Office of the Corrections OMBUDS

Monthly Outcome Report

March 2025

Unexpected Fatality Reviews: 2

Case Investigations: 191

Assistance Provided: 41
Information Provided: 85
DOC Resolved: 31
Insufficient Evidence to Substantiate: 8
No Violation of Policy: 25
Substantiated: 1

Intake Investigations: 153

Administrative Remedies Not Pursued: 0
Declined: 0
Lacked Jurisdiction: 10
Person Declined OCO Assistance: 19
Person Released from DOC Prior to OCO Action: 19
Technical Assistance Provided: 105

Resolved Investigations:

346

Assistance Provided, Information Provided, or Technical Assistance Provided in

67%

of Investigations

Monthly Outcome Report: March 2025

	Complaint Summary	Outcome Summary	Case Closure Reason
Unexpected Fatality Reviews			
Reentry Center - Bellingham - Whatcom			
1.	An incarcerated individual passed away 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-24-012 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website.	Unexpected Fatality Review
Washington State Penitentiary			
2.	Incarcerated individual passed away 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-24-023 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website.	Unexpected Fatality Review
Case Investigations			
Airway Heights Corrections Center			
3.	Person reports that he received a diagnosis that requires a special machine to manage. The person is concerned that DOC will not provide the machine due to the cost.	The OCO provided assistance. OCO staff reviewed the patient's records and contacted DOC health services staff who confirmed the cost of the machine was a factor in knowing if it could be covered by the DOC Health Plan. DOC staff agreed to have the request reviewed by the Care Review Committee (CRC). OCO found that the CRC approved the requested machine.	Assistance Provided
4.	Incarcerated individual relayed concerns about DOC not following through on the outcome of a previous OCO case in which the individual was allowed to resubmit an infraction appeal.	The OCO spoke to DOC about this and confirmed that DOC will allow the individual to still resubmit the appeal at this time and DOC is going to come to the unit to speak with the individual to ensure that the appeal is going to the right place.	Assistance Provided
5.	Person reported that he has not received physical therapy following a work-related injury.	The OCO provided assistance by continually following up with DOC staff and ensuring that he received physical therapy. The OCO reviewed DOC records and reached out to DOC staff, who confirmed this individual has been seen and has follow-up care	Assistance Provided

		scheduled. DOC staff acknowledged delays in physical therapy appointments due to staffing issues. The OCO also noted and addressed concerns with DOC records regarding his care.	
6.	An anonymous caller reported PREA concerns about a specific incarcerated individual and their negative behavior toward trans people.	The OCO provided assistance by elevating the concern to facility leadership and reviewing the PREA packets after DOC completed its review. The OCO found the PREA reviews were completed per policy.	Assistance Provided
7.	Incarcerated individual relayed concerns about an infraction.	The OCO reviewed the individual's records and confirmed the infraction is no longer on the individual's record.	DOC Resolved
8.	Incarcerated individual relayed concerns about a delayed infraction appeal.	The OCO reviewed the individual's records and confirmed the infraction is no longer on their record.	DOC Resolved
9.	Person reports that he attempted to refill his medications and the delivery of his keep-on-person medication was significantly delayed.	DOC staff resolved this concern prior to OCO action. OCO staff reviewed the patient's records and substantiated that his medication was not issued for a significant amount of time after it arrived at the facility. OCO staff contacted DOC Health Services staff and were informed that the distribution process had recently been changed to improve delivery times for keep-on-person medications.	DOC Resolved
10.	Incarcerated individual relayed concerns about losing their job due to a health status report (HSR).	The OCO spoke with DOC about this issue. The OCO confirmed that the individual returned to their regular job duties. The OCO informed the individual that if they have concerns about the specific staff conduct related to this, they will need to file a grievance through to level 2 first.	DOC Resolved
11.	Incarcerated individual shared concerns regarding being approved to go to a reentry center but being later denied for no reason.	DOC staff resolved this concern prior to the OCO taking action on this complaint. After review of DOC records, this office was able to confirm that this individual was transferred to a reentry center.	DOC Resolved
12.	Incarcerated individual relayed concerns about an infraction.	The OCO reviewed the related records and confirmed the infraction is no longer on the individual's record.	DOC Resolved
13.	Incarcerated individual relayed concerns about an infraction.	The OCO reviewed the individual's records and confirmed the infraction is no longer on the individual's record.	DOC Resolved
14.	Incarcerated individual relayed concerns about an infraction that was dismissed but is still showing in the system.	The OCO reviewed the individual's records and confirmed the infraction is no longer on the individual's record.	DOC Resolved
15.	Incarcerated individual relayed concerns about placement in segregation.	The OCO reviewed the individual's records and confirmed that the investigation has been completed, and the infraction has been submitted. The OCO informed the individual that they will need to have the infraction hearing and appeal it before the OCO can investigate the infraction and that they will remain in IMU until the infraction hearing occurs and depending on the outcome, a new custody facility plan (CFP) may be created.	Information Provided
16.	Incarcerated individual relayed concerns regarding placement in segregation.	The OCO reviewed the individual's placement and confirmed that they have been placed in the transfer pod, allowing them more time out of cell and more access to things such as commissary while their infraction hearing is pending.	Information Provided
17.	Patient reports concerns about access to an assistive walking device while pending a provider appointment about difficulties with walking.	The OCO reviewed recent medical emergencies and could not identify evidence that the patient had reported a medical emergency related to difficulty walking. The patient was seen for blood pressure concerns and reviewed for a cane, which	Information Provided

