visibly see that the individual's wrist was swollen and immobile. This office then contacted health services and DOC headquarters to request an x-ray.
Negotiated Outcomes: The OCO received confirmation that she was taken out for x-ray within hours of OCO contact.

Assistance Provided

Reported Concerns: While onsite, facility staff requested the OCO help negotiate with an individual who had covered her windows in the COA. The individual in crisis was requesting the OCO.
OCO Actions: The OCO sat cell front with the individual for an hour while she discussed her concerns. She then agreed to uncover her window and camera.

Substantiated

Reported Concerns: Person reported deaf individuals are being denied equal access to telephone communication with family and friends because there is no video phone system at the facility.
OCO Actions: The OCO was able to substantiate this concern but was unable to achieve a resolution. The OCO reviewed this individual's resolution request and found that it had also been substantiated by DOC headquarters. The Americans with Disabilities Act mandates that deaf and hard of hearing individuals must have equal access to effective telecommunications, such as a Video Relay System (VRS), as the rest of population has to telephone calls. The OCO reached out to DOC Health Services and ADA staff and helped them attend the Securus quarterly meeting with DOC along with DOC leadership present, where Securus acknowledged that they were out of FCC compliance. Securus stated that they would roll out designated video tablets for deaf and hard of hearing individuals to use to call their friends and family. The OCO asked Securus at multiple quarterly meetings when the video tablets would be made available and continued to ask DOC staff for updates. The OCO's monitoring of this compliance concern continued for more than eight months and the video tablets still have not been made available.

Unexpected Fatality Reviews

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

UFR 24-011: The Unexpected Fatality Review Committee reviewed the unexpected death of a 29-year-old person in June 2024. The Unexpected Fatality Review Committee Report dated January 13, 2025 is a publicly available document. A Corrective Action Plan (CAP) was completed on January 23, 2025.

UFR 24-012: The Unexpected Fatality Review Committee reviewed the unexpected death of a 36-year-old person in July 2024. The Unexpected Fatality Review Committee Report dated January 27, 2025 is a publicly available document.

UFR 24-015: The Unexpected Fatality Review Committee reviewed the unexpected death of a 42-year-old person in September 2024. The Unexpected Fatality Review Committee Report dated January 10, 2025 is a publicly available document.

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

Monthly Outcome Report: January 2025

	Complaint Summary	Outcome Summary	Case Closure Reason
Unexpected Fatality Reviews			
Coyote Ridge Corrections Center			
1.	Incarcerated Individual passed while in DOC custody.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-24-015 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The committee recommends Health Services review and update the current red bag nursing protocol to ensure restocking the red bag is completed following emergency drills and educate staff to increase compliance.	Unexpected Fatality Review
Washington Corrections Center for Women			
2.	Incarcerated individual passed away unexpectedly while in DOC custody.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-24-011 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The UFR committee recommended: 1. DOC should remind custody staff of appropriate use and location of the ligature removal tool, 2. DOC should provide clarification to staff that the DNR request does not apply to self-harm events per DOC 620.010, 3. DOC should direct staff to ensure cell windows are not fully covered, 4. DOC should update the identification badge DNR flag language to include "Does not apply in instances of self-harm".	Unexpected Fatality Review
Case Investigations			
Airway Heights Corrections Center			
3.	Multiple people incarcerated at AHCC reported concerns about access to education, more consistent yard times and the "fresh air pad," incentive programs, more space to hold their property, and to allow	The OCO provided assistance. The OCO spoke with multiple members of facility leadership. After these conversations DOC shared that AHCC is revamping their education programs to provide more educational and vocational opportunities for people living at camp. DOC shared that due to continued issues with dangerous contraband, they are unwilling to open the "fresh-air pads." However, DOC agreed to review the yard	Assistance Provided

	visitors entry to visitation even when they arrive late.	schedule for the camp in the spring which OCO will follow up on in the coming months. Facility leadership also agreed to provide incarcerated people at camp access to more incentive programs, more room to hold their personal property, and will allow visitors access to visitation if they are late.	
4.	External person reported abuse by visitation staff when visiting their loved one.	The OCO contacted the facility to discuss these concerns raised by a family member. The leadership team from the facility then contacted this individual for more information. The facility has shared that they are implementing new changes to the visiting process to provide a positive experience for the visitors.	Assistance Provided
5.	Multiple people incarcerated at AHCC reported concerns about access to education, more consistent yard times and the "fresh air pad," incentive programs, more space to hold their property, and to allow visitors entry to visitation even when they arrive late.	The OCO provided assistance. The OCO spoke with multiple members of facility leadership. After these conversations DOC shared that AHCC is revamping their education programs to provide more educational and vocational opportunities for people living at camp. DOC shared that due to continued issues with dangerous contraband, they are unwilling to open the "fresh-air pads." However, DOC agreed to review the yard schedule for the camp in the spring which OCO will follow up on in the coming months. Facility leadership also agreed to provide incarcerated people at camp access to more incentive programs, more room to hold their personal property, and will allow visitors access to visitation if they are late.	Assistance Provided
6.	Multiple people incarcerated at AHCC reported concerns about access to education, more consistent yard times and the "fresh air pad," incentive programs, more space to hold their property, and to allow visitors entry to visitation even when they arrive late.	The OCO provided assistance. The OCO spoke with multiple members of facility leadership. After these conversations DOC shared that AHCC is revamping their education programs to provide more educational and vocational opportunities for people living at camp. DOC shared that due to continued issues with dangerous contraband, they are unwilling to open the "fresh-air pads." However, DOC agreed to review the yard schedule for the camp in the spring which OCO will follow up on in the coming months. Facility leadership also agreed to provide incarcerated people at camp access to more incentive programs, more room to hold their personal property, and will allow visitors access to visitation if they are late.	Assistance Provided
7.	Multiple people incarcerated at AHCC reported concerns about access to education, more consistent yard times and the "fresh air pad," incentive programs, more space to hold their property, and to allow visitors entry to visitation even when they arrive late.	The OCO provided assistance. The OCO spoke with multiple members of facility leadership. After these conversations DOC shared that AHCC is revamping their education programs to provide more educational and vocational opportunities for people living at camp. DOC shared that due to continued issues with dangerous contraband, they are unwilling to open the "fresh-air pads." However, DOC agreed to review the yard schedule for the camp in the spring which OCO will follow up on in the coming months. Facility leadership also agreed to provide incarcerated people at camp access to more incentive programs, more room to hold their personal property and will allow visitors access to visitation if they are late.	Assistance Provided
8.	Incarcerated person reported concerns about delays in their release plan.	The OCO provided assistance. The OCO verified the person will be delayed in their release due to court required evaluations. The OCO asked DOC staff to speak to the person to help them understand the delays in their release and DOC staff spoke with him. The OCO also shared this information with the person and provided information about their situation.	Assistance Provided

9.	Multiple people incarcerated at AHCC reported concerns about access to education, more consistent yard times and the "fresh air pad," incentive programs, more space to hold their property, and to allow visitors entry to visitation even when they arrive late.	The OCO provided assistance. The OCO spoke with multiple members of facility leadership. After these conversations DOC shared that AHCC is revamping their education programs to provide more educational and vocational opportunities for people living at camp. DOC shared that due to continued issues with dangerous contraband, they are unwilling to open the "fresh-air pads." However, DOC agreed to review the yard schedule for the camp in the spring which OCO will follow up on in the coming months. Facility leadership also agreed to provide incarcerated people at camp access to more incentive programs, more room to hold their personal property, and will allow visitors access to visitation if they are late.	Assistance Provided
10.	Multiple people incarcerated at AHCC reported concerns about access to education, more consistent yard times and the "fresh air pad," incentive programs, more space to hold their property, and to allow visitors entry to visitation even when they arrive late.	The OCO provided assistance. The OCO spoke with multiple members of facility leadership. After these conversations DOC shared that AHCC is revamping their education programs to provide more educational and vocational opportunities for people living at camp. DOC shared that due to continued issues with dangerous contraband, they are unwilling to open the "fresh-air pads." However, DOC agreed to review the yard schedule for the camp in the spring which OCO will follow up on in the coming months. Facility leadership also agreed to provide incarcerated people at camp access to more incentive programs, more room to hold their personal property, and will allow visitors access to visitation if they are late.	Assistance Provided
11.	Multiple people incarcerated at AHCC reported concerns about access to education, more consistent yard times and the "fresh air pad," incentive programs, more space to hold their property, and to allow visitors entry to visitation even when they arrive late.	The OCO provided assistance. The OCO spoke with multiple members of facility leadership. After these conversations DOC shared that AHCC is revamping their education programs to provide more educational and vocational opportunities for people living at camp. DOC shared that due to continued issues with dangerous contraband, they are unwilling to open the "fresh-air pads." However, DOC agreed to review the yard schedule for the camp in the spring which OCO will follow up on in the coming months. Facility leadership also agreed to provide incarcerated people at camp access to more incentive programs, more room to hold their personal property, and will allow visitors access to visitation if they are late.	Assistance Provided
12.	Multiple people incarcerated at AHCC reported concerns about access to education, more consistent yard times and the "fresh air pad," incentive programs, more space to hold their property, and to allow visitors entry to visitation even when they arrive late.	The OCO provided assistance. The OCO spoke with multiple members of facility leadership. After these conversations DOC shared that AHCC is revamping their education programs to provide more educational and vocational opportunities for people living at camp. DOC shared that due to continued issues with dangerous contraband, they are unwilling to open the "fresh-air pads." However, DOC agreed to review the yard schedule for the camp in the spring which OCO will follow up about in the coming months. Facility leadership also agreed to provide incarcerated people at camp access to more incentive programs, more room to hold their personal property, and will allow visitors access to visitation if they are late.	Assistance Provided
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	visitors entry to visitation even when they arrive late.	"fresh-air pads." However, DOC agreed to review the yard schedule for the camp in the spring which OCO will follow up on in the coming months. Facility leadership also agreed to provide incarcerated people at camp access to more incentive programs, more room to hold their personal property, and will allow visitors access to visitation if they are late.	
14.	Person reports that he was not provided important lab results about an infection. The person also reported concern regarding the treatment he received for the infection. When he attempted to use the resolution program, his resolution request went missing. The person requested that this problem be addressed so that it does not happen to another person.	The OCO provided assistance. OCO staff reviewed the patient's records, resolutions, DOC policy, and Washington State Quality Assurance Commission Guidelines. OCO staff did not find a violation of the protocol related to the management of the reported infection. OCO staff substantiated that the person did not receive the lab results through the normal process established by DOC. It is a standard of care that patients be notified of lab results per the Washington State Quality Assurance Commission Guidelines for Communicating Test Result to Patients. OCO staff contacted DOC Headquarters staff regarding issues found in the resolution process. DOC staff agreed to address the issue through retraining.	Assistance Provided
15.	Incarcerated individual relayed concerns regarding placement in segregation.	The OCO reviewed the individual's housing placement and confirmed that they were released from segregation prior to OCO involvement.	DOC Resolved
16.	Person reported that his dentures broke and DOC has not fixed them.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and reached out to DOC staff, who confirmed that this individual received new dentures.	DOC Resolved
17.	Person reports that DOC is deducting legal financial obligations (LFOs) for cause numbers that have been waived in their county of origin.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The individual filed a resolution request, and the business office reported that the incarcerated individual was correct and he should be getting a refund.	DOC Resolved
18.	Incarcerated individual shared concerns regarding not being provided with a special diet that meets their nutritional and health needs despite other facilities accommodating them.	DOC staff resolved this concern prior to the OCO taking action on this complaint. This office was able to confirm that this individual was accommodated per their request. The OCO was also able to confirm this individual has transferred from the facility in question.	DOC Resolved
19.	Incarcerated individual shared concerns regarding DOC not assisting them in obtaining programming that would help them become qualified to release into a reentry center.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO was able to confirm that this individual joined the programming they were requesting.	DOC Resolved
20.	Incarcerated individual relayed concerns regarding being approved for an extraordinary medical placement (EMP) but having a difficult time getting an approved release home.	The OCO reviewed the individual's records and confirmed that a social worker is trying to find the individual a family home and an approved release home is being sought.	Information Provided
21.	Incarcerated person reported concerns about staff behavior at the facility they are located.	The OCO provided information about filing a resolution request regarding staff behavior to alert DOC of the concerns as they arise. This concern generally reported staff behavior, without providing details of what staff were engaged in the behavior reported. The OCO shared how to file a resolution request about these behaviors to be reviewed by the facility leadership. The	Information Provided

