Office of the Corrections OMBUDS

Monthly Outcome Report

December 2024

Unexpected Fatality Reviews: 2

Case Investigations: 139

Assistance Provided: 22
Information Provided: 56
DOC Resolved: 13
Insufficient Evidence to Substantiate: 12
No Violation of Policy: 34
Substantiated: 2

Intake Investigations: 103

Administrative Remedies Not Pursued: 0
Declined: 0
Lacked Jurisdiction: 5
Person Declined OCO Assistance: 20
Person Released from DOC Prior to OCO Action: 3
Technical Assistance Provided: 75

Resolved Investigations:

244

Assistance Provided, Information Provided, or Technical Assistance Provided in

63%

of Investigations

OCO Casework Highlights

December 2024

Assistance Provided

Reported Concerns: Person reports that they were not given a health status report (HSR) after experiencing a lower extremity injury. Due to not being moved to appropriate housing, the patient experienced additional injury.
OCO Actions: OCO staff reviewed the patient's records and noted patient education for use of ordered durable medical equipment (DME) was not documented. OCO staff contacted DOC health services staff and requested that patient education be prioritized with injuries requiring the use of DME. OCO staff noted that the requested health status report (HSR) is not currently supported by criteria. OCO staff asked DOC to add lower extremity injuries to the HSR criteria and asked the facility to purchase additional tools to aid in patient education in the use of durable medical equipment.
Negotiated Outcomes: After OCO outreach, DOC confirmed that updates to the HSR protocol are in progress and agreed to purchase additional tools for patient education regarding DME.

Assistance Provided

Reported Concerns: An incarcerated individual's family members applied for an Extended Family Visit at the same time. However, some members of the family were approved while the remaining family members' application had not been responded to by the DOC. The family members and incarcerated individual attempted to resolve the concern through the appropriate communication channels at both the facility and headquarters level before requesting assistance from the OCO.
OCO Actions: The OCO contacted DOC headquarters staff and inquired about the status of the remaining family members' application.
Negotiated Outcomes: After the OCO inquiry, headquarters staff and facility staff worked together to locate and approve the application. The incarcerated individual and family members are now approved for Extended Family Visits.

Assistance Provided

Reported Concerns: An individual reports that DOC moved him out of the transfer pod and placed him back in the IMU because of recent negative behavior observation entries (BOE). This person had not received any copies of his BOEs and was unaware of the write-ups. Part of the individual's concern is that he cannot appeal a BOE if he does not know it exists.
OCO Actions: The OCO contacted DOC and asked if they would provide the individual with copies of his recent negative BOEs.
Negotiated Outcomes: After OCO outreach, the DOC agreed and provided the individual with the requested copies.

Assistance Provided

Reported Concerns: Incarcerated individual relayed concerns regarding placement in solitary confinement due to an infraction he did not commit.
OCO Actions: The OCO reviewed the infraction materials and had questions regarding the guilty finding. The OCO contacted facility leadership and asked for a new review. Additionally, this office contacted the DOC headquarters to see if the individual can be removed from the MAX program.
Negotiated Outcomes: After OCO outreach, the DOC reviewed the case and agreed to dismiss the infraction.

Assistance Provided

Reported Concerns: Incarcerated individual relayed concerns regarding not being able to read or write and needing assistance with this.
OCO Actions: The OCO contacted DOC about this concern.
Negotiated Outcomes: At OCO request, assistance for reading and writing for this individual was brought before the accommodation review committee (ARC). After the ARC meeting, the OCO confirmed that the individual was approved for C-Reader pen that when dragged over words reads the text aloud. The OCO informed the individual that they were not approved for an access assistant for writing due to their placement in IMU as this poses a safety concern and informed the individual that once they are at a lower custody level, they can reapply with the ARC.

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 24-014: The Unexpected Fatality Review Committee reviewed the unexpected death of a 58-year-old person in August 2024. The Unexpected Fatality Review Committee Report dated December 13, 2024 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: December 2024

Complaint Summary	Outcome Summary	Case Closure Reason
Unexpected Fatality Reviews		
Airway Heights Corrections Center		
1. Incarcerated individual died 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-24-014 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The UFR Committee recommended that DOC continue exploring ways to work with community hospitals to support incarcerated individuals.	Unexpected Fatality Review
GRE/CPA		
2. Incarcerated individual died while on Graduated Reentry (GRE).	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-24-010 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The UFR Committee recommended that DOC should continue to advocate for resources to expand Medication Assisted Treatment (MAT).	Unexpected Fatality Review
Case Investigations		
Airway Heights Corrections Center		
3. External person reports that DOC did not schedule an urgent procedure for an incarcerated individual.	OCO staff provided assistance. OCO staff substantiated there was an administrative error that prevented the patient from attending the scheduled procedure. OCO staff contacted DOC staff and were informed that corrective action was taken. OCO staff also verified that the procedure has taken place. OCO staff will continue to monitor the progress of the steps being taken by the DOC to mitigate this issue in the future.	Assistance Provided
4. Incarcerated person reported concerns about access to Graduated Reentry (GRE) and had concerns with DOC denying them access to this program.	The OCO provided assistance by identifying errors in the approval process. After identifying the errors, DOC agreed to re-review the person's Graduated Reentry (GRE) eligibility. Although DOC's GRE determination remained the same after outreach, the OCO verified the person received and	Assistance Provided

		understood the reasons for the GRE denial, and options they have to be considered for a Reentry Center after their programming is complete.	
5.	External person reported concerns about errors in an incarcerated person's file. The external and incarcerated person requested the errors be corrected by DOC but the issue was not fully resolved.	The OCO provided assistance. The OCO spoke with numerous DOC staff and asked that the person's file be reviewed and have any errors resolved. As a result of OCO outreach, the DOC identified and removed minor errors. The OCO was unable to substantiate the file errors resulted in negative impact toward the person or their access to medical care, jobs or programming. The OCO recommends incarcerated people utilize the resolution program and appeal their responses to the third level requesting the department resolve any errors identified in their file.	Assistance Provided
6.	Incarcerated individual relayed concerns regarding placement in segregation.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that they have been released from segregation by DOC prior to OCO involvement.	DOC Resolved
7.	Person reports experiencing new symptoms related to a chronic condition and he is concerned that nothing will be done to relieve them.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff reviewed the patient's records and found the patient had been treated for the reported symptoms soon after reporting the issue to the OCO.	DOC Resolved
8.	Person reports that he is in need of the next phase of treatment that has not yet been scheduled.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff reviewed the person's consults and found the specialist had ordered advanced imaging prior to the start of the requested treatment. OCO staff monitored the patient's consults until the requested treatment was completed and verified that follow up will be scheduled as requested by the specialist.	DOC Resolved
9.	An individual reports that Airway Heights has enacted a new memorandum 590.100 attachment 3 which requires family members to throw away all food they bring to an extended family visit (EFV) and do not use.	The DOC resolved this concern prior to the OCO's involvement. This office reviewed the individual's resolution request and DOC staff told this person that facility memorandum 590.100 attachment 3 has been suspended.	DOC Resolved
10.	Incarcerated individual shared concerns regarding DOC passing them up on a job selection for a scheduling conflict but selecting someone else with the same circumstances.	The OCO provided information regarding the job selection process and why they were not selected for the position. The OCO was unable to substantiate any staff misconduct in this incident as the position they were attempting to obtain was a full-time position, and they had scheduled programming they could not miss. The OCO encouraged this individual to work with their counselor to attempt to obtain a job.	Information Provided
11.	Incarcerated individual shared concerns regarding DOC not providing them with proper medical care and purposefully misconstruing their resolution request on the matter.	The OCO was able to confirm that this individual has been provided with extensive medical care and is currently completing a treatment plan outlined by DOC medical staff. This office informed this individual that they can reach out to this office if DOC fails to provide them with the care they have requested. This office was unable to substantiate any staff misconduct within the resolution request received.	Information Provided