		was not clinically indicated. The OCO provided information to the patient about reporting symptoms and discussing Health Status Reports (HSRs) for walking devices with a provider.	
18.	Incarcerated individual relayed concerns about DOC taking out more than they are supposed to for child support.	The OCO reviewed the related grievance and confirmed that the Division of Child Services discontinued the individual's child support collections but if they were to restart, DOC must deduct child support per the percentages identified in RCW 72.09.111 and 72.09.480 which includes 20% of outside qualifying deposits and 15% of work deposits from within the institution.	Information Provided
19.	Patient reports concerns about access to medical appointments and requested testing, diagnosis, and treatment options.	The OCO elevated the concerns through DOC Health Services leadership and confirmed the patient received a CT scan. This office reviewed the patient's appointment, testing, and treatment access. The OCO confirmed that the patient expressed improvement in symptoms during recent medical encounters. The OCO provided information about the patient's options if symptoms reappear.	Information Provided
20.	Incarcerated individual relayed concerns regarding dental emergencies.	The OCO spoke with DOC about this concern and confirmed that the individual does have a dental appointment scheduled and informed the individual that the OCO is aware of extreme delays related to dental scheduling.	Information Provided
21.	Person reports that current pain management options are not sufficient for his pain. The patient is requesting a specific medication and was told by DOC staff that he was not eligible for that medication.	The OCO provided information to the patient regarding the criteria for treatment with the medication that was requested by the patient. OCO staff reviewed the person's record and noted that they do not currently meet the criteria for the requested medication. OCO staff provided information to the patient regarding the process for updating his pain management treatment.	Information Provided
22.	Individual reports the Department of Natural Resources (DNR) employees are making racist remarks and telling him things such as he should not be speaking Spanish because he is in America. The individual is experiencing this type of discrimination during his time on the DNR work crew.	The OCO does not have jurisdiction over DNR staff. However, the OCO provided this individual with the Human Resources Department mailing address for DNR.	Information Provided
23.	Incarcerated individual shared concerns regarding not being provided with their requested treatment option.	The OCO provided information regarding why their requested treatment option is not possible at this moment and steps they can take to work towards such an option later in their sentence.	Information Provided
24.	Incarcerated individual shared concerns regarding their counselor not assisting them with release planning.	This person was released prior to the OCO taking action on the complaint.	Information Provided
25.	Person reported they were turned away from medical for a medical emergency without the medical provider being consulted. The person was later sent to the emergency department after reporting a second medical emergency to a different staff member. The person attempted to use the resolution program but was told an appeal was never received and was	The OCO provided tort claim information to the person. OCO staff reviewed the patient's records and substantiated the reported concern. There was insufficient evidence to substantiate an appeal was received within resolution program time limits. OCO staff are in ongoing discussions with DOC leadership about improvements to record management. Individuals who have been harmed or who have suffered a loss as a result of negligent actions by a state employee or agency can submit a tort claim to the Office of Risk Management	Information Provided