		OCO does share concerns related to staff with DOC leadership and monitors trends from concerns reported.	
22.	Incarcerated individual shared concerns regarding DOC medical staff abruptly cancelling their surgery before their imminent release.	The OCO provided information regarding why the surgery was canceled. This office was able to confirm that the individual was informed of the cancellation close to the surgery date despite the surgery itself being cancelled prior to then.	Information Provided
23.	Incarcerated person reported concerns about another incarcerated person's treatment from DOC staff.	The OCO provided information directly to the incarcerated person the concern was about. The OCO reviewed relevant documents and could not substantiate the concern due to a lack of evidence. The OCO shared with the person how to report concerns related to DOC staff internally via the resolution program and in the serious infraction hearing.	Information Provided
24.	Person reports that he was told that the DOC Health Plan no longer supported his requested dental care.	The OCO provided the person with information regarding the DOC Health Plan's dental coverage. OCO staff reviewed the patient's records, DOC Health Plan, and health services protocols. OCO staff noted that the person is not eligible for his requested remedy. Limitations in the DOC Health plan for this remedy include timeline to release from DOC custody.	Information Provided
25.	Incarcerated individual shared concerns regarding DOC not providing them with adequate medical care.	The OCO provided information regarding why the treatment option they wish to utilize is unavailable to them and the steps they must complete before utilizing advanced treatment options. The OCO encouraged this individual to continue to work with their provider to find a treatment plan that best works for them.	Information Provided
26.	An incarcerated individual reported that their counselor would not give them a gender preference form, and when they filed a resolution request, it was not accepted because they did not include the DOC form number.	The OCO provided technical assistance via the hotline by giving the person the form number he needed and recommended resubmitting the resolution request. This office also verified that this person is no longer at this facility and has a new counselor who may provide the gender preference form. The OCO encouraged this person to file another resolution request if they experience the same issue with their new counselor. This office also gave information regarding the transgender toolkit, which is available on their tablet.	Information Provided
27.	Incarcerated individual relayed concerns regarding the transportation vehicles being very cold.	The OCO spoke with DOC about this concern and confirmed that there are a few transport vehicles that do not have heat or AC in the rear. On very cold days and if individuals are sensitive to heat, a backup vehicle will be checked out that still has heat in the rear. There is no current protocol to request these vehicles, but DOC stated that if an individual lets the officers know, and if reasonable, the officers will make an effort to help such as providing a jacket or utilizing a different vehicle.	Information Provided
28.	Incarcerated individual shared concerns regarding DOC failing to properly address medical concerns in adequate timeframes and DOC staff brushing off concerns.	The OCO was unable to substantiate the concern due to insufficient evidence. This office was able to confirm that facility medical staff provided this individual with care as soon as they heard of the concern and DOC staff were unable to find any injuries to the individual despite their account.	Insufficient Evidence to Substantiate
29.	Person reports their medical provider did not file the correct information after a workplace injury, resulting in his case being closed.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff contacted DOC Health Services staff and reviewed the records that were submitted by the person's medical provider. OCO staff provided the person with information on how to request an independent examination from Labor and Industries.	Insufficient Evidence to Substantiate

30.	Incarcerated individual relayed concerns regarding staff violating their rights during a GRE termination hearing as they did not allow the individual to present evidence or call witnesses.	The OCO reviewed the infraction packet and hearing audio and found no violation of policy in the infraction as the individual did not get employment as required and continually chose to violate the rules of the GRE program despite multiple warnings and written contracts. The OCO also found that the individual did not compile any of their own evidence during the hearing, which is why they had no evidence to present or witnesses to call.	No Violation of Policy
31.	Incarcerated individual shared concerns regarding DOC staff violating federal statutes by sharing medical information within a resolution request without their permission.	The OCO was unable to substantiate a violation of policy by DOC. Per DOC policy 550.100, resolution specialists are allowed to disclose information if it is pertinent to the complaint listed. The OCO was also able to confirm that this individual requested their resolution request be withdrawn regarding this matter.	No Violation of Policy
32.	Incarcerated individual relayed concerns regarding a PREA investigation.	The OCO reviewed the materials for the PREA investigation and found no violation of policy as the investigation was properly conducted and the allegations were deemed unsubstantiated.	No Violation of Policy
33.	Person reported that they are being required to change their medical treatment due to a transfer back to prison.	The OCO was unable to substantiate a violation of DOC policy 600.000. OCO staff verified the person has been offered alternative treatment options for their condition. OCO cannot compel a medical provider to order specific medications. Per DOC policy 600.000, clinical decisions are the sole province of the responsible health care practitioner and are not countermanded by non-clinicians	No Violation of Policy
Cedar Creek Corrections Center			
34.	Incarcerated individual shared concerns regarding being wrongfully infracted by DOC staff.	DOC staff resolved this concern prior to the OCO taking action on this complaint. This office was able to confirm that DOC staff removed the infraction from this individual's record after the hearing.	DOC Resolved
Clallam Bay Corrections Center			
35.	Person reported that he has multiple food allergies and that he was prescribed a snack by the dietician that contains a food he is allergic to and was instructed to remove the item he is allergic to. Person said he was given this snack by the kitchen and that he removed the item he is allergic to, but he still had an allergic reaction and had to be taken to the hospital. Person expressed frustration for not being allowed to have a Health Status Report (HSR) to accommodate all of his allergies, as he is only allowed to have an HSR to accommodate one allergy per DOC policy and has to remove items that he is allergic to.	The OCO provided assistance. The OCO reached out to DOC staff and substantiated that this individual was prescribed a snack that contained an item he is allergic to and was told to remove that item, and that he received this snack from the kitchen, and it caused an allergic reaction that caused him to be hospitalized. The OCO met with DOC staff, who provided more information about the limitations of the special diet process and said they would meet with this individual to discuss diet options. DOC staff informed the OCO that they have discontinued the snack that contained the item the individual is allergic to and have prescribed him an alternative snack. The OCO is aware of systemic concerns with the special diet process and individuals not being able have more than one HSR to accommodate an allergy and will continue to review these issues.	Assistance Provided
36.	Individual reports they were recently resentenced from life without parole. Now that they have a release date, they can regain good conduct time. However, they still do not have an	The OCO set up an in-person meeting with this individual, contacted the DOC classifications and reviewed DOC policy. This office was able to verify that there is a new custody facility plan being developed by DOC staff. Once the plan is complete, if the individual is unsatisfied with the pathway, they can appeal to	Assistance Provided

	updated custody facility plan with a new pathway.	DOC Headquarters. The OCO can confirm they will have a pathway to gain back some of their good conduct time, which will impact their release date.	
37.	External person reports the facility her loved one is moving to is dangerous and he has safety concerns.	The OCO verified that this individual was transferred to an alternative facility and no longer has a safety concern.	DOC Resolved
38.	Incarcerated individual shared concerns regarding DOC failing to provide adequate medical care.	The OCO provided information regarding their preferred treatment plan and why it currently is not an option. This office encouraged this individual to continue working with their provider to find an adequate treatment plan.	Information Provided
39.	Incarcerated individual relayed concerns regarding high blood pressure and nose bleeds.	The OCO spoke to DOC about this concern and confirmed that DOC saw the individual several times for these concerns and they have been addressed.	Information Provided
40.	Person reports that he is being moved to a facility that does not have the ability to provide the MAT program. He is requesting to be on the MAT program prior to release.	OCO staff provided information to the person regarding the reason that facility does not offer the MAT program. OCO staff reviewed the MAT protocol and noted that the person was not currently eligible due to time until release. OCO staff informed the person that they can request a transfer to a different facility at their next classification review. OCO staff also provided the person with information about classification appeals.	Information Provided
41.	Incarcerated individual shared concern regarding DOC attempting to jeopardize their safety by placing them in a certain facility.	The OCO provided information as to why this individual is being housed at the custody level they are currently at. This office was able to confirm that this individual has recent serious infraction behavior and they were demoted as a result. The OCO was also unable to confirm that there are any imminent safety concerns based on this individual's placement.	Information Provided
42.	Incarcerated individual relayed concerns regarding extended placement in segregation.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that the individual is in segregation because of a recent infraction and they are currently in the transfer pod waiting for placement in safe harbor.	No Violation of Policy
43.	Incarcerated individual relayed concerns regarding an IIU (intelligence and investigations unit) investigation in which their food was disposed of.	The OCO reviewed the concern and confirmed that the investigation resulted in a WAC 603 drug introduction infraction and a demotion to MAX custody. The OCO confirmed that it is facility policy to dispose of any consumable goods during long stays in segregation, thus there was no violation of policy in the disposal of the food.	No Violation of Policy
44.	Incarcerated individual relayed concerns regarding being placed on the out of state transfer list.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that they were placed on the out of state transfer list due to their influential STG (security threat group) affiliation and related behavior.	No Violation of Policy
45.	Individual reports that their classification counselor put them in for promotion to minimum level 1 (MI1) custody and graduated reentry (GRE), however MI1 was denied because they had not completed the therapeutic communities (TC) program.	The OCO reviewed the reentry center and GRE request along with DOC policy 390.590 and 300.500. This office found that there was no violation of DOC policy. The OCO did verify that this individual does have a reentry plan and approved housing with an upcoming release date.	No Violation of Policy
46.	Person stated that per a DOC memo, incarcerated individuals in MAX	The OCO was unable to substantiate a violation of policy by DOC. The memo this individual referred to was from 2021 and has been rescinded. Per DOC policy 320.255 Restrictive Housing	No Violation of Policy

	Custody under level 2 confinement are allowed to have a television.	Level System Grid (Attachment 2), televisions are only available for individuals under level 3 confinement.	
47.	Incarcerated individual relayed concerns regarding being placed on a MAX plan.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that there is evidence that they are actively involved in a security threat group (STG) which is the basis for the placement on a MAX plan.	No Violation of Policy
Coyote Ridge Corrections Center			
48.	Individual reports that a staff member is bragging about messing with people's extended family visits (EFVs) and intentionally calling them and telling them EFVs are on different days than they are scheduled for officially and targeting families in visitation.	The OCO shared this information with the facility leadership. The DOC will review this concern and follow up with the appropriate staff.	Assistance Provided
49.	Incarcerated individual shared concerns regarding their DOC number not being accepted by Securus and that blocking their ability to make calls.	The OCO provided assistance. The OCO reached out to DOC and Securus staff to ensure this concern was resolved. After this office's inquiry, DOC staff were able to share that the issue has been resolved.	Assistance Provided
50.	Patient reports concerns about dental and medication access.	The OCO provided assistance by elevating the concerns through DOC Health Services leadership. This office confirmed recent medication changes and the confirmed the patient was scheduled and received a dental appointment with an updated treatment plan.	Assistance Provided
51.	External person reports that their loved one was denied a single cell assignment that had been previously approved.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff were unable to substantiate that the person had been approved for a single cell or had a Health Status Report for one in the past. OCO staff were also unable to substantiate that the person would qualify for the single cell classification under the current eligibility criteria set by DOC. OCO staff reviewed the person's records and found that DOC is informally accommodating this person's housing needs.	DOC Resolved
52.	Person reports he has been waiting several months to have surgery and is requesting to have the recommended surgery completed.	The OCO provided information to the person regarding why his surgery has not yet taken place. OCO staff reviewed the person's consultations and verified the surgery has been rescheduled for the near future.	DOC Resolved
53.	An individual made a concern on behalf of an incarcerated individual regarding lack of communication about medical test results.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO was able to confirm that this individual has been seen and is receiving care as requested. The OCO encouraged this individual to reach back out to this office if they do not receive the care they were told they would receive by DOC.	DOC Resolved
54.	External person reports that DOC has failed to repair an incarcerated person's durable medical equipment and tablet. This has caused this person to not be able to contact family or hear what is happening in the facility. The incarcerated person has made many accommodation requests that have not been fulfilled.	The OCO provided information to the person regarding a pending accommodation request. OCO staff reviewed the person's records and contacted DOC staff. OCO staff verified that some of the person's requests have been fulfilled and one is pending review. OCO staff contacted DOC Health Services staff and confirmed the person's durable medical equipment has been repaired and returned. OCO staff also confirmed that the person received their tablet.	Information Provided

55.	A loved one made a complaint on behalf of an incarcerated individual regarding DOC failing to provide them with adequate medical care and living conditions.	The OCO was able to confirm that this individual has been receiving appropriate care when requested and needed. The OCO provided information regarding their care plan and encouraged this individual to reach out to this office again if their medical care is inadequate.	Information Provided
56.	Another incarcerated individual reports concerns about someone's access to medical care.	The OCO received direct contact from the incarcerated patient who opened a separate case about this concern.	Information Provided
57.	Incarcerated individual relayed concerns regarding needing an ADA single cell.	The OCO spoke to DOC about this concern and confirmed that they were screened for a single cell and it was referred to the care review committee (CRC), but a decision has not yet been made. The OCO informed the individual that if they disagree with the CRC decision, they can appeal the decision. After the appeal has been responded to, they can contact the OCO again to revisit this concern.	Information Provided
58.	An incarcerated individual reports that he did not pack his belongings and DOC staff put items in his religious box that should not have been packed that way. This person reports that he received a property disposition form saying he cannot send out the items found in his religious box and they will be destroyed in 90 days.	The OCO provided information about the appeals process for property concerns. This office also spoke with DOC staff at the facility and shared some information from that conversation with the individual.	Information Provided
59.	A loved one made a complaint on behalf of an incarcerated individual regarding DOC not providing them with adequate medical care and DOC staff mistreating them.	The OCO was able to confirm that this individual has been receiving health care as requested and for their continued care. The OCO was unable to confirm any mistreatment by DOC staff. The OCO encouraged this individual to continue working with their provider and to contact this office if they are not receiving adequate medical care in the future.	Information Provided
60.	Person reports that his tort claim was denied, he lost $3000 worth of property, and he should get some sort of reimbursement.	The OCO provided information about appealing a tort claim decision. The individual may write to DES, including his claim number, and can present any new information he would like considered for the appeal.	Information Provided
61.	Incarcerated individual shared concerns regarding DOC blocking their children from participating in visitation.	The OCO provided information as to why their children were denied from visitation. The OCO reviewed the documentation related to the concern and were able to see this individual has not met requirements to allow the children visitation.	Information Provided
62.	A loved one reported that an incarcerated individual was told by the Indeterminate Sentence Review Board (ISRB) that he needs to take specific programs to be eligible for release. The individual said he spoke to program staff, who said he does not need to take these programs. The individual said he feels he is being discriminated against.	The OCO provided information about ISRB authority. The ISRB has broad authority to require individuals complete specific programming to be eligible for release and has required this individual take specific programming. DOC policy 320.100(II)(A) states that "The Board will set minimum terms of confinement consistent with the purposes, standards, and sentencing ranges per RCW 9.94A and RCW 9.95.040" and RCW 9.95.0002(8) states that "the members of the indeterminate sentence review board will possess and shall exercise independent judgment when making any decisions concerning offenders. These decisions include, but are not limited to, decisions concerning offenders' release, revocation, reinstatement, or the imposition of conditions of supervision". The OCO reviewed DOC records and found that this individual is being rescreened for the required	Information Provided