12.	Incarcerated individual shared concerns regarding DOC staff damaging their property.	The OCO was unable to substantiate the concern due to insufficient evidence. Upon reviewing documents relevant to this concern, there is no definitive evidence that points to DOC staff or this individual damaging their glasses. This office provided information regarding how to file a tort claim to request reimbursement for their damaged glasses.	Insufficient Evidence to Substantiate
13.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
14.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
15.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
16.	Person reports their provider changed his medications without meeting with him first. The patient is requesting to return to his regular treatment.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed the patient's records and the DOC formulary and pharmaceutical management manual. OCO staff confirmed that the patient was not compliant with all aspects of the treatment and the provider documented that this presented a risk to the patient. OCO staff confirmed this is within the exceptions named in the pharmaceutical management manual. OCO staff verified the patient was able to meet with his provider and was returned to his treatment plan.	No Violation of Policy
Cedar Creek Corrections Center			
17.	An incarcerated Individual's family members applied for an Extended Family Visit at the same time. However, some members of the family were approved while the remaining family members' application had not been responded to by the DOC. The family members and incarcerated individual attempted to resolve the concern through the appropriate communication channels at both the facility and headquarters level before requesting assistance from the OCO.	The OCO provided assistance. The OCO contacted DOC Headquarters staff and inquired about the status of the remaining family members' application. After the OCO inquiry, headquarters staff and facility staff worked together to locate and approve the application. The incarcerated individual and family members are now approved for Extended Family Visits.	Assistance Provided
18.	Incarcerated individual relayed concerns regarding staff not addressing their concerns in their grievances.	The OCO reviewed approximately one dozen of the individual's most recent grievances and confirmed there was no violation of DOC policy as the grievances have been properly addressed and responded to in an appropriate timeframe. The OCO informed the individual that they can review the resolution program manual to see what things can be grieved and what things must be appealed such as infractions and custody facility plans (CFPs).	No Violation of Policy
19.	Incarcerated individual relayed concerns regarding being	The OCO reviewed the individual's records and confirmed the individual is housed at a camp facility and not a residential	No Violation of Policy

	terminated from their job and being transferred to a residential housing unit.	housing unit. The OCO also confirmed that the individual was transferred to another facility for more programming and work opportunities as due to their earned release date (ERD), their options were very limited at their previous facility.	
Clallam Bay Corrections Center			
20.	Incarcerated individual reports they have safety concerns and the DOC keeps placing them in general population. They attempted to debrief; however, they were given a MAX program. They are releasing in December and do not want to release from solitary confinement.	The OCO reviewed the case and contacted DOC Headquarters regarding the debrief packet. This office found that the packet was never forwarded to the correct DOC staff. The OCO requested for the packet to be sent again, and it was, however the safety placement was still denied. The individual has now released from solitary confinement into the community.	Assistance Provided
21.	Incarcerated individual relayed concerns regarding wanting to be placed in safe harbor.	The OCO reviewed the individual's records and confirmed that the individual has been placed in safe harbor housing by DOC prior to OCO involvement.	DOC Resolved
22.	A loved one reports concerns about the safety of an individual who is being threatened by other incarcerated individuals.	The OCO reviewed the individual's current housing placement and determined this person was placed in segregation for protective custody and then was moved to a different unit. This individual can request a keep separate from their counselor if they feel threatened by other incarcerated individuals and may request a facility transfer at their next custody facility plan (CFP).	Information Provided
23.	Person reports he is currently on a MAX program and was brought to segregation under investigation for a staff assault at a different facility but was not infracted. He said he is being punished for something he did not do.	The OCO reviewed this individual's MAX placement, custody facility plan, and infraction history, then contacted the DOC Classifications for further information. This office attempted to negotiate a resolution to this concern. However, the DOC maintains that this individual's security threat group ties and past behavior create a security risk while housed in the general population.	Information Provided
24.	Incarcerated individual relayed concerns regarding a 603 infraction for drug possession that has resulted in their inability to use the phone.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements. The OCO informed the individual that per DOC policy 460.050, a loss of all telecommunication privileges is a sanction for a 603 infraction.	No Violation of Policy
25.	Incarcerated individual relayed concerns regarding staff not allowing them to attend their administrative segregation (ad-seg) hearing.	The OCO was able to substantiate this concern. The OCO reviewed the individual's records and confirmed the documented reason why the individual was not allowed to go to the ad-seg hearing was because they were on a security enhancement plan. The OCO spoke to facility leadership and confirmed that the individual should have been allowed to go to the ad-seg hearing. The OCO is in further conversations with DOC about this, to ensure that individuals are able to attend their hearings.	Substantiated
26.	Person reports he did not receive appropriate treatment following surgery.	The OCO was able to substantiate this concern. OCO staff reviewed the person's medical records and substantiated that recommendations for treatment were not carried out in the timeframe required. OCO staff provided the patient with	Substantiated

		tort claim information. The OCO will continue to monitor this type of concern.	
Coyote Ridge Corrections Center			
27.	Incarcerated individual relayed concerns regarding not being able to appeal an infraction.	The OCO reviewed the concern and asked DOC if they would be willing to accept an appeal at this time. Upon OCO request, DOC agreed and the OCO informed the individual that they will need to get the appeal paperwork from the hearings department.	Assistance Provided
28.	A loved one reports that her family member is very old and was supposed to be released from prison, but instead, additional time was added to his sentence because the indeterminate sentence review board (ISRB) would like him to participate in programming.	The OCO reviewed the individual's records and contacted DOC about this concern. This office verified that DOC has added his name to the waitlist for substance use disorder (SUD) programming.	DOC Resolved
29.	Person reported that they never received the treatment that DOC agreed to provide in a previous OCO case, but only received a consult.	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 the treatment.	DOC Resolved
30.	Person reported that DOC is not refilling a prescription that he has refilled in the past.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reached out to DOC staff, who said that the provider determined that this prescription was only for short term treatment of his symptoms and could be harmful if used long term. The OCO confirmed with DOC staff and in DOC records that this individual is scheduled to meet with a specialist to determine the root cause of his medical problem.	DOC Resolved
31.	Incarcerated individual relayed concerns regarding an incident with staff that led to an infraction and placement in segregation.	The OCO reviewed the individual's placement in segregation, as well as infraction and grievance history. The OCO informed the individual that for the OCO to investigate staff conduct concerns, they must grieve it to at least a level 2 first and must appeal a guilty infraction finding first and receive the response from DOC. The OCO confirmed that the individual is in segregation due to threatening staff that resulted in the pending infraction. The OCO informed the individual that they will remain in IMU until the outcome of the infraction hearing per DOC policy 320.255.	Information Provided
32.	External person reported their loved one has been approved for special consideration in housing at a prior facility, but is not able to get that accommodation at his current facility.	The OCO provided information to the patient regarding how that housing request is handled in his current facility. The requested housing must be ordered by a medical provider and patients in that unit are continuously evaluated for changing needs.	Information Provided
33.	Incarcerated individual relayed concerns regarding their mail being taken and having to go to the Sergeant's office to put their DOC number on their mail.	The OCO reviewed the related grievance and confirmed that it did not reach a level 3 as required by the OCO prior to investigation. Thus, the OCO informed the individual that the grievance must be pursued internally before the OCO can investigate further. Per DOC policy 450.100, a DOC number must be written in ink upon receipt by the individual. There is	Information Provided

		no violation of policy by having an individual do this in the Sergeant's office.	
34.	Incarcerated individual relayed concerns regarding an incident with staff that led to an infraction and placement in segregation.	The OCO reviewed the individual's placement in segregation, as well as infraction and grievance history. The OCO informed the individual that for the OCO to investigate staff conduct concerns, they must grieve it to at least a level 2 first and must appeal a guilty infraction finding first and receive the response from DOC. The OCO confirmed that the individual is in segregation due to threatening staff that resulted in the pending infraction. The OCO informed the individual that they will remain in IMU until the outcome of the infraction hearing per DOC policy 320.255.	Information Provided
35.	Incarcerated individual relayed concerns regarding OCO getting them a resolution with DOC in a previous case but DOC not following through on what they said they were going to do.	The OCO spoke to DOC regarding this concern and provided the individual with information regarding what next steps they need to take.	Information Provided
36.	Person reports that DOC providers keep confusing his medical issues and treatments. The person is requesting a specialist consult, alternative treatment options, and for a procedure to be rescheduled.	The OCO provided information to the patient about his consult status. OCO staff reviewed the patient's records and contacted DOC staff. OCO staff verified the patient has active orders for medications for the reported issues. OCO staff monitored the patient's consultations until scheduling was verified for treatment and a new specialist consult.	Information Provided
37.	Incarcerated individual relayed concerns regarding receiving an infraction for refusing housing but said it was due to safety concerns.	The OCO spoke to DOC about this concern and requested that they dismiss the infraction. DOC was unwilling to overturn the infraction as the individual refused a lower bunk placement unless it was in a single cell.	Information Provided
38.	Incarcerated individual relayed concerns regarding the way in which a cell search was conducted.	The OCO reviewed the related grievance and confirmed that while the grievance was unsubstantiated, DOC agreed to provide a reminder to staff about how to properly conduct cell searches.	Information Provided
39.	An individual had a previous case with the OCO about legal financial obligations (LFO) and called to say that DOC did not follow through by crediting his money from the County Court.	The OCO followed up with DOC who reported that his refund from the County was applied to his account and no more LFOs are being deducted. If he has further questions regarding his banking information he can write to headquarters: DOC Headquarters - Trust Accounting, PO Box 41100, Olympia, WA 98504.	Information Provided
40.	Incarcerated individual shared concerns regarding DOC staff wrongfully infracting them and losing their job over the infraction.	The OCO was unable to substantiate the concern due to insufficient evidence. This individual received an infraction for possessing an item through unapproved channels and the infraction was written per DOC policy given the evidence. This individual was provided with the proper avenue to appeal the infraction, and the decision was upheld. To substantiate retaliation, the OCO must be able to prove that a negative action from a DOC staff member is not only linked close in time to an incarcerated individual's protected action but there must be evidence of a clear relationship between the two acts.	Insufficient Evidence to Substantiate