	unable to elevate the resolution to higher levels.	(ORM). ORM is required by law (RCW Chapter 4.92) to receive these claims.	
26.	Person reported property concerns about pictures of his family going missing. Person also reported concern with the resolutions process and wanted to be compensated for the property.	The OCO provided information about the status of his property and information about the tort claim process. The OCO reviewed this individual's resolution request and could not find documentation of his pictures. The OCO also found that this individual was transferred to a different facility. The OCO reached out to DOC staff, who confirmed that they received his property from his previous facility. This office could not substantiate that DOC violated the Resolutions Program Manual in its resolution's response.	Information Provided
27.	Incarcerated person reported concern about visitors getting turned away when late. The person reports the visitors have called the facility to tell staff they were late and were turned away.	The OCO spoke with DOC staff about this concern and verified that the issue has been addressed at the facility level. The OCO provided information to the person about filing resolution requests if the issue persists to allow the facility to address the concern further if needed.	Information Provided
28.	Incarcerated individual relayed concerns about an infraction and having to serve the sanctions while the infraction was under appeal.	The OCO informed the individual that sanctions are not stayed on appeal and individuals must serve the sanctions as soon as they are given. WAC 137-28-400 states "the time limitations expressed in these regulations are not jurisdictional and failure to adhere to any particular time limit shall not be grounds for reversal or dismissal of a disciplinary proceeding."	Information Provided
29.	Incarcerated individual relayed concerns about staff conduct and discrimination.	The OCO reviewed the level 1, 2 and 3 grievance responses and confirmed that DOC maintains the reason the individual was required to write the correspondence in English is because it was determined that their English Language Proficiency (seen through documentation in OMNI as well as previous correspondence and college-level work in English) did not require translation services per DOC 450.500. The OCO could not substantiate the allegation of discrimination.	Insufficient Evidence to Substantiate
30.	Incarcerated individual relayed concerns about a use of force.	The OCO reviewed the individual's records and were unable to find any incident reports or grievances related to a use of force that they were involved in.	Insufficient Evidence to Substantiate
31.	Incarcerated individual relayed concerns about a pending infraction that has not been written for months and is impacting their custody level.	The OCO reviewed the individual's records and were unable to find any recent infractions or any changes to their custody level.	Insufficient Evidence to Substantiate
32.	Incarcerated Individual's family is concerned because their loved one was involved in a fight. The family is concerned about the quality of the investigation because they are being told by DOC staff that the video of the incident does not clearly define who is the aggressor.	The OCO reviewed the security surveillance videos and was able to identify the incarcerated individual clearly on the video as the instigator of a multi-person fight. The incarcerated individual did not appeal the guilty finding of the reduced WAC 505 violation for fighting, thus the OCO was unable to further review the infraction.	Insufficient Evidence to Substantiate
33.	Incarcerated individual relayed concerns about a facility transfer.	The OCO reviewed their custody facility plan (CFP) and confirmed that the transfer was temporary for medical reasons but due to numerous infractions, they have been demoted custody levels and their new facility placement is being properly addressed.	No Violation of Policy

34.	Person reports that the DOC has taken too long to respond to their publication rejection appeal.	The OCO reviewed the publication rejection and found that the rejection was completed per the timeframes in DOC policy.	No Violation of Policy
Clallam Bay Corrections Center			
35.	An incarcerated person reported safety and housing concerns on behalf of someone in segregation at the prison.	The OCO provided assistance by reaching out directly to the incarcerated person for more information about their concerns and requested resolutions. The OCO elevated the housing concerns and the individual was placed in different housing.	Assistance Provided
36.	Person reported a dental concern and wanted to get a root canal treatment. Person said his request for a root canal went to the Care Review Committee (CRC), and that he had not heard back regarding the appeal.	The OCO provided assistance. The OCO reached out to DOC staff about the CRC appeal, and upon OCO request, staff sent this individual a new copy of the CRC response to his appeal. The OCO reviewed DOC records and found that root canals are not covered by the DOC dental plan, which meets the community standard of care.	Assistance Provided
37.	Incarcerated individual relayed concerns about placement in segregation.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that they have been released from segregation.	DOC Resolved
38.	Incarcerated person reported concerns about missed meals while in solitary confinement and related treatment.	The OCO shared information with the person about reporting concerns related to food and verified that minimal meals were missed due to refusal of the meals. The OCO verified the person did miss meals on four occasions in the five months he has been housed in segregation. The meal refusals were documented per DOC protocol. The OCO also explained processes within the resolution program.	Information Provided
39.	Patient reports concerns about the distance from the local hospital and requested transfer to another facility.	The OCO elevated the concerns through DOC health services leadership. After an updated review of the patient's conditions and medical needs, transfer to a different facility was not medically indicated at this time. The OCO provided information about the process for reconsideration in the future if medical conditions change.	Information Provided
40.	Incarcerated individual shared concerns regarding DOC not properly diagnosing their injury and failing to provide adequate medical care.	The OCO provided information regarding tort claims as well as information pertaining to contacting the Department of Health (DOH) regarding concerns with about a provider.	Information Provided
41.	Incarcerated individual shared concerns regarding wanting specific dental procedures.	The OCO provided information regarding why there has been a delay in their dental care and why their requested treatment is not an option. This office provided further information regarding the patient paid healthcare plan. This office encouraged this individual to reach out to Health Services to take care of concerns as they arise.	Information Provided
Coyote Ridge Corrections Center			
42.	Person reports concerns about an infraction and mental health medication.	The OCO provided assistance by elevating the concern through DOC Health Services leadership. The OCO substantiated a delayed mental health assessment, and after OCO outreach, the patient was scheduled with their provider and their medications were adjusted. The OCO also provided information about appealing infractions and following up with the OCO if the concerns remain unresolved through that process.	Assistance Provided
43.	Patient reports concerns about access to a specialist.	The OCO elevated the concerns to DOC health services leadership and confirmed the patient is currently receiving	Assistance Provided