		program. The OCO could not substantiate any staff misconduct or discrimination.	
63.	Incarcerated individual shared concerns regarding DOC failing to provide adequate medical care.	The OCO was able to confirm that this individual has been receiving appropriate care when requested and needed. The OCO provided information regarding their care plan and encouraged this individual to reach out to this office again if their medical care is inadequate.	Information Provided
64.	Individual submitted a DOC records request and says the department is taking a long time to fulfill the request.	The OCO contacted the public records department at DOC, and staff confirmed that the records were paid for and had been sent to the requestor. The OCO provided information from the Attorney General's website to the individual that says you may file a lawsuit in the Superior Court of the county where the agency record is located if you believe there was an unreasonable delay.	Information Provided
65.	Incarcerated individual shared concerns regarding DOC medical staff ignoring them and not providing them with proper medical care.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO was able to confirm that this individual has been receiving care as requested and has upcoming appointments scheduled. This office was unable to identify any evidence that DOC medical staff were ignoring them or refusing to provide them with medical care.	Insufficient Evidence to Substantiate
66.	External person reported concerns regarding an incarcerated person's safety due to recent treatment they have experienced from DOC staff. The external person reports staff infracted them and have placed them in segregation.	The OCO verified the incarcerated person is no longer in segregation. This office was unable to substantiate any immediate safety threats in the person's current placement based on available information. The OCO was unable to substantiate a violation of DOC policy. The OCO reviewed DOC staff actions and found the staff acted within policy. DOC did infract this person, and the infraction was upheld by DOC's "some evidence" standard. The OCO also verified the sanctions issued as a result of the infraction matched DOC sanction guidelines per DOC policy 460.050.	No Violation of Policy
GRE/CPA			
67.	Person was terminated from graduated reentry (GRE) for testing positive for Suboxone despite documentation showing he received a Sublocade injection within the last twelve months. He also reports that DOC took $600 in deductions from his funds that were accumulated while on GRE and the money was supposed to help his reintegration.	The OCO was unable to substantiate the concern due to insufficient evidence. This office reviewed the individual's electronic file and correspondence from DOC. The OCO confirmed this person had two recent drug tests that were both negative for Suboxone about a week prior to the positive test. That means if the injection was still showing up in his system, his drug tests prior to this one would have also been positive for Suboxone. The OCO encouraged this individual to file a resolution request regarding his banking deductions.	Insufficient Evidence to Substantiate
Mission Creek Corrections Center for Women			
68.	Incarcerated individual shared concerns regarding DOC staff wrongfully terminating them from their job due to an incident that took place during the job without their involvement.	The OCO spoke with DOC staff who informed this office that this individual provided them with knowledge of the incident which did implicate them. Due to the cooperation of the individual, DOC staff provided this individual with a pathway to gain their full privilege's back after a given timeframe. The OCO provided information about the pathway DOC has provided.	Information Provided
69.	Person reports they have a single wisdom tooth that needs to be removed, and it has taken a year to get scheduled with an outside	The OCO reviewed the person's resolution request and spoke with health services about their dental plan. The OCO discovered this individual did not have the tooth extracted and was referred to an outside provider. This office spoke with DOC staff and	Information Provided

	provider. Additionally, health services says it will be another 18 months after the extraction before the individual can be fitted for dentures.	confirmed their current dental plan and upcoming appointment. The OCO also shared information about how long it takes to heal from a tooth extraction and when to kite medical about scheduling a denturist appointment.	
Monroe Correctional Complex			
70.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and spoke to DOC about clarification regarding the infractions. Based on OCO outreach, DOC agreed to reduce the WAC 661 sexual harassment to a WAC 728 possess sexually explicit material.	Assistance Provided
71.	Person reported that months ago DOC staff told him he was referred to an outside clinic for medical shoes but was recently told to purchase his own shoes.	The OCO provided assistance. The OCO reviewed DOC records and found that this individual was not scheduled with an outside clinic. The OCO reached out to DOC staff, who scheduled this individual to talk with his provider about a referral to an outside clinic for medical shoes.	Assistance Provided
72.	Incarcerated individual relayed concerns regarding a CCP (community custody) revoke and feeling like they were not mentally stable enough to understand what was happening.	The OCO spoke to DOC regarding the field group violation and whether or not the individual was screened for an advisor due to mental difficulties. As a result of OCO outreach, DOC agreed to remand the individual for another hearing where the screening will take place as a part of another hearing process as the individual has a right to be screened and the Hearing Officer will decide if attorney representation is proper.	Assistance Provided
73.	The Concerned Lifers' Organization (CLO) called to request the OCO attend one of their future meetings.	The OCO provided assistance by following up with the event host for more information and scheduled a time to attend a future CLO meeting.	Assistance Provided
74.	Person reported concern about transferring back to a facility where he was previously assaulted. Person said he had been trying to talk to mental health, but no one has come to talk to him.	The OCO provided assistance. The OCO reached out to DOC staff, who spoke with this individual who said that his safety concerns have been resolved but he had not yet seen mental health. The OCO worked with DOC staff who got him scheduled with mental health, which the OCO confirmed via DOC records.	Assistance Provided
75.	Patient reports medical and mental health concerns.	The OCO provided assistance by elevating this concern to DOC Health Services leadership and confirmed a neurology appointment and follow up.	Assistance Provided
76.	Individual reported they were placed on MAX custody and may be discharged from the residential treatment program. They were also involved in a use of force and injured.	The OCO reviewed the camera footage from the use of force and could not see the incident clearly due to the placement of the video camera's. This office then contacted DOC classifications to ensure this individual could complete their MAX program in the residential treatment unit. The DOC confirmed that they would stay in the residential treatment unit. In addition, the individual was worried about certain staff in their living unit. The OCO confirmed the staff were removed from the unit. The individual has completed the MAX program and is now in a lower custody level.	Assistance Provided
77.	Patient reports concerns about access to medical care.	The OCO provided assistance by elevating the patient's concerns through DOC Health Services leadership and DOC agreed to follow up with the patient.	Assistance Provided
78.	Patient reports concerns about expiring Health Status Reports (HSRs), access to physical therapy (PT), recent test results, and follow up.	The OCO provided assistance by elevating the concerns through DOC Health Services leadership and DOC agreed to schedule an additional appointment to discuss recent test results with the patient. The patient was approved for physical therapy through the care review committee, and the OCO confirmed PT	Assistance Provided

		appointments are scheduled and occurring. This office confirmed the HSRs were addressed by DOC prior to OCO action.	
79.	An incarcerated individual reports housing and safety concerns on behalf of another incarcerated individual in solitary confinement.	The OCO provided assistance by elevating the transgender housing concerns through DOC leadership. The transfer was halted due to safety concerns and a new custody facility plan was created. The OCO contacted the incarcerated person directly for more details and confirmed this case can be closed now that the safety concern and transfer have been addressed.	Assistance Provided
80.	Incarcerated individual reports concerns regarding her unit placement. The individual reports concerns about her cellmate, and Intensive Management Unit (IMU) placement after reporting the concerns. The individual shared that there is a DOC investigation underway, and asked the OCO to review the investigation and her segregation placement.	The OCO provided assistance. The OCO reviewed the individual's initial placement and found there was no documented evidence that her and her cellmate were not compatible or that any move requests were filed prior to the investigation starting. The OCO verified DOC did place the individual in IMU after the concerns were reported, however DOC placed her in IMU because there were concerns about the safety of DOC staff and other incarcerated people in the unit she was housed. DOC placed her in IMU pending a new housing assignment, which was finalized after multiple months. The OCO spoke with DOC staff about the lack of documentation that the IMU placement was not related to the investigation underway, and after OCO outreach the documentation was updated to contain more information. The OCO reviewed the finalized investigation and spoke to DOC staff about the reason for the findings and requested that the documentation be updated with clearer information about the investigation outcome. DOC did not update the documentation, but understood the reason for the request and agreed to ask DOC investigators to provide clearer reasoning for the outcome of their investigation.	Assistance Provided
81.	Patient reports that he was approved for dentures years ago and is just now getting dental treatment. Recently, he had some teeth pulled and DOC failed to take out the stitches in a timely manner and only approved one week of a puree diet. The patient reports that he filed a resolution request but has not heard anything back.	DOC resolved this concern prior to the OCO taking action on this complaint. The OCO contacted health services about the patient's dental care and soft mechanical diet. Health services confirmed that the patient was seen the same day as outreach and is fully aware of the pending treatment he needs prior to impressions for his partials. DOC staff also confirmed that the patient was given a health status report (HSR) for a mechanical soft diet until later this year.	DOC Resolved
82.	Person reports that they have not been able to get their hearing aids repaired.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff confirmed that DOC staff resolved this concern for the person during the resolution process. OCO staff contacted DOC staff and verified the person had been reissued his repaired hearing aids.	DOC Resolved
83.	Person reports that he needs surgery and DOC is not scheduling follow up appointments to move his care forward.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff reviewed the patient's records and contacted DOC Health Services staff. OCO staff were informed the patient had seen medical staff multiple times and had a specialist follow-up appointment scheduled.	DOC Resolved
84.	Incarcerated individual shared concerns regarding missing a medical appointment due to a DOC transport delay.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO was able to confirm that this individual received the medical treatment and is scheduled to continue to receive medical treatment. This office was able to confirm that there was a delay due to various factors.	DOC Resolved

85.	Incarcerated individual shared concerns regarding DOC failing to provide adequate medical care.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO was able to confirm that this individual has been receiving care as requested.	DOC Resolved
86.	Incarcerated individual shared concerns regarding their medical appointments being cancelled and not receiving adequate medical care.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO was able to confirm that the off-site medical clinic this individual was scheduled to have an appointment with requested a cancellation. Despite the cancellation, DOC staff rescheduled the appointment and the OCO was able to confirm this individual was seen for their concern.	DOC Resolved
87.	Person reported that medical staff did not respond to his declared medical emergency appropriately. The person reported that he received a behavior observation entry as a result and requested that this be removed.	The OCO provided information regarding the person's medical concerns. OCO staff reviewed the patient's records and noted the patient was assessed using the correct emergency protocol for the symptoms reported by the patient. OCO staff confirmed that the patient was referred for additional testing that returned normal results. OCO staff reviewed the behavior observation entry and found it complied with DOC policy.	Information Provided
88.	Person reported that his resolution requests from a previous facility have not been responded to.	The OCO provided information about the OCO's work on his concerns regarding the resolution program in a different OCO case, as well as options for accessing responses for older resolutions requests. The OCO also reviewed his resolution request and found that he did receive responses and that he did have access to the program.	Information Provided
89.	Individual reported that staff threatened to take them somewhere with no cameras, and they were antagonizing individuals. Resolutions are pushing back for rewrites and then telling individuals they are changing the topic when they submit rewrites.	This office contacted facility leadership to share concerns and verified that this individual was transferred from the facility and reclassified.	Information Provided
90.	Incarcerated individual relayed concerns regarding still being on a behavior program that was supposed to be only six months but was extended to 12 months.	The OCO spoke to DOC regarding this concern and confirmed that DOC informed the individual that their treatment plan was recently updated and will expire in a few months.	Information Provided
91.	Incarcerated individual shared concerns regarding DOC wrongfully imposing sanctions on them they did not previously have.	The OCO provided information regarding why there are additional conditions placed on their sentence from when they were originally sentenced. This office also shared the OCO's jurisdiction and the inability to investigate concerns related to one's J&S (judgement and sentence) imposed by the courts.	Information Provided
92.	Anonymous individual raised concerns about drug usage in living units.	The OCO elevated this concern to facility leadership who is continuing to investigate the concern.	Information Provided
93.	Incarcerated individual reports cellmate concerns. The person requested the OCO keep the complaint confidential, close the case, and send the requested information via mail.	The OCO provided the requested contact information.	Information Provided
94.	Person reports a need for a special diet for a severe medical issue. The	The OCO provided information to the person regarding the current limits to special diets and the status of his specialist	Information Provided

	person is requesting to be placed on a special diet.	consult. The OCO is in ongoing discussions with DOC regarding the availability of diets that meet the medical needs of patients.	
95.	Incarcerated individual relayed concerns regarding their facility placement and a desire to be in medium custody.	The OCO reviewed the individual's custody facility plan (CFP) and spoke to DOC regarding this concern. The OCO confirmed that the individual will need to wait for their next CFP to be considered for medium as they are on MAX now due to their usage of weapons in an assault.	Information Provided
96.	Incarcerated individual shared concerns regarding DOC staff blocking their resolutions from being adequately investigated.	The OCO provided information regarding why their resolutions were not further investigated. The OCO was able to confirm that this individual was utilizing the incorrect process for many of their concerns. This individual has filed numerous resolution requests that were investigated further.	Information Provided
97.	Incarcerated individual relayed concerns regarding not getting the proper adhesive barrier ring for their stoma bag.	The OCO spoke to DOC regarding this concern and confirmed that DOC established a protocol with the individual that if they want to change any of their supplies, an appointment will be scheduled to go over the changes and the supplies will be purchased with the individual's understanding that it will take time until they arrive.	Information Provided
98.	Incarcerated individual relayed concerns regarding the inability to have a TV while in an ADA cell in segregation.	The OCO spoke to DOC regarding this concern and confirmed that there are several work orders for maintenance to make the hole where the tv cord/cable cords go through for DOC to replace the TVs.	Information Provided
99.	Incarcerated individual shared concerns regarding DOC mailroom staff withholding their mail.	The OCO provided information regarding receiving mail at a facility. This office was able to confirm that the DOC facility had not received their mail.	Information Provided
100.	Incarcerated person reported concerns about DOC denying them transfer to graduated reentry (GRE). The person reports they meet the eligibility requirements and believe they should be accepted and transferred into the GRE program.	The OCO provided information about the reason the person was denied GRE. The OCO reviewed DOC's decision and found this person was denied GRE based on safety risks to the community that cannot be mitigated within the GRE program. DOC can deny eligible people based on multiple factors, including community risk. This decision was made by DOC headquarters that DOC was unwilling to promote this person to the custody level required for GRE or a reentry center.	Information Provided
101.	Incarcerated individual relayed concerns regarding a previous OCO case in which they were told DOC would come talk to them about the outcome of a staff conduct investigation.	The OCO spoke to DOC regarding this and confirmed that DOC did come and speak to the individual about this.	Information Provided
102.	Incarcerated individual shared concerns regarding DOC failing to provide them with adequate ADA accommodations.	The OCO provided information regarding why DOC did not provide their requested accommodations. The OCO was able to confirm that this individual was placed in administrative segregation due to a disciplinary concern which limits the type of ADA accommodating property an individual can have. The OCO was able to confirm that there is no medical necessity for the medical shoes requested and that this individual has standard issue shoes.	Information Provided
103.	Person expressed concerns about receiving a behavioral observation entry (BOE) from staff, which he said was in retaliation to filing a complaint against that staff. Person said that he	The OCO provided information about the best way to write resolution requests about staff conduct. The OCO reviewed the BOE and reached out to DOC headquarters staff. Both the OCO and DOC headquarters conducted a full review and could not substantiate a pattern of retaliation. DOC headquarters said that	Information Provided