41.	Person reports that DOC did not treat an infection in a reasonable time. The person also stated they were supposed to have a follow up appointment that was never scheduled.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff reviewed the patient's consultations and resolution documents and were unable to confirm the person's reported diagnosis. OCO staff verified the person was offered treatment for the reported infection, which was declined by the patient. OCO staff confirmed the person was seen by his provider to discuss a different treatment option.	Insufficient Evidence to Substantiate
42.	Incarcerated individual relayed concerns regarding DOC putting an infraction into the system a day after the investigation was due, therefore violating their due process rights.	The OCO reviewed the individual's disciplinary history and informed the individual that WAC 137-28-400 states “the time limitations expressed in these regulations are not jurisdictional and failure to adhere to any particular time limit shall not be grounds for reversal or dismissal of a disciplinary proceeding.”	No Violation of Policy
Mission Creek Corrections Center for Women			
43.	Incarcerated person reported concerns regarding access to a specific program. She reported concerns about the programming impacting her access to a Reentry Center.	The OCO provided information about the person’s situation to them. The OCO spoke with numerous DOC staff to verify that she is required to complete the programming prior to transfer to a Reentry Center. The OCO verified the person is going to begin the required programming soon. The OCO shared that there is a possibility of transfer to a Reentry Center depending on when she completes the required programming.	Information Provided
Monroe Correctional Complex			
44.	An individual reports that DOC moved him out of the transfer pod and placed him back in the IMU because of recent negative behavior observation entries (BOE). This person had not received any copies of his BOEs and was unaware of the write-ups. Part of the individual's concern is that he cannot appeal a BOE if he does not know it exists.	The OCO contacted DOC and asked if they would provide the individual with copies of his recent negative BOEs. The DOC agreed and provided the individual with the requested copies.	Assistance Provided
45.	Incarcerated individual relayed concerns regarding placement in solitary confinement due to an infraction he did not commit.	The OCO reviewed the infraction materials and had questions regarding the guilty finding. The OCO contacted facility leadership and asked for a new review. The DOC reviewed the case and agreed to dismiss the infraction. This office then contacted the DOC Headquarters to see if the individual can be removed from the MAX program.	Assistance Provided
46.	A community member anonymously reported that the many leaders of prominent Jewish organizations will not be permitted to attend the Hannukah celebration. They said many of these community members were allowed to attend last year.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reached out to facility staff and discussed this concern. Facility staff shared how many family members, friends, and community leaders would be attending and discussed how things differ from previous years. The OCO found that the community leaders the group most wanted to attend were approved prior to OCO contact, while accommodating the safety and security needs of the facility.	DOC Resolved

47.	Incarcerated individual relayed concerns regarding difficulties getting two particular grievances investigated.	The OCO reviewed the two grievances and confirmed that one was investigated, and the response was provided to the individual, and for the second grievance, the individual requested it be withdrawn.	DOC Resolved
48.	Incarcerated individual relayed concerns regarding an infraction where the time the urinary analysis (UA) was taken and the time on the lab report conflict.	The OCO reviewed the infraction materials and sought clarification from DOC regarding this. DOC stated that because the lab results were solely for secondary confirmation purposes as the UA results were positive at the facility, despite the time differentiations, DOC was unwilling to dismiss the infraction.	Information Provided
49.	An incarcerated individual reports he wants a keep separate order removed and has followed the process by having his counselor submit the correct DOC form. However, the keep separate still stands, and he does not understand why.	The OCO provided information about the keep separate process. This office verified that DOC 17-087 was submitted, but the removal was denied and the keep separate will remain in place. During this person's next custody facility plan review, he can talk to his counselor about this issue again.	Information Provided
50.	Person reports that DOC is not honoring their gender preference request when it comes to DOC strip searching them.	The OCO spoke with DOC staff who confirmed female officers will not be involved in this individual's strip searches. DOC staff report they are making recommendations to change the language for policy 420.310 specifically around DOC 02-420 Preference Request. The current policy also says that the Superintendent/Designee can deny a request which means they can terminate an existing approved preference request.	Information Provided
51.	Person reported concerns that DOC is not keeping him separate from someone he has safety concerns with.	The OCO provided information about reporting concerns to unit staff. The OCO reviewed DOC records and reached out to staff, who verified that he is appropriately housed per policy.	Information Provided
52.	Incarcerated individual reports that DOC says they work to rebuild families yet repeatedly refuse to transfer him to a facility where his family can visit.	The OCO confirmed that the individual lost custody points from multiple infractions and was transferred to another facility across the state. The OCO provided information about how this person can appeal their next custody facility plan (CFP) decision if they are not transferred to a prison closer to their family.	Information Provided
53.	Incarcerated individual relayed concerns regarding being retaliated against for filing grievances by getting infractions.	The OCO reviewed the individual's disciplinary record and confirmed that two were dismissed and found no violation of DOC policy 460.000 for the third infraction as the infraction elements are met. The OCO informed the individual that if there are other concerns outside of infractions regarding staff conduct, they will need to be grieved to a level 2.	Information Provided
54.	Person reports that he was supposed to have medical treatment continued after coming into DOC custody. Person stated he was told it was approved but has not been scheduled.	The OCO provided information to the person regarding their active consults. OCO staff verified the requested appointment is scheduled. OCO staff will continue to monitor other consults on the appointment tracker until they are confirmed to be scheduled.	Information Provided
55.	Incarcerated individual relayed concerns regarding not getting graph books that were sent in to them.	The OCO spoke to DOC about this and confirmed that the individual and their family/friends have been ordering hobby craft and commissary items via the mailroom, but these items are not processed via the mailroom. DOC policy	Information Provided

		450.100 states that packages are not to be processed and delivered by the mailroom. They are to be received and signed for by recreation staff or the chaplain who issues the items.	
56.	Person reports he needs advanced imaging and pain management for an ongoing health concern.	The OCO provided information to the patient. OCO staff reviewed the specialist consult recommendations. OCO staff contacted DOC Health Services staff to confirm access to pain management. OCO staff verified the patient has the pain management treatment available that was recommended by the specialist. OCO staff verified the person attended their requested imaging appointment.	Information Provided
57.	The individual reports that DOC is retaliating against him by delaying his PREA investigations and refusing to give him an appeal form after he was found guilty of an infraction.	The OCO has another open case regarding PREA investigations related to this person. This office provided information that appeals can be written on regular paper, not just the form, and incarcerated individuals may request the form from other DOC staff members, not just the hearings officer.	Information Provided
58.	Incarcerated individual relayed concerns regarding a particular staff member they are having difficulties with.	The OCO reviewed the individual's grievance history and found no grievances had been filed regarding this staff member. The OCO informed the individual that for the OCO to investigate concerns about staff conduct, they must be grieved to at least a level 2. The OCO also reviewed the related PREA that was deemed unfounded as the individual could not provide any examples of the original allegations and admitted that their original report was not the truth.	Insufficient Evidence to Substantiate
59.	Incarcerated individual relayed concerns regarding a particular staff member they are having difficulties with.	The OCO reviewed the individual's grievance history and found no grievances had been filed regarding this staff member. The OCO informed the individual that for the OCO to investigate concerns about staff conduct, they must be grieved to at least a level 2. The OCO also reviewed the related PREA that was deemed unfounded as the individual could not provide any examples of the original allegations and admitted that their original report was not the truth.	Insufficient Evidence to Substantiate
60.	Person reports that she was injured after being assaulted in the shower last year by the quick response strike team (QRST).	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO has another case open for this person regarding the use of force incident from last year. This office reviewed the resolution request related to this concern and DOC staff reported this individual was assessed after the incident and had no injuries.	Insufficient Evidence to Substantiate
61.	Incarcerated individual relayed concerns regarding wanting to have an infraction dismissed and moving facilities due to safety concerns.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements. The OCO confirmed the individual had a special housing assignment so they should not be having safety concerns, but informed the individual that if they are having safety concerns, they will need to express those to their counselor so they can get to the intelligence and investigations unit for verification.	No Violation of Policy
62.	Incarcerated individual relayed concerns regarding an infraction for an individual being out of bounds.	The OCO reviewed the infraction materials and asked DOC if they were willing to dismiss the infraction as it appears there was no intention to go in the sally port, just confusion about what door to enter on behalf of the individual. However, DOC was unwilling to dismiss the infraction as there is a yellow	No Violation of Policy