		testing, being monitored, and the pending results will determine if cardiology and/or neurology follow up is needed. The OCO confirmed the additional testing was completed, a referral for a specialist appointment was placed, and an appointment was scheduled.	
44.	Incarcerated individual relayed concerns regarding difficulties with their assigned wheelchair pusher who is leaving them in random places.	The OCO spoke to DOC about this concern who was unaware of this concern. After OCO outreach, DOC spoke with the ADA coordinator who followed up with the unit supervisor to address these concerns.	Assistance Provided
45.	Incarcerated individual shared concerns regarding DOC staff breaking their tablet and not providing them with a new one.	DOC staff resolved this concern prior to the OCO taking action on this complaint. After speaking with the individual, the OCO was informed that they have been given a new tablet.	DOC Resolved
46.	A family member reported that their video visit was terminated and that their husband received an infraction for his alleged behavior during the video visit.	The OCO provided information to the family member and the incarcerated individual about how to appeal the infractions and how to appeal the suspension of the visitor's visits.	Information Provided
47.	Incarcerated person reported a concern regarding DOC staff actions that resulted in a use of force. The incarcerated person requested the OCO investigate the staff actions that led to force being used on them.	The OCO provided information regarding DOC protocols and the findings of the incident. The OCO reviewed the incident and verified that the staff's actions complied with relevant DOC protocols and policies. The OCO also reviewed the use of force and spoke with facility leadership about the force used and the methods of documenting the incident. The OCO shared with the person that the actions of staff complied with current policies and provided information about DOC protocols.	Information Provided
48.	Incarcerated person reported concerns about their safety at the facility they were housed.	The OCO provided information about reporting safety concerns and verified this person was moved to a different facility prior to OCO involvement.	Information Provided
49.	Incarcerated individual relayed concerns about their facility placement due to safety reasons.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that the individual did not raise any safety concerns during their FRMT. The OCO informed the individual that they will need to contact the intelligence and investigations unit to express any safety concerns so that they can be validated.	Information Provided
50.	Incarcerated individual relayed concerns about placement in segregation.	The OCO reviewed the individual's records and confirmed that they have moved from segregation to the transfer pod. The OCO also confirmed they have an in-review custody facility plan (CFP) and have included information on how to appeal if they disagree with the outcome.	Information Provided
51.	Incarcerated individual relayed concerns regarding needing a medical appointment for shoulder pain.	The OCO spoke to DOC about this concern and confirmed that the individual received an assessment and has been scheduled for physical therapy.	Information Provided
52.	Incarcerated individual relayed concerns about their children's visitation being denied.	The OCO reviewed the visitation denial and appeal and confirmed that the visit denial was upheld as minors cannot visit due to the nature of the crime of conviction. Per DOC policy 450.300(IV)(A)(1)(a)(2) when the court authorizes visits for minors, DOC can still deny visits after conducting a full review.	No Violation of Policy
53.	Incarcerated individual shared concerns regarding being isolated	The OCO was unable to substantiate a violation of policy by DOC. After review of DOC records, this office was able to confirm that DOC complied with COVID-19 Screening Testing	No Violation of Policy