	filed a resolution request, but it was not accepted because of the appeals process for the BOE, and he wants to be allowed to file a resolution request about the conduct of this staff.	this individual's resolution request was focused on the BOE, so per the Resolution Program Manual it cannot be accepted. Resolution requests about staff conduct should be focused on the staff's behavior and a pattern of behavior and should not describe any BOEs or infractions from that staff, because BOEs and infractions have a separate appeal process.	
104.	Person reports that his treatment stopped for a chronic issue and that DOC was not scheduling further appointments. The person is requesting continued care.	OCO staff provided information to the person regarding the status of their specialist consultations and treatment plan. OCO staff verified that the person is scheduled for multiple specialists for the reported issues.	Information Provided
105.	Person reports that his medical care was insufficient following an assault. The person states staff are not letting him appeal his resolution request regarding shower movements. The person requested that his medical care after the assault be reviewed.	OCO staff provided information to the person regarding the medical care they received following an assault. OCO staff reviewed the person's medical records and resolution requests. OCO staff noted that the emergency response immediately following the assault complied with the emergency medical response protocol. OCO staff were not able to substantiate a violation of DOC policy by medical staff regarding the patient's treatment plan. OCO staff found that the resolution request appeal regarding shower movements had been accepted and was substantiated by DOC resolution program.	Information Provided
106.	Incarcerated individual relayed concerns regarding the inability to have a TV while in an ADA cell in segregation.	The OCO spoke to DOC regarding this concern and confirmed that there are several work orders for maintenance to make the hole where the tv cord/cable cords go through for DOC to replace the TVs.	Information Provided
107.	Incarcerated individual relayed concerns regarding being targeted by staff for filing grievances and grievances not being properly addressed.	The OCO reviewed the individual's grievance history and noticed several were closed as administrative withdrawn without further information, thus the OCO contacted DOC who informed this office that those were closed as rewrites were requested but never returned from the individual. Based on this review, there was insufficient evidence to show that staff are targeting the individual for filing grievances or that the grievances are not being properly addressed.	Insufficient Evidence to Substantiate
108.	Incarcerated individual shared concerns regarding DOC staff harassing them and stating they were suspended from work programming despite no suspensions being placed.	The OCO was unable to substantiate the concern due to insufficient evidence. 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. This office was able to confirm that this individual committed acts while working which warranted disciplinary action taken by DOC staff. This individual's work programming was never suspended.	Insufficient Evidence to Substantiate
109.	Incarcerated individual shared concerns regarding DOC staff harassing them due to their identified gender and forcing them to wear certain clothing.	The OCO was unable to substantiate the concern due to insufficient evidence. This office reviewed numerous documents relevant to this concern and can determine that staff were not targeting this individual but were trying to ensure they complied with DOC policy 450.050. DOC staff attempted to accommodate this individual based off of their preference sheet but were unable to completely meet the request of the individual.	Insufficient Evidence to Substantiate
110.	Person reports they were electrocuted in the shower by staff. The electrocution could have killed her and she has not been seen by a	The OCO could not find a record of this individual being electrocuted by staff. In addition, the OCO could not find an incident report record for this concern and cannot substantiate the complaint.	Insufficient Evidence to Substantiate

	cardiologist after it happened to check for further damage.		
111.	Incarcerated person reported concerns about DOC denying them transfer onto the graduated reentry (GRE) program. The person requested the OCO review their GRE denial.	The OCO was unable to substantiate a violation of policy. The OCO reviewed the DOC's decision to deny this person transfer to the GRE program and a reentry center and verified the denial complies with DOC policy 390.590 and 300.500 as DOC can determine that certain risk factors cannot be mitigated in a specific program setting.	No Violation of Policy
112.	Incarcerated individual relayed concerns regarding a use of force.	The OCO reviewed the use of force packet and related video and confirmed that the proper use of force was used due to the emergent nature of the situation.	No Violation of Policy
113.	Incarcerated person requested assistance accessing showers privately for safety. The person also had concerns about DOC using the sanction that suspends people's access to commissary.	The OCO was unable to substantiate a violation of policy by DOC. The OCO verified that the facility provides access to showers in a way that meets people's safety concerns. The OCO also verified that the sanction was issued per DOC policy 460.050.	No Violation of Policy
114.	Person reported deaf individuals are being denied equal access to telephone communication with family and friends because there is no video phone system at the facility.	The OCO was able to substantiate this concern but was unable to achieve a resolution. The OCO reviewed this individual's resolution request and found that it had also been substantiated by DOC headquarters. The Americans with Disabilities Act mandates that deaf and hard of hearing individuals must have equal access to effective telecommunications, such as a Video Relay System (VRS), as the rest of population has to telephone calls. The OCO reached out to DOC Health Services and ADA staff and helped them attend the Securus quarterly meeting with DOC with DOC Leadership present, where Securus acknowledged that they were out of FCC compliance. Securus stated that they would roll out designated video tablets for deaf and hard of hearing individuals to use to call their friends and family. The OCO asked Securus at multiple quarterly meetings when the video tablets would be made available and continued to ask DOC staff for updates. The OCO's monitoring of this compliance concern has continued for more than eight months and the video tablets still have not been made available.	Substantiated
Olympic Corrections Center			
115.	Incarcerated individual shared concerns regarding being forced to take a program despite not being provided with needed accommodations.	The OCO provided assistance. This office reached out to DOC staff who shared they will work with this individual and provide them with resources to request the accommodations they need to be successful within the program. DOC staff also shared that they will be providing the whole class with information on how to request accommodations after OCO outreach.	Assistance Provided
116.	Incarcerated person reported concerns about DOC not allowing them to transfer to a reentry center in a specific county.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the person's reentry center denial and verified DOC denied the person reentry center access per DOC policy 300.500 as DOC headquarters determined that safety risks could not be mitigated at a reentry center.	No Violation of Policy
Other			
117.	An external person reported concerns about a person on community custody.	The OCO provided the person with information about how to report their concerns.	Information Provided

118.	An external person called and reported concerns about her loved one who is serving community custody.	The OCO provided the external person with information about how to address the concern with DOC.	Information Provided
	Stafford Creek Corrections Center		
119.	Individual reports they were recently resentenced from life without parole. Now that they have a release date, they can regain good conduct time. However, they still do not have an updated custody facility plan with a new pathway.	The OCO set up an in-person meeting with this individual, contacted the DOC classifications and reviewed DOC policy. This office was able to verify that there is a new custody facility plan being developed by DOC staff. Once the plan is complete, if the individual is unsatisfied with the pathway, they can appeal to DOC Headquarters. The OCO can confirm they will have a pathway to gain back some of their good conduct time, which will impact their release date.	Assistance Provided
120.	Person reported that his resolution requests were getting rejected because DOC said he was under conditions of confinement (COCs), and there was an appeal process.	The OCO provided assistance. The OCO conducted an extensive review of this individual's resolutions requests and documentation surrounding his placement into solitary confinement and conditions of confinement (COC). The OCO substantiated that it was not clearly documented when he was taken off of COCs, and multiple facility staff were unclear of his confinement status. The OCO also substantiated that the length of time he was documented as being on COCs violated the timelines in DOC policy 320.255. Per DOC policy 320.255, his extension of being on COCs required Assistant Secretary approval, and the OCO substantiated that approval was never given. The OCO spoke with unit staff and facility leadership about the discrepancies in the documentation, who were unable to explain the discrepancies. This office spoke with DOC headquarters about ways to prevent issues like this in the future, such as putting these notifications in writing, and the head of Mission Housing instructed all restrictive housing unit supervisors to notify individuals when they are taken off of COCs.	Assistance Provided
121.	Person reports that the durable medical equipment (DME) is not sufficient to meet his needs. The person stated that his request for a different option was denied because he has the ineffective item.	The OCO provided assistance. OCO staff reviewed the person's records and contacted DOC Health Services staff. OCO staff requested the patient be scheduled for an appointment with their provider to discuss accommodation options available to him. Durable medical equipment is issued by need that is determined by the person's medical provider, sometimes requiring care review committee approval if not explicitly covered by the DOC health plan. OCO staff were informed that there was a pending specialist consult related to this issue. OCO staff monitored the consultation and contacted DOC when scheduling did not occur. OCO staff confirmed that more imaging was requested by the specialist before the consultation can be scheduled and that imaging was being scheduled. OCO staff provided this information to the patient as well as contact information for the DOC staff who can answer questions about his specialist consultations.	Assistance Provided
122.	Incarcerated individual shared concerns regarding DOC not prescribing them medication and that it causes them mental stress.	The OCO provided assistance. The OCO spoke with DOC staff regarding this concern and were able to ensure that this individual received care for their medical concern. Despite it not being the desired treatment option the individual requested,	Assistance Provided

		DOC medical staff is actively working with the individual to find a suitable treatment plan.	
123.	Incarcerated individual with a diagnosed chronic condition reports he was denied an ADA accommodation for a single cell and white noise machine.	The OCO provided assistance by elevating the concern through ADA and health services leadership. DOC agreed to an updated assessment and re-review for ADA single cell accommodation. After OCO outreach, the single cell was reviewed and approved as clinically indicated. The OCO also confirmed there is an active HSR for a white noise machine for this patient.	Assistance Provided
124.	Person reports that his durable medical equipment was broken by staff and DOC refused to replace it due to his release date.	OCO staff provided assistance. OCO staff reviewed the patient records, resolution requests, DOC health plan, and dental protocols. The OCO elevated this concern to DOC headquarters as a part of systemic work on dental concerns statewide. DOC agreed to approve this patient's request.	Assistance Provided
125.	Incarcerated individual shared concerns regarding DOC staff not following policy and wrongfully writing them a negative BOE (Behavioral Observation Entry).	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO was able to confirm that this individual appealed the BOE and DOC staff corrected the entry.	DOC Resolved
126.	Person reports that it has taken an unexpectedly long time to get his durable medical equipment repaired. The person requests that the item be repaired and returned to him.	DOC staff resolved this concern prior to OCO action. OCO staff contacted DOC health services staff and were informed the durable medical equipment (DME) had been repaired and would be returned to the patient when it arrives at the facility. OCO staff followed up with DOC staff to verify the DME was returned to the patient.	DOC Resolved
127.	Person reported that he was injured at work and that DOC has not allowed him to return to his job due to the injury.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and reached out to DOC staff, who confirmed that this individual has returned to his job.	DOC Resolved
128.	Incarcerated individual relayed concerns regarding extended placement in segregation.	The OCO spoke to DOC about this concern and confirmed that the individual will remain at their current facility and custody level temporarily until their ongoing medical procedures are completed.	Information Provided
129.	Incarcerated individual relayed concerns regarding doing everything DOC requested them to do to restore their visits, but still not being able to have the visits.	The OCO spoke to DOC headquarters regarding this and confirmed that the individual will need to submit an appeal for restoration of in person visitation privileges to the Assistant Secretary.	Information Provided
130.	Person states that he is in need of specialist follow up for additional surgery. The person is requesting to see the specialist and to be placed back on the special diet he had been ordered previously.	The OCO provided information to the person regarding the recommendations given by the outside specialist. OCO staff reviewed the person's medical records and contacted DOC health services staff. OCO staff noted that the original follow up appointment was cancelled by the outside clinic following additional testing that was completed at the request of the specialist. OCO staff were informed that many people have been removed from special diets following an audit that verified if patients met the criteria for the special diet. OCO is in ongoing discussion regarding special diets with the DOC.	Information Provided
131.	Incarcerated person is being charged medical copays when they did not request to be placed on sick call for raising a medical concern.	The OCO provided information about how this person can resolve this concern. The individual may send a kite to the health services manager with the date of the appointment and the reason they think they should not have been charged a copay.	Information Provided