		line indicating out of bounds prior to entry into the door, thus the "some evidence" standard utilized by DOC is met.	
63.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and asked DOC if they were willing to dismiss the infraction as it appears there was no involvement in a fight or allowing individuals to go out of bounds. However, DOC was unwilling to dismiss the infraction as per the WAC handbook, attempting or conspiring to commit one of the following violations, or adding and abetting another to commit one of the violations, shall be considered the same as committing the violation.	No Violation of Policy
64.	Individual reports they were kicked out of SOTAP programming based on the testimony of someone who is unreliable.	The OCO reviewed the individual's records related to the SOTAP discharge and found no violation of DOC policy 570.000 as the discharge was due to not meeting expectations and engaging in problematic behavior. This office verified that the individual appealed the initial discharge but the decision was upheld. This person can request to be screened for SOTAP again after their next board hearing.	No Violation of Policy
65.	Incarcerated individual relayed concerns regarding DOC violating their health status report (HSR) by making them work which resulted in an infraction.	The OCO reviewed the infraction materials and spoke with several DOC staff members including medical regarding the HSRs. Regarding the infraction, the OCO found no violation of DOC policy 460.000 as the infraction elements were met. Regarding the HSRs, the OCO confirmed that the individual does not have an HSR for no work, rather, the HSR is for no bending or long-standing meaning there was a work restriction but no prevention from working. As a result, the OCO could not find any evidence showing that DOC is in violation of any policy related to the HSRs.	No Violation of Policy
66.	Incarcerated individual relayed concerns regarding having difficulties with a particular staff member and getting an infraction.	The OCO reviewed available evidence and was not able to substantiate staff misconduct or unprofessionalism. The OCO also reviewed the related infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
67.	Incarcerated individual relayed concerns regarding having to transfer facilities because they do not want to participate in programming as they believe that would be admitting guilt to their crime.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that the individual is going to be transferred due to not being amenable to crime related programming. The OCO informed the individual that DOC and the courts can require that individuals participate in certain crime related programming.	No Violation of Policy
68.	Incarcerated individual relayed concerns regarding a grievance and wanting OCO to amend DOC policy so that people will not suffer sanctions pending appeals.	The OCO reviewed the grievance response and confirmed that WAC 137-28-400 states "the time limitations expressed in these regulations are not jurisdictional and failure to adhere to any particular time limit shall not be grounds for reversal or dismissal of a disciplinary proceeding." The OCO provided the individual with an informational flyer regarding the DOC policy change process.	No Violation of Policy
69.	Incarcerated individual relayed concerns regarding being placed in a single cell.	The OCO spoke to DOC about the reason for the single cell placement and confirmed that due to PREA concerns, the single cell placement is the most appropriate housing assignment at this time.	No Violation of Policy
Olympic Corrections Center			

70.	Incarcerated individual relayed concerns regarding a female officer being present in the room during a urinary analysis (UA).	The OCO reviewed the documentation for the PREA 24-24258 and spoke to DOC about this concern. The OCO confirmed that the female officer did not administer the UA or view the UA process. The OCO also informed the individual that per DOC policy, female officers can participate in the urine specimen collection process of a male incarcerated individual as long as a male staff member is the collecting and searching officer.	No Violation of Policy
Reentry Center - Reynolds - King			
71.	Person said that he was not getting accommodations for his medical condition when getting a urinalysis test. Person reported that when in prison, he had a Health Status Report (HSR) which allowed for more time for a urinalysis test or an oral swab due to medical issues, but this was removed before transfer to a reentry center.	The OCO provided assistance. The OCO reached out to DOC reentry staff, who said the original HSR is being honored and he is allowed additional time for a urinalysis test or an oral swab. DOC staff said they have now put the process in writing to avoid any confusion. DOC staff stated that at reentry centers, residents seek care in the community, so they have no medical staff to update or enter HSRs. Documentation regarding medical accommodation provided to the resident is given to facility staff and kept on file.	Assistance Provided
Stafford Creek Corrections Center			
72.	External person reported that DOC staff forced a person to alter a medical item before they would be willing to issue the item. The item was a medical order and was not a security threat, but was the wrong color and the alteration required was not necessary.	The OCO provided assistance. OCO staff contacted DOC staff with the issue. DOC staff agreed the situation was handled incorrectly and process improvements are actively being identified. The OCO will continue to monitor progress on these changes.	Assistance Provided
73.	Person reports being given a lack of information regarding his test results and future treatment options. The person requests to see their established specialist for continued care.	The OCO provided assistance. OCO staff reviewed the patient's consultations and contacted DOC Health Services staff. OCO staff requested that an appointment be rescheduled that had fallen off due to external circumstances. OCO staff verified the patient has seen the requested specialist.	Assistance Provided
74.	Person reports that the resolution stated in a previous OCO case has not been carried out by DOC medical. The person requests that their treatment continue with the recommendations he has already received from specialists.	The OCO provided assistance. OCO staff reviewed the person's consultation recommendations and contacted DOC staff. OCO staff verified that additional steps were necessary before the next referral could be placed. OCO monitored the consults on the appointment tracker and followed up with DOC staff when a delay in scheduling was noted. OCO staff verified the person's appointment has been scheduled.	Assistance Provided
75.	Person reports that they were not given a health status report (HSR) after experiencing a lower extremity injury. Due to not being moved to appropriate housing, the patient experienced additional injury.	OCO staff provided assistance. OCO staff reviewed the patient's records and noted patient education for use of ordered durable medical equipment (DME) was not documented. OCO staff contacted DOC health services staff and requested that patient education be prioritized with injuries requiring the use of DME. OCO staff noted that the requested health status report (HSR) is not currently	Assistance Provided

		supported by criteria. OCO staff asked DOC to add lower extremity injuries to the HSR criteria; DOC confirmed that updates to the HSR protocol are in progress. OCO also asked the facility to purchase additional tools to aid in patient education in the use of durable medical equipment and DOC agreed.	
76.	Incarcerated individual relayed two concerns regarding two infractions. First, they wanted to know why they were given a WAC 633 for an assault when it was a fight and should have been a WAC 505. Second, they expressed concerns about not knowing about the appeal process for infractions.	The OCO reviewed the individual's disciplinary record. The OCO contacted DOC regarding the specific infraction he received; DOC reported that this individual approached another person from behind and assaulted them, leading to the 633 violation. The infraction appeal process is laid out in the incarcerated individual handbook which this person had received. Additionally, the OCO verified that this individual is now aware of and using the infraction appeal process.	Information Provided
77.	Person reports that visits with his wife were terminated, and he received an infraction for inappropriate touching.	The OCO confirmed that the individual's visits with his wife were terminated for one year due to previous infractions related to visitation. This person's wife may reapply for visitation privileges one year after the initial termination.	Information Provided
78.	Incarcerated individual relayed concerns regarding being discriminated against because DOC will not give them a job with ADA access.	The OCO spoke to DOC regarding this concern and confirmed that the individual is having difficulty getting work due to their priority code which is calculated by their identified risks/needs and sentence structure and has nothing to do with the individual's disability.	Information Provided
79.	Incarcerated individual relayed concerns regarding wanting a keep separate removed.	The OCO spoke to DOC regarding this concern and confirmed that DOC is willing to re-review the keep separate. The OCO informed the individual that they will need to work with their counselor to submit this change.	Information Provided
80.	Person reports not being given access to pain management and specialist consultation for multiple issues.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff reviewed the person's medical records and contacted DOC staff. OCO staff confirmed the patient has had access to multiple treatments and is currently ordered medication to treat the reported symptoms as well as continued follow up with a specialist. Regarding the specific specialist consultation request, OCO staff could not locate any evidence in medical records that this request has been discussed with the patient's provider. OCO staff provided information to the person regarding the steps required to get a consultation to an outside specialist.	Insufficient Evidence to Substantiate
81.	Loved one relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
82.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
83.	Patient reports being denied by the DOC for multiple accommodation and Health Status Report requests.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the person's requests and found they were reviewed within protocol. OCO staff noted that DOC has provided accommodations to meet the same needs that abide by DOC policy and Health Status Report (HSR)	No Violation of Policy

		criteria. OCO staff provided information to the person regarding the specific reasons for the denied requests.	
84.	Incarcerated individual shared concerns regarding being wrongfully terminated from their job and DOC staff mistreating them.	The OCO was unable to substantiate a violation of policy by DOC. Upon review of the termination, the OCO found that this individual refused to complete a common work task given by DOC staff and was referred for termination to the FRMT (facility risk management team), which is a group that can uphold or overturn program denials per DOC policy 700.000. Based on the actions taken by this individual on the job, they were terminated from their position per an FRMT decision.	No Violation of Policy
85.	Incarcerated individual relayed concerns regarding mail rejections.	The OCO reviewed the rejection and appeal for the mail and confirmed that it was due to a violation of DOC policy 450.100 attachment 4 (4)(p) and DOC policy 450.100 attachment 4 (4)(j).	No Violation of Policy
86.	Incarcerated individual relayed concerns regarding mail rejections.	The OCO reviewed the rejection and appeal for the mail and confirmed the mail violated DOC policy 450.100 attachment 3 (4)(p) and DOC policy 450.100 attachment 3 (4)(x).	No Violation of Policy
87.	Incarcerated individual relayed concerns regarding staff conduct.	The OCO spoke to DOC regarding the grievance not being accepted and confirmed that the grievance was not accepted because the grievance narrative mirrors the infraction narrative and the individual does admit to refusing search, so this appears to be a retaliatory grievance filed as a result of the individual getting an infraction.	No Violation of Policy
Washington Corrections Center			
88.	Person reported that several patients did not receive medication due to facility lock down. The person also requested that the OCO review his removal from treatment.	The OCO substantiated the reported issue with medication administration and provided assistance. OCO staff contacted DOC Health Services leadership to discuss what led to patients not receiving medication. OCO staff asked that communication to custody regarding daily medication schedules be changed, and DOC agreed.	Assistance Provided
89.	Person reports they were receiving a $1.60 for their hazmat pay, and then a new correctional unit supervisor (CUS) started working in the unit and reduced his pay.	The OCO provided information about the current hazmat pay. Whenever custodians are directed to clean up blood and body fluids (examples: spinal fluid, blood, semen, breast milk and vaginal fluid) OR are tasked to clean up large amounts of feces smeared on walls etc., that require them to be gowned, shielded and wear booties, they are entitled to $2.40 per cleanup per DOC policy 700.100 IV. A. 1., in addition to their normal pay.	Information Provided
90.	Person reports multiple concerns regarding postoperative care. The patient requested that OCO staff review the surgeon's recommendations and compare to what DOC ordered.	OCO provided the requested information to the patient. OCO staff reviewed the requested records and determined that the DOC orders followed those specified by the surgeon.	Information Provided
91.	Person reported a concern regarding his transfer while awaiting an urgent surgery. The person requested an investigation on the facility medical director's provided care.	The OCO provided information to the patient regarding the entity that does licensure investigations, The Washington Medical Commission. OCO staff reviewed the patient's records and were unable to substantiate a violation of DOC policy 610.110. OCO staff contacted DOC staff to discuss	Information Provided