	despite not being positive for any communicable diseases.	and Infection Control Guideline and DOC policy 670.000 by isolating the individual for a period of time given the potential risk of communicable disease. This office was also able to confirm that this individual has since moved back into their original cell placement.	
54.	Person reports that his medication was changed before the weekend, leaving him unable to discuss the change with his provider. He is requesting to remain on the medication he had been on for years before coming into DOC custody.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed the pertinent DOC Health Services protocol and noted that the person does not meet the criteria to remain on the desired medication. OCO staff verified that DOC had communicated this information to the patient.	No Violation of Policy
55.	Incarcerated individual relayed concerns about a visitation denial.	The OCO reviewed the visitation denial and confirmed that it is documented that the visitor is a victim of their current or prior offense which, per DOC 450.300 attachment 1, makes them ineligible to visit.	No Violation of Policy
56.	Incarcerated individual relayed concerns about good conduct time that was taken for an infraction.	The OCO reviewed the infraction and confirmed that this was the individual's second serious infraction in a 12-month period thus the good conduct time that was taken was correct per DOC 460.050.	No Violation of Policy
57.	Incarcerated individual shared concerns regarding DOC rejecting their mail.	The OCO was unable to substantiate a violation of policy by DOC. The source of the mail was deemed a safety and security risk and such violated DOC 450.100. After review of DOC records, this office was able to confirm that this individual's mail rejection appeal was sent to DOC headquarters where the rejection was upheld.	No Violation of Policy
Mission Creek Corrections Center for Women			
58.	Incarcerated person reported concerns about safety in her current assigned housing.	The OCO verified the person is safe and provided information regarding reporting concerns about other incarcerated people. The OCO reviewed the person's file, spoke with DOC staff regarding the safety concern and verified this person is located in safe housing and is releasing soon.	Information Provided
59.	Incarcerated person reported a concern about DOC directing her to complete a program prior to approving her transfer to Graduated Reentry (GRE) or a Reentry Center. The person reports DOC staff are not helping her access reentry tools and services.	The OCO reviewed DOC's actions and verified this person participated in the programming and recently transferred to a Reentry Center. This office verified the transfer was delayed. The OCO verified DOC staff met with this person prior to the transfer to discuss reentry options multiple times. The OCO provided information to the person about the transfer delay and provided further details related to their situation.	Information Provided
60.	Incarcerated person reported concerns regarding her denial into a Reentry Center and requested the OCO review it. The person reported DOC denied her transfer to a Reentry Center outside of DOC policy 300.500.	The OCO was unable to substantiate a violation of policy by DOC. This office reviewed the DOC decision to deny the person transfer to a reentry center and found DOC denied the person this access per DOC policy 300.500 which states, "All other denials (i.e. not policy-driven or those that warrant additional review) will be scheduled for HCSC (Headquarters Community Screening Committee) review." The OCO verified the HCSC reviewed and denied this person access to a Reentry Center due to a lack of programming.	No Violation of Policy
61.	Incarcerated individual relayed concerns about getting infracted for refusing therapeutic communities (TC) programming and then getting	The OCO reviewed the individual's records and spoke to DOC about this concern. The OCO confirmed that the first infraction was dismissed due to a technicality. DOC tried to work with the individual to get them enrolled in TC again after that, however,	No Violation of Policy

	infracted again when the first infraction was dismissed.	because the individual refused programming, they were infracted again. DOC can require that individuals participate in treatment as indicated by their crime of conviction.	
62.	Incarcerated person reports DOC placed them into a program that is not required. The person reports completing the program is lengthy and she will not be able to access Graduated Reentry (GRE) or a Reentry Center because of the program time frames.	The OCO was unable to substantiate a violation of policy. The OCO reviewed the person's file and verified they met the requirements to complete this programming prior to GRE or a Reentry Center considering them for approval.	No Violation of Policy
Monroe Correctional Complex			
63.	Person reports the Care Review Committee (CRC) denied a medication that was recommended by an outside specialist. The person is requesting to be able to purchase the medication through the Patient Paid Health Plan without having to see a separate specialist.	The OCO provided assistance. OCO staff reviewed the person's record and contacted DOC Health Services staff to request review of the patient's situation by the Facility Medical Director (FMD). OCO staff were informed that the review took place and DOC Health Services staff agreed that the patient would be able to get the medication through the Patient Paid Health Plan if additional review by the Care Review Committee was not indicated. OCO staff were informed the patient has an appointment scheduled with his medical provider to discuss these options.	Assistance Provided
64.	Incarcerated person reported concerns about the dinner served that night. The person reported people were served dinner boats with "use by" dates that were expired.	The OCO provided assistance. The OCO spoke with DOC staff regarding the reports. DOC staff reported the food was adequate to serve. DOC explained the meals had been frozen prior to the "use by" date. Because of this, the food is safe to serve. DOC did replace one meal that appeared to be inedible. OCO requested if food was not going to be re-issued, that DOC share information about the dinner meal. CI issued a memo explaining this practice and the reason the "use by" dates were expired but still appropriate for consumption.	Assistance Provided
65.	Incarcerated individual relayed concerns regarding DOC not allowing them access to the law library when they have self-harmed.	The OCO spoke with DOC about this concern. DOC was unaware of this concern as the individual is on the mixing list which provides full law library access. At OCO request, DOC will meet with the individual to discuss this concern further and ensure that they have proper law library access.	Assistance Provided
66.	Patient reports concerns about access to dental care and severe pain.	The OCO provided assistance by elevating the concern through DOC health services leadership. This office substantiated the recommended follow-up appointment was not submitted, causing delays. After OCO outreach, the patient was seen, his blood pressure was checked and found to be within normal levels and the patient was able to receive dental treatment that day after clinical assessment.	Assistance Provided
67.	Patient reports difficulty using dentures due to vision impairment and requested implants.	The OCO reviewed and elevated the concerns to DOC health services leadership. The OCO confirmed the case was elevated to the DOC Care Review Committee (CRC) for review but the implants were denied at level 3 as not medically necessary and are not covered by the current DOC Health Plan. The OCO provided information regarding options through the patient paid health plan. After OCO outreach, DOC agreed to schedule the patient with the ADA specialist to discuss accommodation options and provide education about handling dentures with vision impairments. DOC also agreed to schedule the patient	Assistance Provided