132.	Person reports that he needs follow up from a specialist that was supposed to have happened already.	OCO staff provided information to the person regarding his consultation status and reason the appointment was delayed. OCO staff reviewed the person's consultations and noted there was an issue in the communication of the appointment with the transport team resulting in an appointment not being attended. This communication issue has been occurring in multiple facilities and was addressed with DOC staff and retraining has taken place.	Information Provided
133.	An incarcerated person requested a facility separation between him and another individual but was only approved for a unit separation.	The OCO contacted the facility and spoke with DOC staff about the approved separation. A facility separation must go through headquarters and be approved by the Facility State Separation Prohibition Committee (FASSAP). This person's separation was reviewed by that committee and they determined only a unit separation is necessary at this time. There is no way to appeal this decision, but the individual can bring up the concern again during his next custody facility plan (CFP) review.	Information Provided
134.	Incarcerated individual shared concerns regarding DOC not providing them with adequate medical care.	The OCO was able to confirm that this individual has been seen for matters regarding their medical concern. The OCO provided information regarding the importance of continuing to work closely with their provider to take care of problems as they arise.	Information Provided
135.	Incarcerated individual relayed concerns regarding needing a single cell for medical and safety reasons.	The OCO spoke to DOC regarding this and confirmed that the individual does not meet the single cell criteria under DOC policy 420.140.	Information Provided
136.	Person reported that he was denied graduated reentry (GRE) due to not taking programming, but he said he has completed the requirements of his Judgement and Sentencing.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed DOC records and found that this individual has not taken programming required by DOC. DOC policy 390.600 states, "I. The Department may impose conditions or request conditions on an eligible cause(s) that relates to the crime of conviction, the risk to re-offend, and/or community safety for purposes of risk reduction and monitoring compliance with supervision requirements." The OCO could not find a violation of DOC policy 390.590 or 390.600 as graduated reentry considers multiple risk factors and views lack of crime related programming as a risk factor that cannot be mitigated by the program.	No Violation of Policy
137.	Person wants to know why DOC has the right to do whatever they want with his medical records that belong to him.	The OCO was unable to identify evidence to substantiate there was a violation of policy. DOC policy 640.020 says for individuals who are indigent, copies from the previous six months will be provided at no charge. Individuals will be charged for duplicate copies. The DOC reports that the medical records provided were their copy for this person's DOC medical file. If this person wants a duplicate, he will have to make a request and pay the copying fee.	No Violation of Policy
Washington Corrections Center			
138.	Person reported that his dental partial was broken during transport and has not been replaced.	The OCO provided assistance. The OCO reviewed this individual’s resolution request and reached out to DOC staff regarding his dental partial. After OCO outreach, DOC staff met with this individual and developed a plan to address this person’s dental concerns and replace the dental partial. The OCO escalated his concern to DOC Health Services leadership, who declined to expedite him getting scheduled for treatment and new dentures. The OCO continued to track this individual's dental care and bring this concern to Health Services leadership	Assistance Provided

		as a part of systemic work on dental concerns statewide. The OCO confirmed in DOC records that this individual received the required treatment and is scheduled to receive new dentures.	
139.	Person reported that he has an infected tooth and has not been able to get dental care for months.	The OCO provided assistance. The OCO met with this individual in person and brought his concern to DOC staff. The OCO elevated this concern to DOC headquarters as a part of systemic work on dental concerns statewide. The OCO confirmed with DOC staff and in DOC records that this individual received dental care.	Assistance Provided
140.	The individual transferred from another facility as a violator and did not bring any hygiene items with him. When he got to receiving he was not given a duck bag and only had a bar of soap.	The OCO contacted the facility about this concern, and DOC agreed to bring him a duck bag so he would have hygiene items to use in receiving.	Assistance Provided
141.	Person reports that he was in the shower singing, and a DOC officer tapped on the window above the shower, breaking the glass.	The OCO reviewed the individual's resolution request and associated incident report. This office spoke with DOC staff about the concern who verified the details, noting the situation was taken care of immediately, the individual was not hurt and checked out by medical, and the broken window was repaired.	DOC Resolved
142.	Incarcerated individual shared concerns regarding DOC failing to provide them with adequate dental care.	The OCO provided information regarding why this individual was not provided with the care they wanted. This office was able to confirm that the treatment they requested was determined to be not medically necessary. DOC staff treated this individual for their concern.	Information Provided
143.	Incarcerated person reported concerns about staff misconduct and retaliation.	The OCO provided information about their situation. The OCO verified that DOC acted within policy based on the evidence available. The OCO shared that DOC will provide him with the outcome of the investigation they requested. If they have concerns once the investigation is complete, the OCO can review the investigation. The OCO shared resources about how to continue to report staff concerns if they persist.	Information Provided
144.	Person reports that he requested to be seen for a chronic condition at multiple facilities and did not receive an appointment with his primary care provider. The person stated that every time he transfers, he is told to kite for an appointment but has not been seen.	The OCO provided information to the person regarding the scheduling of his requested appointment. OCO staff substantiated that the patient did not receive an appointment with his primary care provider after following DOC staff instructions to kite for an appointment. OCO staff verified an appointment was scheduled for after the person's release. OCO staff also provided tort claim information as individuals who have been harmed or who have suffered a loss as a result of negligent actions by a state employee or agency can submit a tort claim to the Office of Risk Management (ORM). ORM is required by law (RCW Chapter 4.92) to receive these claims.	Information Provided
145.	Patient reports concerns about housing placement and consideration for residential treatment unit (RTU).	The OCO discussed this concern with DOC mental health leadership and the individual's mental healthcare provider. At this time RTU is not clinically indicated, and the patient and provider recently discussed alternatives, including a single cell and other accommodations. These accommodations were provided as health status reports (HSRs). The OCO provided information about the RTU pathway if the patient changes their mind and wants to be reconsidered in the future.	Information Provided

146.	Person reports a safety concern regarding a facility keep separate.	The OCO reviewed this individual's housing placement and verified that DOC investigated his concern. Headquarters decided to uphold the quad separation. This person may address this concern at their next custody facility plan (CFP) and ask to transfer to another prison.	Information Provided
147.	Person reports that he has repeatedly alerted DOC staff of his safety concerns, and they have not been taken seriously.	The OCO contacted the facility about this person's safety concern and confirmed DOC addressed the issue. This person was placed in protective custody while an investigation was conducted and is now housed in a different unit. DOC staff reported they would contact the individual and review his concerns. The OCO encouraged this individual to work closely with his counselor regarding any existing safety concerns and provide detailed information that can be verified.	Information Provided
148.	Incarcerated individual shared concerns regarding DOC not providing proper accommodations despite having an HSR (health status report).	The OCO provided information to this individual regarding their HSRs. The OCO spoke with DOC staff regarding this matter and were informed that this individual's accommodations were unable to be properly fulfilled at the facility they are housed at. The OCO was able to confirm that this individual was transferred to a facility that can adequately accommodate them. This individual was in transit due to concerns outside of DOC custody which halted the fulfillment of their HSRs.	Information Provided
149.	Incarcerated individual shared concerns regarding DOC not providing them with adequate means of privacy.	The OCO was able to confirm that this individual was moved from the facility in question for unrelated reasons. The OCO provided information regarding current security and safety procedures implemented by DOC and why DOC cannot accommodate their request.	Information Provided
150.	Incarcerated person reported concerns about the unit they are currently housed in. The person reported they would rather transfer to a partial confinement setting such as graduated reentry (GRE).	The OCO provided information about why they are not eligible for GRE and how to address issues in their unit. The OCO visited the unit reported and spoke with multiple people living and working there. There were multiple issues reported by the people. The OCO spoke with facility leadership about the various issues, including heating of the building. The OCO will continue to monitor this unit’s access to programming, which has improved since the unit was opened.	Information Provided
151.	Incarcerated individual relayed concerns regarding an infraction that they believe they were wrongfully found guilty of.	The OCO reviewed the corresponding grievance and infraction materials and spoke to DOC about this concern. The OCO asked DOC if they would be willing to dismiss the infraction as it was confirmed that the lab report was not included in the infraction packet, so the individual did not have the opportunity to review all non-confidential documents to provide a proper defense. DOC was unwilling to dismiss the infraction as they maintain that the infraction elements were met and the lab report was determined evidentiary and was entered on record during the hearing.	Information Provided
152.	Individual reported that the officers had their handcuffs on too tight and pulled their arms through the cuff port, injuring them, and that staff in the IMU harassed him. They also report that the DOC did a use of force investigation and found that he was a threat even though the individual was experiencing a mental health crisis.	This office reviewed the use of force packet and video and spoke with DOC leadership. Per DOC policy 410.200, incarcerated individuals are not allowed access to use of force videos. To access that video record, individuals will need to publicly disclose it upon release. After reviewing the video evidence, this office communicated concerns to DOC regarding staff actions. DOC reviewed these mistakes and the staff received updated training. The OCO does not have the authority to discipline DOC staff nor the ability to assist with litigation. Individuals do have	Substantiated

	He wrote to DOC public records requesting the video footage, and they said they had no responsive records.	the option to file a tort claim as any individual harmed or suffered a loss due to negligent actions by a state employee or agency can submit a tort claim to the Department of Enterprise Services Office of Risk Management. Tort claims information can be found in the law library.	
Washington Corrections Center for Women			
153.	An external person reported that staff targeted their loved one when their room was searched, and they were told their TV did not belong to them. This resulted in the individual being taken to segregation and infracted.	The OCO reviewed evidence including the infraction and the handheld video from the day of the incident and contacted facility leadership. The OCO could not review the outcome of the infraction because they never appealed the guilty finding. The OCO provided information to the individual that moving forward, if they disagree with the outcome of the infraction hearing, they need to file an appeal and contact this office if the appeal is denied. The OCO did have concerns after reviewing the handheld video recording of the interaction with staff on that day. The OCO found the incident did not meet the criteria listed in DOC policy 410.200 for a use of force because, if a use of force is necessary, resistance must be evident and the amount of force used must be directly related to the level of resistance or perceived threat, and the amount of force used must be reasonably necessary to resolve an incident. The individual was threatened with OC spray at cell front when they were speaking with staff. The individual eventually came out of their cell and were then escorted to restrictive housing. The OCO contacted the facility to voice concerns that the OC spray was unnecessary. The facility reviewed and agreed it was inappropriate and indicated that it will address the matter with the staff involved.	Assistance Provided
154.	While onsite, the facility requested the OCO help negotiate with an individual who had covered her windows in the COA. The individual in crisis was requesting the OCO.	The OCO sat cell front with the individual for an hour while she discussed her concerns. She then agreed to uncover her window and camera.	Assistance Provided
155.	Person reports concerns about being triggered around knives and requested a different job placement.	The OCO provided assistance by elevating the concern to DOC mental health leadership and the individual was removed from the kitchen work position. This office also provided information about individual's options and next steps for an alternative job placement.	Assistance Provided
156.	Person reported to the OCO in person that she had been involved in a use of force days ago and thought her wrist was broken. She said medical was refusing to x-ray it.	OCO staff present at cell front observed the individual's swollen wrist. This office then contacted health services and DOC headquarters to alert them to this person's request for an x-ray. The OCO received confirmation that she was taken out for x-ray within hours of OCO contact.	Assistance Provided
157.	During the OCO open hours visit in September, the OCO met with this individual in person at the facility. They shared with the OCO that their medical shoes were hurting their feet, and medical was not working with them to get a new pair.	This OCO contacted health services and discussed the situation. The OCO asked if this individual could receive new shoes that did not hurt their feet. DOC agreed to look into a different type of shoe and has now reported that the individual was issued new shoes.	Assistance Provided
158.	An external person reported that an incarcerated individual was pulled from her job and assigned to a new	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and reached out to DOC staff, who confirmed that this individual left the job she could not perform and is now employed in a new position.	DOC Resolved

	job that she was physically incapable of performing.		
159.	Incarcerated person reported concerns about delays in their release planning and requested assistance with ensuring the plan is complete so they can release on their earned release date (ERD).	DOC resolved this concern prior to OCO action. The OCO verified the person's release plan was approved the day after they reported the concern to the OCO.	DOC Resolved
160.	Person reports being taken off a medication they had taken for a long time when entering DOC custody. The person is requesting to be placed back on the medication.	The OCO provided information to the person regarding the DOC protocol related to their medication. OCO staff reviewed the patient's records and were not able to substantiate a violation of DOC protocol. OCO staff contacted DOC Health Services staff and verified the medical issue is being addressed with alternative treatments.	Information Provided
161.	Person reported sustaining a serious injury at work. Person reported that staff acted with indifference. Person reported that she is not able to access her medical records and is having trouble accessing the law library or getting legal help from her peers.	The OCO provided information. The OCO reviewed DOC records and the incident report and substantiated that this incident occurred. The OCO met with this individual and visited the kitchen and talked with both DOC and incarcerated staff in the kitchen. The OCO reached out to DOC staff, who verified that the underlying problem has been addressed, so incidents like this will not occur again. Per DOC policy, individuals are not guaranteed the ability to get legal help from their peers. DOC policy 590.500 states: "II. Assistance in Legal Matters A. An incarcerated individual may confer with another incarcerated individual in researching and preparing legal pleadings. 1. No incarcerated individual may represent, attend, hear, or participate in another individual's legal matter before a legal tribunal unless called as a witness." Incarcerated individuals have access to the law library through their Securus tablets. The OCO provided information about accessing her medical file.	Information Provided
162.	Incarcerated individual shared concerns regarding DOC not providing them with adequate dental care.	The OCO provided information regarding next steps with their treatment plan. This office was able to confirm that this individual has been seen for dental concerns and is being treated as needed or when requested.	Information Provided
163.	Individual reported multiple concerns related to issues at the facility including staff targeting and discriminating against trans people; housing of trans people in close custody in single cells; staff falsifying incident reports and infractions; problems with the PREA system; Infraction appeals are resulting in more serious sanctions than the original sanctions; DOC not adhering to the DRW trans settlement; showers in MSU are vinyl curtains and not securable from inside; bathroom stalls can be opened from outside the stall; cracks in the bathroom stall are large so you can see inside; staff allowed PRIDE but trans individuals were not allowed a	The OCO has spoken with the facility and DOC headquarters leadership and reviewed policy. The DOC has hired new headquarters staff to help assist with trans issues statewide. The OCO did ask the facility about the vinyl shower curtains, and the facility does not plan on replacing them with locking doors for safety and security reasons. This office is aware of the issues at the facility with infractions and sanctions and will continue to work with the facility regarding this concern. The OCO has received multiple complaints regarding strip searches for trans individuals, and this office continues to bring those concerns to the Women's Division.	Information Provided