		process improvement opportunities identified in this investigation.	
92.	Person reports that he declared a medical emergency that was not responded to in an appropriate time.	The OCO substantiated this concern and provided information to the patient. OCO staff contacted DOC health services staff and were informed that corrective action was being taken. OCO staff provided tort claim information to the patient.	Information Provided
93.	Incarcerated individual relayed concerns regarding filing a grievance about a loss of property and not getting a response or LOGID number.	The OCO located a grievance regarding this concern and confirmed that DOC provided the individual with a response.	Information Provided
94.	Person reported that a specific resolutions staff was not filing appeals, misinterpreting resolutions requests, and is a barrier to accessing the resolutions program.	The OCO was unable to substantiate this concern due to insufficient evidence. The OCO conducted a comprehensive audit of this individual's resolutions requests and could not substantiate that appeals were not filed or that the resolutions specialist was not following policy. This staff member no longer works in the resolutions program.	Insufficient Evidence to Substantiate
95.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
96.	Incarcerated individual shared concerns regarding DOC staff telling them they would take care of shipping their property but deciding not to handle it.	The OCO was unable to substantiate a violation of policy by DOC. Per DOC policy 440.020, an incarcerated individual will be responsible for the disposition or shipping of their property at their own expense if it exceeds the transport limit. The OCO was able to confirm that this individual was in communication with DOC staff who informed them that their property could be shipped but they had to pay for it.	No Violation of Policy
Washington Corrections Center for Women			
97.	Individual reports they were infracted for misusing their medication. They took all of it in an attempt to take their own life and were taken to the hospital.	The OCO contacted DOC Headquarters for a review of this infraction. It has now been removed from the individual's record as DOC is not supposed to infract individuals for self-harm incidents.	Assistance Provided
98.	Individual reports that she is a boarder, and her release date is in a few months. She says nobody is setting up a reentry plan for her.	The OCO contacted Headquarters Classifications regarding re-entry. Classifications has contacted the sending state, and she will receive a reentry navigator. The facility staff confirmed this will be scheduled.	Assistance Provided
99.	Incarcerated individual shared concerns regarding DOC failing to provide them with adequate medical care.	The OCO provided information regarding treatment options this individual could utilize for their medical concern.	Information Provided
100.	Person reported that she has needed dental care for months.	The OCO provided information about ongoing monitoring of dental concerns. The OCO has substantiated statewide delays to dental care and is continuing to monitor and meet with DOC Headquarters on a regular basis. The OCO reviewed DOC records and confirmed with DOC staff that this individual has been seen for a dental evaluation and is scheduled for further dental work.	Information Provided

101.	Individual reported being infracted for something they did not do, and throughout the infraction process, staff were unethical. They stated the infraction was in retaliation.	The OCO reviewed the infraction paperwork, video evidence, and appeal information. After review, this office spoke with the facility leadership and DOC Headquarters staff. This office requested for the infraction to be dismissed or reduced. After reviewing the infractions, the DOC decided to uphold the findings based on the some evidence standard. The OCO does maintain this infraction could have been dismissed or reduced; however, this office does not have the authority to dismiss or reduce the infraction. The OCO continues to encourage the DOC to change some evidence standard to a preponderance of evidence standard.	Information Provided
102.	Person reports that she was denied surgery by her provider.	OCO staff provided information to the person regarding the steps taken to review her request for care. OCO staff verified that multiple specialists were consulted and the requested surgery does not currently meet the criteria to be considered medically necessary per the DOC Health Plan.	Information Provided
103.	Person reported needing dental care after breaking teeth.	The OCO provided information about the DOC dental plan. The OCO reviewed DOC records and found that the treatment she was seeking is not covered by the DOC dental plan. The OCO found that this individual has since been released and encourages this individual to seek care in the community. The OCO has substantiated statewide delays to dental care and is continuing to monitor and meet with DOC Headquarters on a regular basis.	Information Provided
104.	Person reports he was given access to mental health medications while being held in a restrictive setting. The person also stated that his medications were later cut off abruptly without follow up from the provider.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff reviewed the person's medical records and substantiated that the medication taper was not ordered correctly. OCO staff verified the person received no follow up with the ordering provider for a significant amount of time. OCO staff contacted DOC Health Services leadership and were informed that corrective action had already been taken.	Information Provided
105.	Incarcerated individual relayed concerns regarding moving facilities to complete therapeutic communities (TC) despite the ability to do it at their previous facility.	The OCO spoke to DOC about the ability for the individual to return to their previous facility in order to do TC and confirmed that TC is not an open-entry/open-exit program, so the individual would not be able to transfer between the programs. The OCO informed the individual that they may have an opportunity after they complete the TC program to return to their previous facility to continue their education as desired.	Information Provided
106.	Incarcerated individual relayed concerns regarding an infraction, particularly that they made an agreement with the intelligence and investigations unit (IIU) that would result in their infraction being dismissed.	The OCO reviewed the infraction materials and found no violation of policy as the infraction elements were met. The OCO informed the individual that if they are having frustrations with DOC staff, they will need to grieve that to a level 2 before the OCO can investigate further.	Information Provided
107.	Individual reports that health services does not take her concerns seriously and keep telling her that nothing is wrong with her. This has been an ongoing problem for years and	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed this individual's medical records for appointments and tests that were conducted over the last year and a half. This office was able to confirm that this individual has been seen extensively for	Insufficient Evidence to Substantiate

	she believes that DOC staff are not being honest about her medical concerns.	their medical concerns and DOC health services have diligently worked to resolve this person's medical issues.	
108.	An anonymous individual reported concerns about a particular staff member and comments that staff member had made.	As this case was reported by an anonymous individual, the OCO did not have further details regarding specifics of the allegations to investigate. The OCO spoke with facility leadership regarding the particular staff member who confirmed that over a two-year timespan, that particular staff member has not had a single grievance written about them. Without further identifying details about the allegations, the OCO was unable to investigate further.	Insufficient Evidence to Substantiate
109.	An individual reports they are nonbinary and DOC staff were excessive with their pat search, attempting to feel if the individual was wearing a binder.	The OCO reviewed the records related to the PREA investigation and confirmed that the officer did not inappropriately touch this individual. The OCO was unable to substantiate the concern due to insufficient evidence.	Insufficient Evidence to Substantiate
Washington State Penitentiary			
110.	A loved one reported that an incarcerated individual's wheelchair was broken, and that while waiting for a new chair, he was given a chair that does not fit and was hurting him.	The OCO provided assistance. The OCO reviewed DOC records and reached out to DOC staff about the chair and they said that it was still in production but they had not heard updates. The OCO continued to follow up and verified that the individual received the new wheelchair and care for the injuries he sustained in the chair that did not fit.	Assistance Provided
111.	Incarcerated individual shared concerns regarding Securus failing to transfer their music over despite asking for help.	The OCO provided assistance. Upon reviewing the complaint, the OCO reached out to DOC/Securus staff and requested that this individual be refunded their money spent or assist in transferring their purchased music. Due to our inquiry, this office was informed by DOC/Securus staff that they have refunded the individual their money spent on the lost music.	Assistance Provided
112.	Incarcerated individual relayed concerns regarding not being able to get dental treatment.	The OCO contacted DOC about this concern. After OCO request, the OCO confirmed that dental came to see the individual. The OCO informed the individual that IMU dental is limited to only emergencies and filings, cleanings are only once an individual's security level is lower.	Assistance Provided
113.	Incarcerated individual relayed concerns regarding not being able to read or write and needing assistance with this.	The OCO contacted DOC about this concern. At OCO request, assistance for reading and writing for this individual was brought before the accommodation review committee (ARC). After the ARC meeting, the OCO confirmed that the individual was approved for C-Reader pen that when dragged over words reads the text aloud. The OCO informed the individual that they were not approved for an access assistant for writing due to their placement in IMU as this poses a safety concern and informed the individual that once they are at a lower custody level, they can reapply with the ARC.	Assistance Provided
114.	Person reported concern that he had a skin condition and had not been treated by medical.	The OCO provided assistance. The OCO spoke with DOC staff, who scheduled this individual for an appointment with his provider to treat the condition.	Assistance Provided
115.	Person reported that the Intensive Management Unit (IMU) is not allowing him to have his Durable Medical	The OCO provided assistance. The OCO repeatedly communicated with DOC staff about finding DME that met the individual's orthotic need and they have been unable to find suitable DME. DOC staff have elevated this concern to the Statewide Security Specialist and identified a shoe that	Assistance Provided