		with the dentist and hygienist for education on proper care of his dentures and meet with him quarterly to do deep cleaning if necessary.	
68.	Anonymous person reports concerns about a community hospital attempting to transfer a patient back to a DOC facility that is not able to provide the level of care needed.	The OCO provided assistance by elevating this concern to the DOC Chief Medical Officer who then communicated with the hospital, which agreed to keep the patient for the level of care needed.	Assistance Provided
69.	External person reports concerns about anti-trans staff conduct at the facility.	The OCO provided assistance by elevating the updated staff conduct concerns to DOC leadership related to a related past staff conduct investigation.	Assistance Provided
70.	Person reported concerns about the conduct of DOC staff while on medical transport, which resulted in his transport and appointment for a medical procedure being cancelled. Person reported that he filed a resolutions request about the incident and then was infracted a month later and expressed concern about retaliation. Person said that after the infraction, the resolutions program did not accept his resolutions request.	The OCO provided assistance by negotiating with DOC headquarters to get his resolution request reviewed, where it was reviewed at both the facility and headquarters level. The OCO also found that after OCO outreach, this individual was rescheduled for his offsite medical procedure, which the OCO confirmed was completed. The OCO reviewed DOC documentation about this incident and discussed the infraction with facility leadership, who declined to dismiss the infraction. Facility leadership and DOC documentation showed that the delay in the infraction being served was due to the DOC staff who was responsible for serving the infraction leaving that position, and facility leadership said that they could not substantiate retaliation.	Assistance Provided
71.	Patient reports concerns about access to mental health staff and active crisis.	The OCO provided assistance by elevating the crisis concerns to DOC health services leadership. DOC agreed to send a mental health provider to conduct a wellness exam.	Assistance Provided
72.	Incarcerated individual shared concerns regarding DOC not providing them with adequate medical care and refusing to provide them with testing.	DOC staff resolved this concern prior to the OCO taking action on this complaint. After review of DOC records, this office was able to confirm that this individual is actively working with their provider to take care of their concern.	DOC Resolved
73.	Incarcerated individual relayed concerns regarding needing additional neurological follow-up.	The OCO spoke with DOC about this concern and confirmed that the neurological appointment and CT scan have been completed.	DOC Resolved
74.	Patient reports concerns related to mental health treatment and medication access.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO confirmed a mental health teleconference review occurred, and the patient's treatment plan and medications were adjusted prior to OCO outreach.	DOC Resolved
75.	Person reported concern about delays with a facility transfer.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and found that this individual has transferred to their new facility.	DOC Resolved
76.	Patient reports a need for an ultrasound.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The patient transferred facilities after opening the case with OCO, and the OCO contacted health services leadership at both facilities who confirmed the patient received an ultrasound.	DOC Resolved
77.	The individual reports he is being retaliated against for filing a Personal Restraint Petition (PRP).	This person called the hotline and let the OCO know that DOC resolved this concern. This individual asked that this office close his case.	DOC Resolved
78.	Incarcerated individual relayed concerns about a potential facility transfer.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that DOC already addressed this issue and informed the individual that they would not be transferring.	DOC Resolved