	PRIDE event; and staff strip searching trans people instead of using the body scanner.		
164.	External person reports their loved one was taken to solitary confinement and not told why.	The OCO reviewed this concern and verified the individual was placed in administrative segregation due to an investigation and released back to population two weeks later. There is no violation of DOC policy 320.200.	No Violation of Policy
165.	Patient reports concerns about being placed on involuntary mental health medication.	The OCO was unable to substantiate a violation of policy by DOC. This office reviewed the documentation related to the patient being placed on involuntary medication and elevated the concern for further discussion with DOC mental health leadership. The OCO found that DOC policy 630.540 was followed in this situation.	No Violation of Policy
	Washington State Penitentiary		
166.	Individual reported that they have been in the restrictive housing for over two years and are waiting to go out of state. The current policy states they must take certain steps to get married while in the IMU and they want the OCO's help to get married.	The OCO reviewed DOC policy 590.200. According to DOC policy, the individual can initiate a marriage application while housed in restrictive housing. Their intended partner must be on their visit list, and the partner must be eligible to legally marry in Washington State. The OCO provided information on how to kite the counselor and ask for DOC form 20-213 Marriage Application.	Assistance Provided
167.	Incarcerated individual reports delayed access to prescription eyeglasses.	The OCO provided assistance by elevating this concern through DOC Health Services leadership. The OCO substantiated delayed vision care and utilized this case as an example to discuss and address concerns about limited optical for prisons on the east side of the state. The OCO confirmed a new eye exam occurred for this patient and prescription glasses were ordered and provided. Reading glasses are not provided through optical and can be ordered from store.	Assistance Provided
168.	Anonymous person called to report a safety concern.	The OCO provided assistance by immediately contacting DOC staff at the facility and alerting them of the concern. DOC acted upon the information.	Assistance Provided
169.	Person reports that the library app is not accessible on his tablet and says other people are having this same issue.	The individual called the OCO and reported that DOC fixed the issue.	DOC Resolved
170.	Individual reports he had a custody facility plan and the counselor said he has so many separatees that there is nowhere for him to go so he is going to remain in restrictive housing.	The OCO verified this individual was approved for close custody.	DOC Resolved
171.	Incarcerated individual relayed concerns regarding not being able to go beyond level 2 in segregation	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that they have been released from segregation.	DOC Resolved
172.	Patient reports a need for residential treatment unit (RTU) placement and a medication access incident.	The OCO reviewed relevant records and reached out to DOC to confirm the patient had been considered for RTU placement. This office confirmed the patient was approved and moved to RTU, elevated the missed medication incident for further review by DOC health services, and confirmed current access to medications.	Information Provided

173.	Incarcerated person reported concerns about DOC staff infracting and using force on them. The person requests the OCO review the incident.	The OCO provided information. The OCO reviewed the use of force and infraction. The OCO found the use of force was not recorded per DOC policy. The OCO spoke with facility leadership about the importance of proper documentation of uses of force and the crucial importance of DOC staff recording the totality of the incident. DOC staff shared they have created plans to mitigate these issues. The OCO will continue to monitor the mitigation of the issues reported by this office to the DOC. The OCO also verified the person is currently housed in another unit and the OCO shared information with the person about how to continue to report staff concerns as they arise. From the evidence available to review, staff acted in compliance with the DOC's restricted use of force policy, besides the video recording of the incident.	Information Provided
174.	Incarcerated individual shared concerns regarding DOC staff blocking their ability to program and obtain a job.	The OCO provided information regarding jobs this individual can obtain. The OCO was able to confirm that this individual is participating in programming. This office encouraged this individual to continue working with their counselor to find a job. The OCO was able to confirm that DOC staff removed any sort of probationary period that may have been placed on them.	Information Provided
175.	Incarcerated individual shared concerns regarding DOC staff not providing them with their DME (Durable Medical Equipment) after a transfer.	The OCO was able to confirm that this individual returned the DME and DOC staff did not withhold the equipment. The OCO provided information regarding this office's findings.	Information Provided
176.	Incarcerated individual shared concerns regarding DOC delaying their transfer and their ability to program due to that delay.	The OCO provided information regarding why this individual's transfer was delayed. The OCO was able to confirm that there was a bed shortage at the facility this individual was scheduled to transfer to. This office was also able to confirm that this individual has been transferred.	Information Provided
177.	Incarcerated individual relayed concerns regarding not wanting to have all their teeth pulled in order to get dentures.	The OCO spoke to DOC about this concern and confirmed that per the prosthetics (denture) protocol, all decayed teeth must be removed and non-restorable teeth must be extracted at least four weeks prior to being deemed ready for impressions. The OCO informed the individual that they can refuse, but then they will not qualify for dentures in DOC. The only alternative is to use DOC policy 600.020 "offsite offender paid healthcare."	Information Provided
178.	Individual reported he has to get permission from Ombuds before his lawyer can be on a phone call with DOC and him.	The OCO does not have the authority to determine a legal phone call. This office has spoken with this attorney, and they should have no issues setting up a legal call.	Information Provided
179.	Incarcerated individual relayed concerns regarding a use of force.	The OCO reviewed the use of force packet and related video. The OCO confirmed that it was documented in the use of force packet that several officers sustained injuries during this incident. Because this was an emergent use of force, only the surveillance footage shows the initial incident where the injuries were sustained. Based on the particular angle of which the incident occurred, there was difficulty verifying what exactly occurred based on footage.	Insufficient Evidence to Substantiate
180.	An external person reported that their loved one feared for their safety and was taken to restrictive housing.	This office reviewed the restrictive housing placement, infraction packet, audio hearing, and video from the day of the incident. The OCO found the individual had been infracted with a staff assault, which resulted in restrictive housing placement. After a	No Violation of Policy

		review of the video evidence, this office did find that the infraction met the elements of a staff assault. The restrictive housing placement and infraction hearing were per DOC policy.	
181.	Incarcerated individual relayed concerns regarding not being able to go beyond level 2 in segregation.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that they are to maintain MAX level 2 due to being an influential member of a security threat group per DOC policy 320.250 (IV)(B)(1)(c).	No Violation of Policy
182.	Incarcerated individual relayed concerns regarding limited housing options.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that because of the individual's recent WAC 603 drug introduction infraction, close custody is the only housing option that is available to them.	No Violation of Policy
183.	Individual reported they have been living in restrictive housing for over two years and has been fighting to move back to the population.	The OCO has reviewed the maximum custody placement and has had numerous conversations with DOC headquarters over the past two years regarding this individual's placement. The DOC maintains that due to their security threat group ties, it is not safe to move them back to the general population. This office has verified the individual is on the out-of-state placement list. There is no timeline in policy to limit the time an individual can be on this list. This office shared with the individual that if they are interested in debriefing and potentially accepting a safe harbor placement, they can send a kite to IIU (the intelligence and investigations unit).	No Violation of Policy
184.	Person reported that he is in solitary confinement after refusing a cell assignment due to security concerns.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed DOC records and found that DOC could not validate his security concerns and has exhausted general population options. The OCO could not find a violation of DOC policy 300.380.	No Violation of Policy
185.	Individual has been housed in restrictive housing while awaiting transfer to a safe harbor close custody facility. He has mental health concerns.	The OCO reviewed this individual's custody facility plan. They were transferred to safe harbor close custody, however due to their self-harm behavior it is not safe for them to reside at this rural facility. They do not have another placement because of keep separates and was recently demoted to maximum custody by the MAX committee for no viable placement. There is no violation of DOC policy 320.250.	No Violation of Policy
186.	Incarcerated individual relayed concerns regarding the level system utilized in segregation.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that they are to maintain MAX level 2 due to being an influential member of a security threat group per DOC policy 320.250 (IV)(B)(1)(c) in addition to having effectively eliminated all general population housing options due to violent behavior.	No Violation of Policy
187.	Incarcerated person reported concerns about DOC denying them transfer to the graduated reentry (GRE) program due to a detainer.	The OCO was unable to substantiate a violation of policy. Per DOC policy 390.590 a person that has an active detainer is not eligible for GRE. The OCO spoke with DOC staff about this restriction, which is driven by law. DOC explained that they will reconsider a person's eligibility if the detainer is removed.	No Violation of Policy

Intake Investigations

Airway Heights Corrections Center

188.	Incarcerated individual relayed concerns regarding being kidnapped and falsely imprisoned.	The OCO declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction

189.	Loved one relayed concerns regarding an assault that occurred.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
190.	Loved one relayed concerns regarding staff harassing an incarcerated individual.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
191.	Loved one relayed concerns regarding an incarcerated individual being denied work release.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
192.	Loved one relayed concerns regarding staff abusing their authority.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
193.	Person reported concerns about staff conduct and retaliation shortly after he arrived at the facility.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program to resolve staff conduct concerns.	Technical Assistance Provided
194.	Person reported that the facility was supposed to be painting and hanging televisions in the visitation room, but nothing has been done.	The OCO provided technical assistance about utilizing the resolution program.	Technical Assistance Provided
195.	Individual reported that their legal mail is not being stored in a secured location.	The OCO provided technical assistance about the resolution program.	Technical Assistance Provided
196.	An incarcerated person reported a concern regarding visitation being suspended or denied.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance and information on self-advocacy steps the incarcerated person can pursue.	Technical Assistance Provided
197.	An incarcerated person reported a concern related to DOC banking.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance about how to appeal resolution requests and where to look for the information regarding their concern.	Technical Assistance Provided
198.	An incarcerated person reports a concern related to property.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance about the resolution program.	Technical Assistance Provided
199.	An incarcerated person reported a concern related to the facilities of the building where they are housed.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to report facility change needs to DOC and how to escalate resolutions to headquarters.	Technical Assistance Provided

200.	An incarcerated person requested assistance from the OCO related to a health status report (HSR) that has expired.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to follow up with medical regarding needs.	Technical Assistance Provided
201.	Person reported that DOC staff failed to de-ice the walkways causing unsafe conditions.	The OCO provided technical assistance about utilizing the resolution program.	Technical Assistance Provided
202.	An incarcerated person relayed concerns regarding property removed during an infraction investigation and not returned after the infraction was dismissed and discontent with communication they have received from DOC headquarters.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program and specific information related to property concerns.	Technical Assistance Provided
203.	An incarcerated person reported a concern regarding visitation being suspended or denied.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance and information on self-advocacy steps the incarcerated person can pursue.	Technical Assistance Provided
204.	Incarcerated person requested information about transferring to a reentry center or graduated reentry (GRE) including what types of programming is needed to be accepted. The person asked how to be involved in these programs.	The OCO provided technical assistance by sharing information about the process of becoming eligible then being accepted into these programs. The OCO shared that the person will be screened for GRE once they are eligible based on their classification and the length of time they must serve. The GRE program will then determine the next steps for eligibility and communicate the outcome to the person. A person's classification counselor can refer them for transfer to a reentry center once they are eligible based on their classification and length of time to serve. The person will receive communication from DOC about their acceptance into a reentry center. The OCO encouraged the individual to review information about these programs on their tablet and by talking with DOC staff about the programs, as available.	Technical Assistance Provided
Clallam Bay Corrections Center			
205.	Loved one relayed concerns regarding damaged property.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
206.	Loved one relayed concerns regarding difficulties obtaining a replacement tablet.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
207.	Loved one relayed concerns regarding an incarcerated individual's high blood pressure.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance

208.	Person reported that DOC has not updated his name to reflect a legal name change although the department had acknowledged the name change during booking.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolutions program.	Technical Assistance Provided
209.	Person reported that DOC should allow transgender individuals to house together for support.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about the DOC's policy change process.	Technical Assistance Provided
210.	Person reported that their property was never received from their prior facility.	The OCO provided technical assistance regarding property concerns.	Technical Assistance Provided
Coyote Ridge Corrections Center			
211.	Loved one relayed concerns regarding an incarcerated individual not getting the proper medications.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
212.	Loved one relayed concerns regarding an incarcerated individual's placement in segregation.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
213.	Person reported concerns about being targeted by two DOC staff members.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC resolution program. The OCO provided technical assistance about tort claims and using the resolution program for staff conduct concerns.	Technical Assistance Provided
214.	Individual reported that their good time was taken and they were never given the opportunity to earn it back.	The OCO provided technical assistance about the DOC records correction process.	Technical Assistance Provided
215.	Person reported concerns about staff retaliation and that he was not present at the Facility Risk Management Team (FRMT) hearing where DOC staff changed his statement agreeing to remain at the facility he was at to reflect that he agreed to be transferred to a different facility, when he did not. He also reports that staff wrote a false infraction and other staff agree that the video evidence refutes the infraction narrative.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about appealing an infraction and using the resolution program.	Technical Assistance Provided
216.	An incarcerated person reported multiple concerns including property, safety and resolution program concerns.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint. To further the incarcerated person’s understanding of various processes, the OCO provided technical assistance about how to escalate a safety concern internal to DOC, what steps are needed prior to the OCO assisting with property and what the incarcerated	Technical Assistance Provided

		person can do internal to DOC to address other concerns that fall under the resolution program.	
Mission Creek Corrections Center for Women			
217.	An incarcerated person reported a concern related to receiving a behavior observation entry (BOE) instigated by information reported to DOC staff by fellow incarcerated people.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance and information on self-advocacy steps the incarcerated person can pursue.	Technical Assistance Provided
Monroe Correctional Complex			
218.	Incarcerated individual reports concerns about legal access.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond the intake investigation phase because the alleged violation was a past rather than ongoing issue and the complainant had not yet pursued internal resolution of the issue through DOC's grievance, administrative, or appellate procedures. The individual has since transferred and there is no DOC resolution request on file for the concern at the new facility.	Declined
219.	A loved one reports that the incarcerated individual was found guilty of an infraction for behavior directly related to a recent stroke.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance regarding the infraction process.	Technical Assistance Provided
220.	Person reported that they received boots from DOC for a job they were doing and now DOC wants the boots back.	The OCO provided technical assistance about the resolution program.	Technical Assistance Provided
221.	Person was experiencing issues accessing the law library on the tablet. This issue was eventually resolved, but believes there should be a plan for legal access if the system goes down and for DOC to have a better plan to address these issues.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance about how to contact Securus.	Technical Assistance Provided
222.	An incarcerated person reported a concern related to the behavior of a DOC staff member.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance and information on self-advocacy steps the incarcerated person can pursue.	Technical Assistance Provided
223.	An incarcerated person reported a concern related to a mistake made at a medical appointment.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance and information on self-advocacy steps the incarcerated person can pursue.	Technical Assistance Provided
224.	Person reported that his one-year-old daughter has not been approved for visitation although his loved one has submitted the application twice.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance about how to resolve the concern through the visitation program.	Technical Assistance Provided
225.	An incarcerated person reported a concern related the behavior of a DOC staff member.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance about how to report DOC staff	Technical Assistance Provided

		behavior internal to DOC prior to reaching out to the OCO and additional self-advocacy information.	
226.	Incarcerated individual reports concerns about staff conduct, infractions, and programming access.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about appealing infractions, grieving staff conduct, and addressing programming concerns through the DOC Resolution Program prior to OCO involvement.	Technical Assistance Provided
227.	Person reported that they are having a difficult time getting in touch with a Securus representative.	The OCO provided technical assistance by providing more information about Securus.	Technical Assistance Provided
228.	Person reports that he was terminated from the graduated reentry program and then further sanctioned when he returned to prison. Person states that the termination and going back to prison should be the punishment and he should not have been further sanctioned.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program.	Technical Assistance Provided
229.	An incarcerated person relayed concerns related to not receiving support with paperwork filing needed to further his release planning.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal resolution requests and where to look for the information regarding their concern.	Technical Assistance Provided
230.	An incarcerated person asked the OCO to gather an investigation for them prior to an infraction hearing.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about when to contact the OCO for assistance related to an infraction concern.	Technical Assistance Provided
Olympic Corrections Center			
231.	Person reported concerns about how DOC staff conducted a cell search and that there is a conflict of interest regarding an associated disciplinary hearing. Person also reports that DOC staff were not honest with him about why he was being held at a previous facility longer than expected.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC resolution program. The OCO provided technical assistance about appealing an infraction.	Technical Assistance Provided
Other			
232.	Person reports concerns while at American Behavioral Health Systems (ABHS).	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
233.	Individual relayed concerns regarding staff conduct in the Kittitas County Jail.	The OCO declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
234.	Individual relayed concerns regarding receiving a violation while on GPS monitoring.	The OCO declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
235.	Individual relayed concerns regarding the commissary prices and conditions in Pierce County Jail.	The OCO declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction

Reentry Center - Wenatchee Valley - Chelan			
236.	Person reported that their counselor wants them to have another drug assessment after they were placed in the medication assisted treatment (MAT) program.	The OCO provided technical assistance about utilizing the resolution program.	Technical Assistance Provided
Stafford Creek Corrections Center			
237.	Loved one relayed concerns regarding an incarcerated individual's ongoing neck pain.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
238.	Loved one relayed concerns regarding staff conduct during a visit.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
239.	External Person reports that their loved one's time has been miscalculated, and they should be released.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
240.	Loved one relayed concerns regarding a PREA case.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
241.	A loved one shared concerns on behalf of an incarcerated individual regarding being placed in the wrong custody level.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
242.	Incarcerated individual shared concerns regarding DOC not providing them with medical care despite having medical complications.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
243.	Person reports that they are having a difficult time getting medical shoes and access to see a podiatrist.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance about using the resolution program.	Technical Assistance Provided
244.	Person reports that they are a veteran with an honorable discharge therefore, should be able to access full medical coverage.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance about using the resolution program and the health services process.	Technical Assistance Provided

245.	An incarcerated person reported a concern related to release planning and the calculation of their earned release date (ERD).	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance about where to look for information regarding his concern and what steps to take to follow up on this concern.	Technical Assistance Provided
246.	Person reported that DOC stated they found drugs in his legal box. The box was confiscated but he was given half of the contents in the box back and was told he was pending another violation.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about appealing an infraction.	Technical Assistance Provided
247.	An incarcerated person reported a concern related to the behavior of a DOC staff member.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance and information on self-advocacy steps the incarcerated person can pursue.	Technical Assistance Provided
248.	Person reported concerns regarding a separatee issue.	The OCO provided technical assistance about utilizing the resolution program.	Technical Assistance Provided
249.	An incarcerated person relayed that due to ADA related issues they need help filling out forms and accessing the resolution program.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO verified that the person is able to access the resolution program and provided technical assistance about how to request an HSR to meet their needs.	Technical Assistance Provided
250.	An incarcerated person reported a concern related to missing some property at facility transfer.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about property concerns.	Technical Assistance Provided
251.	Person reported concerns about being harassed and targeted by a DOC staff member.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC resolution program. The OCO provided technical assistance about using the resolution program.	Technical Assistance Provided
252.	Individual reported that a DOC staff member was staring at their chest and asked them to change their shirt before they entered the yard. After they changed and returned, the staff member would not let them into the yard.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
253.	Person reported concerns about their earned release date (ERD) and civil commitment review.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
254.	Incarcerated individual reports concerns about staff conduct and behavior observation entries (BOEs).	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about grieving staff conduct concerns prior to OCO involvement.	Technical Assistance Provided
255.	Person requested that DOC change the Intensive Management Unit policy so that people who are on a level 3 program can have access to messaging their loved ones.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance about the DOC policy change process and how to send policy comments to the headquarters policy office.	Technical Assistance Provided

256.	Person reported that their property was not packed out properly and is missing items.	The OCO provided technical assistance about the resolution program.	Technical Assistance Provided
257.	An incarcerated person reported a concern related to the behavior of a staff member contracted by DOC.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance and information on self-advocacy steps the incarcerated person can pursue.	Technical Assistance Provided
Washington Corrections Center			
258.	Individual relayed concerns regarding being assaulted by King County Jail staff.	The OCO declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint. The OCO provided the individual with the contact information for the King County Ombuds who may be able to assist.	Lacked Jurisdiction
259.	Loved one relayed concerns regarding an incarcerated individual's placement in segregation due to limited housing options.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
260.	Loved one relayed concerns regarding an incarcerated individual's placement in segregation.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
261.	An external person reported concerns about her husband living in segregation for over 30 days due to an investigation.	A person called and requested that OCO close this case because he learned more information about his segregation status and would like OCO to focus attention on the other issues he has reported.	Person Declined OCO Assistance
262.	Incarcerated individual shared concerns regarding matters outside of OCO jurisdiction.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
263.	Incarcerated individual shared concerns regarding DOC staff harassing them.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
264.	Incarcerated individual shared concerns regarding the way DOC staff were talking to another individual.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
265.	Incarcerated individual shared concerns regarding DOC staff harassing them.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action

266.	Incarcerated individual shared concerns regarding DOC staff harassing them.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
267.	An incarcerated person reported a concern regarding a resolution request they have filed and not appealed.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal resolution requests.	Technical Assistance Provided
268.	An incarcerated person reported they are in need of a specific health care service.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO verified that health care is being provided for the concern and gave technical assistance to the incarcerated person about how to follow up with DOC health services.	Technical Assistance Provided
269.	Person reported concerns about a serious infraction they received.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC resolution program. The OCO provided technical assistance about appealing an infraction.	Technical Assistance Provided
270.	Incarcerated individual shared concerns regarding DOC miscalculating their MAX release date.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about time calculations and the internal administrative processes provided by DOC.	Technical Assistance Provided
271.	Person reported that the time calculations on his sentence are incorrect and he is being held past the correct release date.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance about records correction and time calculations.	Technical Assistance Provided
272.	Person reported that DOC has not updated their records, and their early release date (ERD) is wrong.	The OCO provided technical assistance about the DOC records correction process.	Technical Assistance Provided
273.	An incarcerated person relayed a concern related to a job and staff behavior related to that job.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about the resolution program and how to follow through with the additional steps needed.	Technical Assistance Provided
274.	An incarcerated person reported concerns related to their placement in IMU and unfair sanctions from an infraction that multiple people were involved in.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance regarding how to appeal infractions, and what steps are available to appeal placement decisions.	Technical Assistance Provided
275.	Person reports they do not believe their housing matches their needs.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to request an appointment from health services, how to report safety concerns and what steps are available to appeal placement decisions.	Technical Assistance Provided
276.	Person reported that county jail and DOC have been taking taxes out of their tribal money.	The OCO provided technical assistance about utilizing the resolution program and banking process.	Technical Assistance Provided

277.	Person reported that he was unfairly infracted with a cell tag, and his due process rights are being violated.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about appealing an infraction.	Technical Assistance Provided
Washington Corrections Center for Women			
278.	Loved one relayed concerns regarding a communication suspension.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
279.	External person reports that an incarcerated individuals is not receiving meals due to a health condition that limits her from walking to the dining hall.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
280.	Incarcerated individual shared concerns regarding DOC staff wrongly infracting them.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
281.	Patient reports concerns about post-operation care after gender affirming surgery.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
282.	Incarcerated individual reports concerns about staff conduct. The person did not request a specific resolution.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about grieving staff conduct issues.	Technical Assistance Provided
283.	Person reported that she and other women are being harassed by a transgender incarcerated individual.	The OCO provided technical assistance about the resolution program.	Technical Assistance Provided
284.	Individual spoke with OCO staff about the lack of medical care at the facility.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance regarding health services and how to file a resolution request.	Technical Assistance Provided
285.	Person reported concerns about DOC staff violating HIPAA laws.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance about using the resolutions program for staff conduct concerns.	Technical Assistance Provided
286.	An incarcerated person reports their earned release date (ERD) is not being calculated correctly due to a miscalculation.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to request that DOC review their time and sentence and explain why their ERD is what it is.	Technical Assistance Provided
Washington State Penitentiary			
287.	Loved one relayed concerns regarding an incarcerated individual not being given their property.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this	Person Declined OCO Assistance

		concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	
288.	Loved one relayed concerns regarding harassment by an officer and an incarcerated individual's placement in segregation.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
289.	Loved one relayed concerns regarding placement in segregation	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
290.	Loved one relayed concerns regarding placement in segregation.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
291.	Loved one relayed concerns regarding placement in segregation and staff conduct.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
292.	Loved one relayed concerns regarding placement in segregation.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
293.	Loved one relayed concerns regarding placement in segregation.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
294.	A loved one made a complaint on behalf of an incarcerated individual regarding the difficulty they are having when trying to contact the incarcerated individual.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
295.	Person reported that they have a health condition that has caused them to not be able to give samples for required testing procedures.	The OCO provided technical assistance about the resolution program and provided more information about health status report (HSR).	Technical Assistance Provided
296.	A loved one made a complaint on behalf of an incarcerated individual and shared concerns regarding DOC visitation staff.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance regarding how to properly report concerns at the facility.	Technical Assistance Provided

297.	An incarcerated person reported a concern related to the behavior of a DOC staff member and regarding an infraction.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance regarding staff conduct concerns.	Technical Assistance Provided
298.	Incarcerated individual reports concerns about legal document access.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about legal access and the DOC resolutions process prior to OCO involvement.	Technical Assistance Provided
299.	An incarcerated person reports a concern related to the behavior of a DOC staff member.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance regarding staff conduct concerns.	Technical Assistance Provided
300.	Person reported that DOC staff confiscated his legal and medical documents following an altercation with that staff person.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program to address staff conduct concerns.	Technical Assistance Provided
301.	Person reported that the Black Prisoners Caucus (BPC) is having multiple issues with DOC staff.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program.	Technical Assistance Provided
302.	Person reported a concern about their laundry not coming back clean and the towels are still dirty.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program.	Technical Assistance Provided
303.	An incarcerated person reported a concern related to the behavior of DOC staff members.	The incarcerated person has not yet sufficiently escalated the concern through the DOC Resolution Program. The OCO provided technical assistance regarding staff conduct concerns.	Technical Assistance Provided
304.	Person reported that they need two hearing aids but DOC will only give them one.	The OCO provided technical assistance about the resolution program.	Technical Assistance Provided
305.	Person shared concerns about the food.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC resolution program. The OCO provided technical assistance about using the resolution program.	Technical Assistance Provided
306.	Person reports that their time calculations are incorrect.	The OCO provided technical assistance about the DOC records correction process.	Technical Assistance Provided
307.	Person reports concerns about access and availability of Medication Assisted Treatment (MAT) in DOC prisons.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about next steps for resolution within DOC prior to OCO involvement.	Technical Assistance Provided
308.	Person reported concerns about different brands of soap.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC resolution program. The OCO provided technical assistance about using the resolution program.	Technical Assistance Provided
309.	Incarcerated person had questions about the OCO office and requested information about legal access.	The OCO provided technical assistance over the OCO hotline. The OCO shared information about the OCO and provided details about how to access the law library at the facility and how to access other legal services on his tablet.	Technical Assistance Provided

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 case-specific or individualized 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.
Technical Assistance Provided	The OCO provided the individual with self-advocacy information.

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

Abbreviations & Glossary

ADA: Americans with Disabilities Act

AHCC: Airway Heights Corrections Center

ASR: Accommodation Status Report

BOE: Behavioral Observation Entry

CBCC: Clallam Bay Corrections Center

CCCC: Cedar Creek Corrections Center

CI: Correctional Industries

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

CO: Correctional Officer

CRC: Care Review Committee

CRCC: Coyote Ridge Corrections Center

CUS: Correctional Unit Supervisor

DES: Department of Enterprise Services

DOSA: Drug Offender Sentencing Alternative

EFV: Extended Family Visit

ERD: Earned Release Date

GRE: Graduated Reentry

HCSC: Headquarters Community Screening Committee

HSR: Health Status Report

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

J&S: Judgment and Sentence

MCC: Monroe Correctional Complex

MCCCW: Mission Creek Corrections Center for Women

OCC: Olympic Corrections Center

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

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

SCCC: Stafford Creek Corrections Center

SOTAP: Sex Offender Treatment and Assessment Program

SVP: Sexually Violent Predator

TC: Therapeutic Community

WaONE: Washington ONE ("Offender Needs Evaluation")

WCC: Washington Corrections Center

WCCW: Washington Corrections Center for Women

WSP: Washington State Penitentiary

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-011

Report to the Legislature

As required by RCW 72.09.770

January 13, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

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Unexpected Fatality Review Committee Report

UFR-24-011 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

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

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on December 5, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Patricia Paterson, Chief of Nursing
- Mark Eliason, Deputy Assistant Secretary
- Dr. Ryan Quirk, Director – Behavioral Health
- Dr. Zainab Ghazal, Administrator
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Program Manager
- Rochelle Stephens, Men's Prisons project Manager

DOC Risk Mitigation

- Mick Pettersen, Director

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Christopher Chen, Associate Medical Director

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

Fatality Summary

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

Date of Incarceration: November 2022

Date of Death: June 2024

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

The cause of death was hanging. The manner of death was suicide.