	Equipment (DME) because it contains a small piece of metal.	will work for this individual and the IMU's security requirements.	
116.	Person reported that DOC has not given him replacement glasses, and that they said they would in a previous OCO case.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reached out to DOC staff, who confirmed that they have provided this individual with new glasses.	DOC Resolved
117.	Individual sent the OCO a closed case review form, which included information that was new to his previous case. He requested the OCO review his drug treatment termination, not the DOSA revoke.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed the individual's most recent resolution request and determined there was a lack of communication between SARU and the incarcerated individual. This individual will be eligible for treatment when his DOSA sentence begins.	DOC Resolved
118.	Incarcerated individual shared concerns regarding DOC updating their CFP (Custody Facility Plan), which determines an individual's classification level, and keeping them in Ad Seg (Administrative Segregation) despite promoting them to medium custody. This individual also shared concerns regarding DOC staff mistreating them.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO was able to confirm that this individual was placed into medium custody. This office also looked into an alleged staff misconduct concern shared by this individual and determined there is insufficient evidence to substantiate the concern.	DOC Resolved
119.	Incarcerated individual shared concerns regarding DOC jeopardizing their safety by not placing them in a facility that can treat their medical condition. Individual also shared concerns regarding DOC staff withholding their property.	The OCO provided information regarding DOC's decision for their transfer decision and why they made the decision. This office was also able to confirm that this individual has the property they were requesting.	Information Provided
120.	Incarcerated individual relayed concerns regarding DOC not verifying their safety concerns.	The OCO spoke to DOC regarding this and confirmed that DOC has no information about the individual wanting to disclose any safety concerns or requesting to begin the debriefing process. The OCO informed the individual that if they wish to do either of these, they will need to participate in the debriefing process with their counselor who will send the information to the local IIU (investigations unit).	Information Provided
121.	Incarcerated individual relayed concerns regarding the IMU visiting rooms being closed.	The OCO spoke to DOC about this concern and confirmed that the visiting rooms are fully operational at this time.	Information Provided
122.	Incarcerated person reported concerns regarding infectious disease protocol in the segregation units.	The OCO provided information about the OCO's ongoing monitoring of solitary confinement units. The OCO verified that the person was off infectious disease protocols at the time the concerns were reported and protocols were followed properly. The OCO will continue to monitor protocols the DOC uses in solitary confinement units.	Information Provided
123.	Incarcerated individual relayed concerns regarding placement in segregation and a desire to transfer to a safe harbor.	The OCO reviewed the individual's custody facility plan (CFP). The OCO confirmed that the individual's new custody facility plan is now in effect and informed the individual that if they disagree with the outcome, they can appeal the decision	Information Provided

		within 72 hours. The OCO also informed the individual that if they are having safety concerns, they can discuss them with their counselor so that SIS can verify them.	
124.	Incarcerated person reported concerns regarding access to a Reentry Center when transferring to Graduated Reentry.	The OCO provided information about reentry programs at DOC. The OCO reviewed the person's situation and found they are not currently eligible to transfer to a Reentry Center, however they can transfer to Graduated Reentry (GRE) by completing a program before transferring to electric home monitoring (EHM). The OCO provided details about why this is the option available to them and provided them resources for further self advocacy.	Information Provided
125.	Incarcerated individual relayed several concerns, first regarding not being able to go beyond a level two while in segregation, second regarding the infractions that resulted in their placement in segregation, third regarding an old infraction, and fourth a desire to know how to request public records.	The OCO reviewed the individual's custody facility plan (CFP) and disciplinary record. The OCO confirmed that the individual's CFP states they are to maintain a level two only due to prolific controlled substance introductions. The OCO confirmed that the two most recent infractions have not yet been appealed, the OCO informed the individual that they must be appealed before the OCO can investigate. The OCO found no violation of DOC policy 460.000 for the 2021 infraction as the infraction elements were met. The OCO provided the individual with information regarding the public records request process.	Information Provided
126.	Person reports that he needs to see a specialist for an ongoing medical condition that he had been treated for at a previous facility.	The OCO provided information to the patient regarding the steps needed to reestablish a specialist consult after signing a refusal of medical care. The consult process has to be restarted from the beginning when a patient is moved away from the clinic where they had established care in the past.	Information Provided
127.	Person reports that parts of the facility grounds do not meet ADA standards and requests changes to be made.	The OCO provided information to the person regarding the requested changes. OCO staff contacted DOC staff who had already met with the person about their requested changes. DOC staff confirmed that a work order has been placed to make those changes.	Information Provided
128.	Incarcerated person requested assistance filing legal documents.	The OCO provided information about accessing legal assistance. The OCO cannot provide legal assistance. However, there are resources available to incarcerated people who are entitled to attorney representation and help through the legal system. The OCO provided this person with information detailing how to access legal resources.	Information Provided
129.	Incarcerated individual relayed concerns regarding placement in segregation and a keep separate.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that they are in segregation due to involvement in a security threat group. The OCO informed the individual that they will need to submit a request about the keep separate order through their counselor to have the CPM review it.	Information Provided
130.	Incarcerated individual shared concerns regarding DOC continuing to pull money out of their account despite that issue being previously resolved.	The OCO provided information to this individual regarding why funds are still being deducted from their account despite being under the impression the issue was resolved.	Information Provided
131.	Incarcerated individual relayed concerns regarding the	The OCO spoke to DOC about this concern and confirmed that the individual did not file a proper appeal, rather, they	Information Provided

	mailroom not responding to their mail rejection appeal.	sent in a kite stating they disagree with the rejection. The OCO informed the individual that they must file a proper rejection appeal by following DOC 450.100 attachment 2.	
132.	Incarcerated individual relayed concerns regarding placement in segregation and not being able to go beyond level two.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that their CFP states they are not to go beyond a level 2 due to the staff assault that resulted in their current MAX placement.	Information Provided
133.	Person reports that DOC medical was not giving him access to pain medication following a surgery.	The OCO provided information to the person regarding their Care Review Committee decision. OCO staff contacted DOC Health Services staff and requested a review of the patient's medication access following surgery. OCO staff noted the patient was given access to pain medication and tapered off those medications according to the medical order.	Information Provided
134.	Incarcerated person reports concern about an infraction they received and reports they received the infraction as a result of retaliation.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the infraction and found that it meets the "some evidence" standard used by DOC. The OCO was unable to substantiate that the infraction was issued as a form of retaliation.	Insufficient Evidence to Substantiate
135.	Incarcerated person reported concerns about their placement into segregation during an investigation.	The OCO was unable to substantiate a violation of policy by DOC. The OCO found this was a relevant investigation and this person was placed into segregation per DOC 320.200. The OCO verified the person was released from segregation after the investigation was completed.	No Violation of Policy
136.	Incarcerated individual shared concerns regarding losing their job and being kept in IMU (Intensive Management Unit) for an extended period of time over infractions that ended up getting dismissed.	The OCO was unable to substantiate a violation of policy by DOC. Per DOC 320.700, an individual will be retained in IMU or Ad Seg (Administrative Segregation) if they're pending an investigation for behavior that represents a significant threat. This office was able to confirm that this individual was a part of an investigation that had elements of such threat.	No Violation of Policy
137.	Incarcerated individual relayed concerns regarding placement in segregation as well as an infraction hearing occurring without their presence.	The OCO reviewed the individual's custody facility plan (CFP) and infraction materials. The OCO informed the individual that they were placed on a MAX program due to their ongoing drug usage. The OCO also confirmed that the individual signed DOC form 05-093 stating they did waive their right to appear at the hearing, thus it was held without them.	No Violation of Policy
138.	Incarcerated individual relayed concerns regarding being video recorded without their consent.	The OCO reviewed the related grievance response and confirmed that because the photo was not publicized, there is no violation of policy.	No Violation of Policy
139.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
140.	Incarcerated individual relayed concerns regarding DOC handling their legal mail incorrectly.	The OCO spoke to DOC about this concern and confirmed that unit staff opened the mail in front of the individual per DOC policy 450.100 and returned the items back to the mailroom so a rejection could be initiated.	No Violation of Policy
141.	Incarcerated individual relayed concerns regarding an infraction where they were not allowed to	The OCO reviewed the infraction materials and spoke to DOC about the concern. The OCO confirmed the reason the individual could not request that it be sent to the lab was	No Violation of Policy