79.	Incarcerated individual relayed concerns about an infraction.	The OCO reviewed the individual's records and confirmed that the infraction is no longer on their record.	DOC Resolved
80.	Incarcerated individual relayed concerns about a potential facility transfer.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that DOC had properly addressed this issue.	DOC Resolved
81.	Incarcerated individual shared concerns regarding DOC staff not providing them with adequate medical care.	DOC staff resolved this concern prior to the OCO taking action on this complaint. After speaking with DOC staff, this office was able to confirm that this individual is being provided with continuous medical care regarding their concern.	DOC Resolved
82.	Incarcerated individual relayed concerns regarding segregation placement.	The OCO reviewed the individual's records and confirmed that the investigation has been completed and the infraction has been submitted. The OCO informed the individual that they will need to have the infraction hearing and appeal it before the OCO can investigate the infraction and that they will remain in IMU until the infraction hearing occurs and depending on the outcome, a new custody facility plan (CFP) may be created.	Information Provided
83.	Incarcerated individual relayed concerns about being retaliated against by staff after filing a PREA which resulted in them being placed in the COA and not getting assistance in using the restroom.	The OCO reviewed the individual's records and spoke with DOC and confirmed that they were prescribed Depends while in COA as the safest solution to their needs which was approved both by medical and custody. The OCO confirmed that they were placed in COA due to self-harm behavior, not due to staff retaliation. The OCO provided the individual with information regarding how to file a grievance related to staff conduct and the PREA process as well as information about how to appeal an infraction.	Information Provided
84.	Incarcerated individual relayed concerns about placement in segregation and a delayed transfer.	The OCO reviewed the individual's records and confirmed that DOC is properly addressing their transfer concerns.	Information Provided
85.	Person reported he was supposed to see a specialist but DOC would not schedule him for the appointment or tell him the name of the clinic.	OCO staff provided information to the patient regarding the specialist consult request. OCO staff reviewed the consult request and noted that the outside clinic declined to accept this person as a patient as they did not feel they would be able to do anything for the patient. OCO contacted DOC Health Services Staff and confirmed that the patient does have active orders for medication to treat the reported issue.	Information Provided
86.	Incarcerated individual shared concerns regarding being transferred and not being given the opportunity to take necessary programming.	The OCO provided information to this individual regarding why they have not been able to take the programming they requested to take and additional information regarding programming guidelines.	Information Provided
87.	Individual reports concerns about being restricted from the DOC Resolution Program. The person also expressed concerns about being restricted from the resolution program related to an update letter from DRW about tracking of the transgender settlement.	The OCO substantiated that the individual was suspended from the DOC Resolution Program due to continued violations and misuse. This office provided information about the person's options for communicating medical, PREA, and other concerns through kite, kiosk, and PREA. OCO also confirmed DOC provided detailed information to the individual about the timeline of the suspension and other options for addressing concerns while suspended. The individual can write to DRW if there are specific concerns they want to flag for their settlement tracking.	Information Provided
88.	Incarcerated individual relayed concerns regarding being placed in	The OCO provided information about DOC's actions. The OCO verified that DOC did place this individual in segregation for a short period of time before transferring him to a residential	Information Provided

	segregation after continued attempts at serious self-injury.	treatment unit (RTU), due to this person being an active danger to themselves. Before transfer to RTU, the person was housed in a facility that could not accommodate their needs in any location other than segregation. DOC staff shared with this office they made this decision to protect the person from harming themselves until he could be moved somewhere that could offer him appropriate mental health care.	
89.	External person reports concerns about an incarcerated patient's access to medical care.	The OCO elevated the concerns through DOC health services leadership and provided information to the patient. The OCO confirmed the surgery was deemed elective and the surgeon did not approve the procedure. The OCO provided information about reporting to DOH regarding surgeons not accepting patients because of concerns that DOC cannot provide adequate post-operative care.	Information Provided
90.	Person reports DOC medical is not following all of the recommendations from the specialist he was sent to.	The OCO provided information to the patient regarding specialist recommendations and DOC health services policy. OCO staff reviewed the patient's records and were unable to substantiate a violation of DOC policy 600.000. Recommendations from outside specialists must be authorized according to Department policies and procedures and ordered by a Department health care practitioner. A DOC medical provider cannot order a treatment that is not supported by the DOC health plan.	Information Provided
91.	Incarcerated individual relayed concerns about being retaliated against by staff after filing a PREA which resulted in them being placed in the COA and not getting assistance in using the restroom.	The OCO reviewed the individual's records and spoke with DOC and confirmed that they were prescribed Depends while in COA as the safest solution to their needs, this was approved both by medical and custody. The OCO confirmed that they were placed in COA due to self-harm behavior, not due to staff retaliation. The OCO provided the individual with information regarding how to file a grievance related to staff conduct and the PREA process as well as information about how to appeal an infraction.	Information Provided
92.	Incarcerated individual relayed concerns regarding there being black mold in the kitchen.	The OCO spoke with multiple DOC staff concerning this issue including facility leadership and confirmed that on-site testing was done throughout the kitchen area and the only place where black mold was found was in the staff office. This area was sealed off and a professional company came to conduct mold mitigation. Additional testing was done throughout the kitchen including the areas the OCO expressed concerns about (dish pit and coolers) and while other mold was found, it was determined to be non-toxic. Testing revealed that just because it looks black, does not necessarily mean that it is black mold or toxic mold. An evening crew has been established to deep clean the kitchen when it is clear of work crews. Safety equipment including eye protection is available for staff, CI and incarcerated workers. To remove the current mold and prevent future mold, better cleaning techniques are being implemented along with aggressive testing and treating non-toxigenic mold to prevent spreading. DOC informed the OCO that they are on the lookout for new growth and will test new areas of concern as they arise.	Information Provided
93.	Person reports that his dental provider is only performing one part of his treatment plan per appointment, with	The OCO provided information to the person. This concern was elevated to DOC leadership as part of a systemic investigation into dental care. DOC Health Services Leadership supports the	Information Provided