A brief timeline of events on the day of the incarcerated individual's death:

Events on the Day of Death
• A custody officer was informed by an incarcerated individual that the deceased incarcerated individual was actively self-harming. • Emergency radio call made. • Custody officers entered the cell and began rendering aid. • Medical staff arrived and assumed care. • Community emergency medical services arrived and assumed care. • Community emergency medical services pronounced the incarcerated individual deceased.

UFR Committee Discussion

The UFR committee met to discuss the findings and recommendations from the DOC Mortality Review Committee and the DOC Critical Incident Review. The UFR committee considered the information from both reviews in formulating recommendations for corrective action.

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

    1. The committee found the incarcerated individual:

        a. Received both 1:1 and group mental health treatment and support including medication.

        b. Had several suicidal attempts throughout their lifetime and openly discussed their suicidal desire, rationale and plans.

c. Consistently denied feeling suicidal in 2024.

d. Requested a Do Not Resuscitate (DNR) status* in the event of having no pulse and not breathing, in accordance with their religious beliefs.

e. Requested their DOC identification badge be updated to include their DNR status.

*Per DOC Policy 620.010 Advance Directives, individuals may, at any time, sign a health care directive outlining their wishes with regard to treatment, including life sustaining treatment. Policy states the health care directive would not apply in the event of self-harm.

2. The committee recommended:

a. The DOC identification badge DNR flag language be updated to include "Does not apply in instances of self-harm."

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

1. The CIR found:

a. Responding officers stopped and resumed life saving measures because of confusion caused by the do not resuscitate (DNR) flag on the ID badge.

b. Exterior cell window coverings created a safety and security concern, making it difficult for staff to observe the individual.

2. The CIR recommended:

a. Message DOC staff to clarify that the DNR request does not apply to self-harm events per Policy 620.010 Advance Directives.

b. Distribute directive to prevent full coverage of windows that block all light out of the cells.

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

1. Emergency Response:

During this event, DOC responders stopped and then resumed life saving measures due to confusion caused by a Do Not Resuscitate (DNR) flag on the incarcerated individual's identification (ID) badge. The DOC Chief Medical Officer followed-up immediately to ensure staff are trained to provide life saving measures after a self-harm event. The committee appreciated that the DNR flag language will be added to the badges.

The committee discussed the location and availability of equipment used to remove ligatures. The DOC standard equipment is kept in every living unit's control booth and is only accessible by staff for safety reasons. The location within the control booth is determined at the facility level. The committee recommends a refresher to custody staff on appropriate use and location of the equipment to ensure functionality and ready access during emergencies.

2. Suicide Risk Assessment:

   DOC provided a summary of the suicide risk assessment process which determines the level of risk of self-harm/suicide for the individual and the necessary response to that risk including housing assignments. If an incarcerated individual is determined to be at imminent risk, they would be placed under close observation in a highly restrictive close observation area (COA) environment which may be perceived as punitive. Residential treatment units (RTU) are housing options for individuals who need additional mental health support and are determined to not be at imminent risk of self-harm. The committee discussed opportunities for RTU versus COA units and the efficacy of the current suicide risk assessment tool.

   The committee discussed the incarcerated individual periodically discontinuing their medications, the follow-up and support provided by clinical staff. They had a medication management appointment five days prior to their death and weekly meetings with their counselor.

3. Incident Follow-up:

   The committee discussed the mental health staff offered immediate and ongoing support to incarcerated individuals following the death.

Committee Findings

The incarcerated individual died as a result of hanging. The manner of death was suicide.

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. DOC should remind custody staff of appropriate use and location of the ligature removal tool.
2. DOC should provide clarification to staff that the DNR request does not apply to self-harm events per Policy 620.010 Advance Directives.

3. DOC should direct staff to ensure cell windows are not fully covered.
4. DOC should update the identification badge DNR flag language to include “Does not apply in instances of self-harm.”

Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-24- 011

Report to the Legislature

As required by RCW 72.09.770

January 23, 2025

DOC Corrective Action, Publication Number 600-PL001

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

Unexpected Fatality Review
DOC Corrective Action Plan

DOC Corrective Action Publication Number 600-PL001

Legislative Directive

Engrossed Substitute Senate Bill 5119 (2021)

Unexpected Fatality Review Governance

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

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

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

Unexpected Fatality Review Committee Report

The department issued the UFR committee report 24-011 on January 13, 2025 (DOC publication 600-SR001). This document includes the required corrective action plan. The department is required to implement the corrective actions within 120 days from the corrective action plan publication.

Corrective Action Plan

CAP ID Number:	UFR-24-011-1
Finding:	The new unit control booth officer did not know where the ligature removal tool was stored.
Root Cause:	Lack of training and orientation for new control booth custody staff on ligature removal equipment.
Recommendations:	DOC should remind custody staff on appropriate use and location of the ligature removal tool.
Corrective Action:	DOC will evaluate standardized storage of ligature removal devices in unit control booths to increase accessibility.
Expected Outcome:	Decreased time to respond in the event of a ligature.

CAP ID Number:	UFR-24-011-2
Finding:	Responding staff paused lifesaving efforts while seeking clarification on DNR applicability.
Root Cause:	DOC has not provided training to staff on providing lifesaving measures during a self-harm event when the incarcerated individual has requested a DNR.
Recommendations:	DOC provide clarification to staff that the Do Not Resuscitate (DNR) request does not apply to self-harm events per Policy 620.010 Advance Directives.
Corrective Action:	DOC will issue a memo directing all staff to provide lifesaving measures when there is a self-harm event regardless of DNR status.
Expected Outcome:	Improved response to incarcerated individuals during a self-harm event.

CAP ID Number:	UFR-24-011-3
Finding:	Responding staff paused lifesaving efforts while seeking clarification on DNR applicability.
Root Cause:	DOC has not provided training to staff on providing lifesaving measures during a self-harm event when the incarcerated individual has requested a DNR.
Recommendations:	DOC should update the identification badge DNR flag language to include “Does not apply in instances of self-harm.”
Corrective Action:	DOC will update the identification badge DNR flag language to include “Does not apply in instances of self-harm.”

Expected Outcome:	Improved response to incarcerated individuals during a self-harm event.
CAP ID Number:	UFR-24-011-4
Finding:	Exterior cell window coverings created a safety and security concern, making it difficult for staff to observe the individual.
Root Cause:	Staff did not require the exterior cell window coverings to be removed in accordance with WAC 137-25-030.
Recommendations:	DOC should direct staff to ensure cell windows are not fully covered.
Corrective Action:	DOC will provide direction to staff regarding covering of cell windows.
Expected Outcome:	Improved safety, security and visibility.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-012

Report to the Legislature

As required by RCW 72.09.770

January 27, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Tim Lang, Secretary
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Unexpected Fatality Review Committee Report

UFR-24-012 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.

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on December 12, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary
- Dr. Rae Simpson, Director - Quality Systems
- Brooke Amyx, Health Services Reentry Administrator
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Program Manager

DOC Risk Mitigation

- Mick Pettersen, Director

DOC Reentry Division

- Sarah Sytsma, Deputy Assistant Secretary - Reentry
- Michelle Eller-Doughty, Reentry Center Operations Administrator

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Judy Zerzan, Medical Director

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

Fatality Summary

Year of Birth: 1988 (36-years-old)

Date of Incarceration: February 2024

Date of Death: July 2024

At the time of death, this incarcerated individual was housed in a community reentry center. His death occurred at his place of employment.

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

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

Days Prior to Death	Event
41 days prior	• He was transferred to a community reentry center.
Day of Death	**Event**
0 days	• Employer notified the reentry center that he was found unresponsive and pronounced deceased by community emergency services.

UFR Committee Discussion

The UFR committee met to discuss the findings and recommendations from the DOC Mortality Review Committee and the DOC Critical Incident Review. The UFR committee considered the information from both reviews in formulating recommendations for corrective action.

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

1. The committee found:

    a. He resided in a prison setting for approximately three months prior to transfer.

    b. He did not have substance use disorder (SUD) treatment as a court ordered condition of his sentence and did not receive a substance use assessment prior to transfer.

    c. Documentation demonstrated he provided contradictory medical history related to previous diagnoses and treatment.

    d. He did not engage in supportive medical care and chose not to continue his previously

prescribed medications.

e. He declined assistance with establishing a primary provider in the community and obtaining appointments for medications for opioid use disorder (MOUD) and follow-up of self-reported health conditions.

f. He was provided a copy of his DOC Community Provider Continuity of Care Report prior to transfer.

g. He was covered by Apple Health.

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

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

1. The CIR found:

a. Case management focused on his employment and residential needs areas and the substance use and mental health needs were not addressed.

b. There was no documentation that he received a urinalysis the month prior to his death.

2. The CIR recommended:

a. Case management should prioritize mental health and substance use disorder treatment and programming needs before employment searches.

b. Case management should direct individuals to get appointments for treatment with a due date, and to follow up with the resident on or about the due date and document follow-up in the electronic record.

c. Reentry leadership should review standard practice for the number of drug tests required and ensure written directive of the minimum standards per resident is provided statewide.

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

1. Addiction care screening and treatment:

DOC discussed planned updates to the addiction care screening tool to encourage incarcerated individuals to accurately report their substance use history. The committee members supported revising the tool.

The committee discussed the current medication administration process including communication requirements for discontinuing a medication.

DOC also discussed the additional staffing resources for the Health Services reentry team to support individuals with substance use disorder (SUD) during the reentry period.

The committee discussed addiction recovery support for individuals residing in a DOC Reentry center.

- Based on a resident's assessed needs, they will be referred to a community provider for assessment and recommended treatment.
- Reentry Centers accept and support residents who have been prescribed medications per section 5 of Policy 610.300 Health Services for Work Release Offenders.
- The Health Services reentry team coordinates with Apple Health and the community pharmacy to obtain medication prior authorization when needed.
- Reentry center staff follow the DOC Pharmaceutical Management and Formulary Manual to determine if a medication is allowed to be kept by the incarcerated individual.
- Prior to his death, this individual declined SUD treatment.

Committee Findings

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

Committee Recommendations

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

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-015

Report to the Legislature

As required by RCW 72.09.770

January 10, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
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Unexpected Fatality Review Committee Report

UFR-24-015 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

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

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on December 19, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Shane Evans, Administrator
- Mark Eliason, Deputy Assistant Secretary
- Patricia Paterson, Chief of Nursing
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Rochelle Stephens, Men's Prisons project Manager

DOC Risk Mitigation

- Michael Pettersen, Director

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Karen Pastori, Health Services Consultant, Prevention and Community Health

Health Care Authority (HCA)

- Dr. Judy Zerzan, Medical Director

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

Fatality Summary

Year of Birth: 1982 (42-years-old)

Date of Incarceration: March 2019

Date of Death: September 2024

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

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

A brief summary of events on the day of the incarcerated individual's death:

Events on Day of Death
• The incarcerated individual is observed leaving his cell and entering the shower room. • Other incarcerated individuals enter the shower room bathroom and heard an unusual noise coming from the deceased individual's shower stall. • An incarcerated individual who heard the noise knocks on the shower stall door and receives no response twice. He then notified a custody officer of his concern. • The custody officer made a radio call for assistance and entered the bathroom with a second officer and found the deceased incarcerated individual unresponsive. • The officers removed him from the shower stall and administered aid. • Medical staff arrived and assumed care. • Community emergency medical services arrived, assumed care and transported him to the community hospital. • He was pronounced deceased by the community hospital.

UFR Committee Discussion

The UFR committee met to discuss the findings and recommendations from the DOC Mortality Review Committee and the DOC Critical Incident Review. The UFR committee considered the information from both reviews in formulating recommendations for corrective action.

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

1. The committee found:

    a. He received recommended health screenings and immunizations.

    b. He was seen for problem focused medical care and no care gaps were identified.

    c. His symptoms and care needs were addressed, and he did not present with symptoms of heart failure.

    d. He may have had an unknown inherited condition/genetic predisposition that led to his heart enlargement found during the autopsy.

2. The committee recommended:

    a. A referral to the Unexpected Fatality Review committee.

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

1. The CIR found:

    a. The red emergency response bag was used for emergency response training earlier in the day and was not inventoried and restocked prior to being placed back in use which violates DOC Policy 890.620 Emergency Medical Treatment and DOC Nursing Protocol N-3100 Red Emergency Response Bag.

2. A root cause analysis (RCA) was conducted for the findings of the CIR and determined:

    a. The findings did not directly correlate to the cause of death and will be remediated per DOC policy 400.110 Critical Incident Reviews.

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

1. Red Emergency Response Bags (Red Bags):

    Committee members expressed concern that the red bag was not restocked after use earlier in the day. DOC Health Services currently has a nursing protocol directing red bags be restocked and sealed after each use, inventoried monthly, and a log be maintained to document compliance. While it is not contributory to this death, committee members agree it is essential to have necessary supplies available during an emergency medical response. The committee recommends Health Services review and update the current protocol and educate staff to increase compliance.

2. Genetic conditions:

    This sudden death may have been related to a heritable genetic condition. DOC Health Services

has provided information to the family about how to request genetic testing.

Committee Findings

The incarcerated individual died as a result of cardiac dysrhythmia due to dilated cardiomyopathy. The manner of death was natural.

Committee Recommendations

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

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

1. The committee recommends Health Services review and update the current red bag nursing protocol to ensure restocking the red bag is completed following emergency drills and educate staff to increase compliance.