	send the substance out to the lab.	because they were not found to be in possession of it, rather to be conspiring to bring it into the facility.	
Intake Investigations			
Airway Heights Corrections Center			
142.	Loved one relayed concerns regarding an incarcerated individual's need to see a hand specialist due to a fracture.	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
143.	Loved one relayed concerns regarding an infraction.	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
144.	Loved one relayed concerns regarding an incarcerated individual not being seen by medical in a timely manner.	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
145.	Loved one relayed concerns regarding difficulties an incarcerated individual is having with a particular officer in the unit.	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
146.	Loved one relayed concerns regarding an incarcerated individual's need to get custom insoles and supportive shoes.	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
147.	Loved one relayed concerns regarding termination of visits with a particular visitor.	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
148.	Loved one relayed concerns regarding difficulties an incarcerated individual is having with a cellmate.	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	Person Declined OCO Assistance

		closed in error, to please contact this office to open a new case.	
149.	Loved one relayed concerns regarding an incarcerated individual's placement in segregation and medical needs.	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
150.	Incarcerated person reported concerns regarding retaliation by DOC staff because he filed lawsuits against the department.	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 appealing an infraction.	Technical Assistance Provided
151.	Incarcerated person reports the phone application on his tablet is not working properly and is causing difficulties making phone calls.	The OCO provided technical assistance about how to resolve concerns with his tablet using the Securus help ticket process.	Technical Assistance Provided
152.	Person reported that their property was packed up and when returned, some items were missing.	The OCO provided technical assistance to the individual about filing a tort claim for the missing items.	Technical Assistance Provided
153.	Person reports he was charged a holding fee for electronic equipment in 2006 under his old DOC number and was recently charged an additional holding under his new DOC number when DOC should have the charge from 2006.	The OCO provided technical assistance about banking deductions.	Technical Assistance Provided
154.	Person reported that DOC packed up their property and some items went missing.	The OCO provided technical assistance about utilizing the resolution program.	Technical Assistance Provided
155.	Individual reported that his lawyer is blocked on Securus.	The OCO provided technical assistance by providing more information about access to legal resources.	Technical Assistance Provided
156.	Person reported that they were packed out by DOC staff and did not receive all of their belongings.	The OCO provided technical assistance about utilizing the resolution program, tort claims process, and offering more information about DOC property policies.	Technical Assistance Provided
157.	Person reports that their loved one's application for visiting was not approved.	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 a visitation decision.	Technical Assistance Provided
158.	Person reported that they received an infraction for their hotpot setting off the smoke detector when it was not intentional.	The OCO provided technical assistance about appealing an infraction.	Technical Assistance Provided

159.	Person reported that they would like the DOC substance abuse policy changed.	The OCO provided technical assistance about utilizing the resolution program.	Technical Assistance Provided
160.	Person reported that they have filed grievances but have not received any responses for them. When the individual spoke to the resolution coordinator, they said that they have no record of the resolution requests.	The OCO provided technical assistance about the resolution program.	Technical Assistance Provided
161.	Individual reported that he was double sanctioned for an infraction he received.	The OCO provided technical assistance about the infraction process.	Technical Assistance Provided
162.	Person reported that DOC employees should wear body cameras for safety and accountability purposes.	The OCO provided technical assistance by providing more information about the DOC policy change process.	Technical Assistance Provided
Clallam Bay Corrections Center			
163.	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
164.	Person called to report that DOC staff will not give them their religious items.	The OCO provided technical assistance about utilizing the resolution program.	Technical Assistance Provided
Coyote Ridge Corrections Center			
165.	Loved one relayed concerns regarding an incarcerated individual not getting the medications that were given in the county jail.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but the office 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
166.	Loved one relayed concerns regarding a desire for the incarcerated individual to be sent to a rehabilitation facility.	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
167.	Person reports that Legal Financial Obligation (LFO) payments are being deducted from his gratuity checks on a cause that he has already paid off many years ago.	The OCO provided technical assistance about how to resolve concerns with banking deductions.	Technical Assistance Provided

168.	Person reported that their cellmate filed a false PREA against them and was taken to the hole. Person also reported that they are being targeted because they are transgender.	The OCO provided technical assistance about the infraction process.	Technical Assistance Provided
169.	Person reported that they are being blocked by DOC from contacting the FBI.	The OCO provided technical assistance by giving more information about legal resources.	Technical Assistance Provided
170.	Individual reported that all indigent items especially hygiene, should be free.	The OCO provided technical assistance about the DOC policy change process.	Technical Assistance Provided
171.	Incarcerated person reported concerns about not being provided an opportunity to appeal his infractions and being housed in solitary for over three weeks.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO verified that he was no longer in solitary confinement and provided technical assistance about appealing an infraction.	Technical Assistance Provided
172.	Person reported that they got an infraction but were not given any paperwork to explain why they were receiving the infraction.	The OCO provided technical assistance about the infraction process.	Technical Assistance Provided
173.	Incarcerated person reported concerns about two infractions and whether the sanctions were appropriate.	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
174.	Individual shared concerns about being transferred to another facility and out of the HVAC program.	The OCO provided the individual with technical assistance about classification and facility placement.	Technical Assistance Provided
175.	Person reports that DOC is deducting Legal Financial Obligation (LFO) payments from his account although the court had waived the LFOs.	The OCO provided technical assistance about how to resolve concerns with banking deductions.	Technical Assistance Provided
176.	Individual reported that a DOC staff member has been targeting them because they filed a resolution request against them.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
177.	Incarcerated individual called to report that DOC staff have been harassing them.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
178.	Person called to report that DOC staff have been harassing her and other trans women.	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 utilize the resolution program.	Technical Assistance Provided
Mission Creek Corrections Center for Women			
179.	A loved one reported concerns about an incarcerated	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	Person Declined OCO Assistance

	individual's ongoing medical needs.	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.	
Monroe Correctional Complex			
180.	A loved one reported that DOC staff are targeting them and would like to be moved to another unit.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns	Technical Assistance Provided
181.	Incarcerated person reports concerns about their medication not being administered until they are added to the MAT line, but DOC has not approved their addition.	The OCO provided technical assistance about the Health Services process.	Technical Assistance Provided
182.	Individual reported that their tooth has been hurting them for a while now and would like to see the dentist as soon as possible.	The OCO provided technical assistance about DOC's appointment process for healthcare and dental.	Technical Assistance Provided
183.	Person is requesting that DOC change their policy and stop removing access to tablets as a disciplinary action.	The OCO provided technical assistance by providing more information about the DOC policy change process.	Technical Assistance Provided
184.	Individual reported that the punishment they received from an infraction was too severe.	The OCO provided technical assistance by giving more information about the serious infraction process.	Technical Assistance Provided
185.	Incarcerated person reported concerns about DOC staff disposing his property.	The OCO provided the individual with technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
186.	Person reported that their classification counselor was not helping them find housing.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
187.	Incarcerated person reported concerns about DOC not conducting a fair, unbiased, and thorough investigation related to a PREA incident.	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 Prison Rape Elimination Act (PREA) investigation process.	Technical Assistance Provided
188.	Person reported that DOC staff lied on an infraction report and feels like they are being discriminated against.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
189.	Person reported that DOC is using an expired temporary restraining order to prevent the individual from seeing and speaking to their children.	The OCO provided technical assistance by giving more information on visitations and legal resources.	Technical Assistance Provided
190.	Individual reported that they have been trying to get their loved one on their visitation list.	The OCO provided technical assistance about the visitation application process.	Technical Assistance Provided

Olympic Corrections Center			
191.	Loved one relayed concerns regarding facility placement.	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.	Person reported that their tablet broke and DOC staff has not answered their request for a new one.	The OCO provided technical assistance about the resolution program and Securus.	Technical Assistance Provided
Other			
193.	Loved one relayed concerns regarding conduct in the Score 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 but provided the family member with the contact information for the King County Ombuds.	Lacked Jurisdiction
194.	Loved one relayed concerns regarding the conduct of a community corrections officer.	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
195.	Individual sent a letter intended for the Oregon Ombuds office.	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
196.	Individual relayed concerns regarding a desire to expose intelligence reports by uncovering terrorist networks inside the United States due to state bodies using private planes to change caribou's migration routes.	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
197.	Individual relayed concerns regarding the use of AI technology to control individuals housed in jail facilities.	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, but provided the individual with the King County Ombuds contact information.	Lacked Jurisdiction
Stafford Creek Corrections Center			
198.	Loved one relayed concerns regarding an incarcerated individual not doing well at their current facility.	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
199.	Loved one relayed concerns regarding an incarcerated individual having difficulties with mental health and a desire to transfer facilities.	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

200.	Person called to report that they feel like a political agenda is being forced on them.	The OCO provided technical assistance about how to utilize the resolution process for staff conduct.	Technical Assistance Provided
201.	Person reported that they re-injured their back while at work and they are having a difficult time accessing healthcare services for their medical issue.	The OCO provided technical assistance about the resolution program and health services.	Technical Assistance Provided
Washington Corrections Center			
202.	Loved one relayed concerns regarding an incarcerated individual needing proper follow-up care after sustaining a fractured neck.	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
203.	The person reports that he received infractions close to his release date and lost 75 days of good time credit (GTC) and his earned release date (ERD) was extended. He appealed the infractions, and they were overturned. DOC gave back his 75 days of good time. However, the facility refuses to change his ERD because they said they have to send out a new 35-day notifier.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
204.	An individual reports that his release date changed and his counselor is not keeping him updated or responding to kiosk messages.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
205.	Person reported concerns about not receiving proper medical care and not receiving a response to submitted medical kites.	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 health services.	Technical Assistance Provided
206.	Person reports several concerns with the treatment they are receiving by staff while in the Intensive Management Unit, particularly regarding their mental health.	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 health services.	Technical Assistance Provided
207.	Incarcerated person shared concerns about an infraction and being held in the Intensive Management Unit (IMU) for two weeks without a 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 appealing an infraction. The individual has also been transferred to another facility and is no longer housed in the Intensive Management Unit (IMU).	Technical Assistance Provided

208.	Incarcerated individual shared concerns about a PREA incident and a serious infraction.	The OCO provided the individual with technical assistance about appealing an infraction and the PREA investigation process.	Technical Assistance Provided
209.	Incarcerated individual reports being harassed by another incarcerated individual and staff are not helping resolve the concern.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided the individual with technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
Washington Corrections Center for Women			
210.	Individual reports every time she does really well (doing homework and grieving) she and other people are sent to COA and just put on more meds to the point that she cannot function. She feels this is retaliation.	The OCO requested mental health records and attempted to meet with the individual in-person, however the individual was not available. The individual has now released.	Person Released from DOC Prior to OCO Action
211.	Individual has safety concerns about sharing a cell with a transgender woman.	The OCO provided technical assistance onsite.	Technical Assistance Provided
212.	OCO staff spoke to an individual at cell front in person and discussed general concerns related to living in the intensive management unit (IMU).	OCO provided technical assistance onsite.	Technical Assistance Provided
213.	Individual spoke with OCO staff in person during the open-hours pilot regarding their medical concerns.	The OCO provided technical assistance onsite. This office also verified that the individual has an active case regarding their medical concerns.	Technical Assistance Provided
214.	Incarcerated individual asked OCO staff numerous questions during open hours pilot.	OCO provided technical assistance onsite.	Technical Assistance Provided
215.	Individual broke her bottom dentures, and DOC told her they would not replace them for five years, per the DOC health plan.	OCO provided technical assistance onsite.	Technical Assistance Provided
216.	Individual reported that Securus frequently has technical issues.	The OCO provided technical assistance by providing more information about how to reach out to Securus for support.	Technical Assistance Provided
217.	Individual spoke with OCO staff during open hours pilot regarding an open case they have with this office.	The OCO provided technical assistance onsite and updated notes in the person's existing case.	Technical Assistance Provided
218.	An individual in the IPU had concerns they shared with OCO staff in-person.	OCO provided technical assistance onsite.	Technical Assistance Provided
219.	Individual spoke with OCO staff about the Hope Team during open hours pilot.	The OCO provided technical assistance onsite.	Technical Assistance Provided

220.	This individual spoke broadly about transgender discrimination and other issues related to that discrimination with OCO staff during open hours pilot.	The OCO provided technical assistance onsite.	Technical Assistance Provided
221.	Individual reports medical issues that are unresolved.	The OCO provided technical assistance onsite.	Technical Assistance Provided
222.	Incarcerated individual asked OCO staff various questions during open hours pilot.	The OCO provided technical assistance onsite.	Technical Assistance Provided
223.	Incarcerated individual asked OCO staff numerous questions during open hours pilot.	OCO provided technical assistance onsite.	Technical Assistance Provided
224.	Individual has had broken teeth and was getting no response from the dental clinic. This person reports that the information on her resolution responses does not match the information she is receiving from DOC staff.	The OCO provided technical assistance onsite. This office also confirmed that the individual has been going to the dentist and has more appointments scheduled.	Technical Assistance Provided
225.	The person reports they are back in prison because their community custody plan was revoked due to new charges. The individual was asking questions about the legal process and jail paperwork.	The OCO provided technical assistance about legal resources and access.	Technical Assistance Provided
226.	Individual spoke with OCO staff during their open hours in-person event.	OCO provided technical assistance onsite.	Technical Assistance Provided
227.	The incarcerated individual asked OCO staff questions related to resolution appeals during open hours pilot.	The OCO provided technical assistance regarding how to appeal a resolution request.	Technical Assistance Provided
228.	An incarcerated individual spoke to OCO staff in person at an open hours pilot project. The person reported concerns related to not knowing how to access medical care.	The OCO provided technical assistance about health services and the approval process for medical needs.	Technical Assistance Provided
229.	Individual reports concerns during open hours pilot and says that school holds are being canceled and DOC is sending women to Mission Creek, where there are no education programs.	The OCO provided technical assistance regarding programming and education.	Technical Assistance Provided

230.	Incarcerated individual asked OCO staff numerous questions during open hours pilot.	OCO provided technical assistance onsite.	Technical Assistance Provided
231.	Incarcerated individual asked OCO staff numerous questions during open hours pilot.	The OCO provided technical assistance onsite.	Technical Assistance Provided
232.	Incarcerated individual asked questions to OCO staff during open hours pilot.	The OCO provided technical assistance onsite.	Technical Assistance Provided
233.	Person reports she worked additional hours outside of her normal shifts at the request of DOC staff, but staff did not document those hours therefore she was not paid for the work.	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 contacting banking.	Technical Assistance Provided
234.	Incarcerated individual asked OCO staff numerous questions during open hours pilot.	The OCO provided technical assistance onsite.	Technical Assistance Provided
235.	This individual spoke broadly about transgender discrimination to OCO staff during open hours pilot.	The OCO provided technical assistance onsite.	Technical Assistance Provided
Washington State Penitentiary			
236.	Loved one relayed concerns regarding difficulty an incarcerated individual is experiencing in accessing mental health while 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
237.	A family member reported that their loved one is not safe at their current facility.	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 housing difficulties for an incarcerated individual despite them participating in the debriefing process.	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.	Loved one relayed concerns regarding an incarcerated individual not getting 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 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.	Incarcerated person reported concerns about DOC staff misconduct.	The OCO provided the individual with technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
241.	An incarcerated person reported a concern related to property.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance at the time of the initial call.	Technical Assistance Provided
242.	Person reported that their wheelchair was taken away by 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 the resolution program.	Technical Assistance Provided
243.	Person reports that DOC staff are discriminating against people of color.	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 filing a resolution request for staff conduct concerns.	Technical Assistance Provided
244.	Incarcerated person reports that when he submits medical kites the responses are not useful or state that he is not writing the kites correctly. This has impeded his ability to schedule an MRI and get appropriate care for his migraines.	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 kiting health services for appointments and emergencies.	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-24-014

Report to the Legislature

As required by RCW 72.09.770

December 13, 2024

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-24-014 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

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

Disclosure of Protected Health Information

RCW 72.09.770 requires DOC to disclose protected health information - including mental health and sexually transmitted disease records - to UFR committee members. 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 November 14, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Rae Simpson, Director – Quality Systems
- 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

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Madison Vinson, Assistant Corrections Ombuds - Policy

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

Health Care Authority (HCA)

- Dr. Charissa Fotinos, Medical Director

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

Fatality Summary

Year of Birth: 1965 (58-years-old)

Date of Incarceration: February 2007

Date of Death: August 2024

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

His cause of death was end-stage liver disease. The manner of his death was natural.

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

Events Prior to Death	Event
3 months prior	• He was placed on seriously ill status per DOC Policy 610.600 (Infirmary/Special Needs Unit Care) and appropriate notifications were made.
1 day prior	• He was taken to a community hospital for care that could not be provided by the facility.
Day of Death	**Event**
0 days	• He returned from the community hospital for end-of-life comfort care/palliative care. • He passed away at 0831 hours.

UFR Committee Discussion

Upon request of the Office of the Corrections Ombud, 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 did not identify any findings or recommendations to prevent a similar fatality in the future.

B. Independent of the mortality review, the DOC conducted a fact-finding to determine the facts surrounding the unexpected fatality. The fact-finding did not identify findings or recommendations which correlated to the cause of death.

C. The UFR committee reviewed the Mortality Review Committee and the fact-finding reports. The

members did not offer recommendations to prevent a similar fatality in the future. The committee discussed:

1. End-of-Life support –

   The committee discussed the benefit of having multidisciplinary teams (MDT) involved in supporting incarcerated individuals with end-of-life support. An MDT may have helped address the psychosocial barriers that contributed to this incarcerated individual declining to move to the inpatient medical unit for supportive care earlier. The Health Services Chief Medical Officer discussed the robust body of correctional literature identifying the stigma associated with dying in prison, and the need to have intentional conversations with incarcerated individuals diagnosed with a terminal illness.

2. Community hospital care –

   The incarcerated individual was sent to a community hospital for care that could not be provided at the facility. He was discharged from the community hospital and returned to the prison inpatient unit to continue comfort care. He died a few hours later. The committee discussed the value and methods of working with community hospitals regarding caring for incarcerated individuals.

Committee Findings

The incarcerated individual died as a result of end-stage liver disease. 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. DOC should continue exploring ways to work with community hospitals to support incarcerated individuals.