	several months between appointments. The person is requesting to receive the rest of his treatment plan in one appointment.	facility dentists in their decision to prioritize seeing more patients in a day rather than completing several treatments for a few patients. The DOC is in the process of expanding dental access across the state. OCO staff provided the patient with information about his place on the dental scheduling queue.	
94.	Patient reports concerns about access to pain management and not receiving special transport for medical conditions.	The OCO elevated the concerns through DOC Health Services leadership and confirmed appointment access and current pain management plan. The patient's current T code does not indicate special transport and was not medically indicated by the medical provider. The individual was released and is no longer at a DOC prison.	Information Provided
95.	Incarcerated individual shared concerns regarding not being provided with a desired treatment option despite wanting to utilize patient-paid healthcare.	The OCO provided information regarding their current treatment plan and status of their patient-paid healthcare application. After review of DOC records and speaking with DOC staff, this office was able to confirm that DOC staff are actively working to provide them with their requested care option and are processing their patient-paid healthcare plan application. This office was also able to confirm that there was a delay in responding to the application for the patient-paid healthcare plan.	Information Provided
96.	Incarcerated individual relayed concerns about not being able to go to incentive yard after receiving an infraction.	The OCO reviewed the individual's grievance and confirmed that incentive yard is separate from regular yard and is used as an incentive for good behavior and individuals will not be able to attend for a certain period of time if they receive an infraction.	Information Provided
97.	Incarcerated individual shared concerns regarding DOC staff not removing a tourniquet after an off-site medical visit and that causing excessive pain.	The OCO was unable to substantiate the concern due to insufficient evidence. After speaking with DOC staff and reviewing DOC records, this office was unable to confirm that this individual had a tourniquet after returning from an off-site medical visit. This office was also able to confirm this individual has received an assessment to confirm the self-reported pain and there has been no evidence to support the self-reported diagnosis.	Insufficient Evidence to Substantiate
98.	Patient reports concerns about being discharged from SUD treatment and requested OCO assistance placing him at ABHS for inpatient treatment. The patient later followed up to request an updated assessment.	The OCO was unable to substantiate a violation of DOC 580.00. The OCO elevated the concerns through DOC health services leadership and found the individual was discharged from SUD treatment due to behavior and noncompliance with programming. The assessment on file matches the level of care the patient was requesting to be reassessed for, and the level of care was reviewed at patient discharge. The OCO cannot influence placement at ABHS for inpatient treatment.	No Violation of Policy
99.	Incarcerated individual relayed concerns about having a mail rejection appeal overturned but still not getting the item.	The OCO reviewed the related records and confirmed that the book was rejected by the Chaplain for safety concerns per DOC 560.200 that states "restriction of a religious activity (or item) must be related to legitimate facility safety and security concerns."	No Violation of Policy
Olympic Corrections Center			
100.	Incarcerated individual relayed concerns about a visitation denial.	The OCO reviewed the related records and spoke to DOC about this. The OCO confirmed that the visitors were denied due to safety concerns and the individual's continued concerning behavior including 15 recent serious infractions.	No Violation of Policy
Other			

101.	External person reports alleged DOC employee misconduct while in the community. Person says a DOC staff member exited a vehicle, put on their vest, badge, gun, and taser, and then proceeded to yell at the civilian.	OCO staff reached out to Community Corrections Division (CCD) Leadership and relayed the community member's concern. CCD leadership informed the OCO that they would review the concern as an employment matter. OCO staff provided the community member with the CCD leader's direct contact information.	Information Provided
Reentry Center - Reynolds - King			
102.	Individual reports that a clinic in Seattle communicated his whereabouts to his re-entry center classifications counselor. The person was concerned that his HIPPA rights were violated and was looking for additional information regarding what can be shared with DOC.	The OCO confirmed that the Seattle clinic is not allowed to reveal information about his substance abuse disorder but may confirm his presence at their location with DOC staff. This information was found in page 47 from the Sharing Information Guide, published by the Washington State Healthcare Authority.	Information Provided
Stafford Creek Corrections Center			
103.	Anonymous individual reports concerns about nursing staff abuse of terminal patients in the medical in-patient unit.	The OCO contacted DOC Health Services leadership at the facility and substantiated active staff conduct investigations related to this concern. This office discussed details with DOC to confirm appropriate review and follow up on these staff conduct issues.	Assistance Provided
104.	Patient reports concerns about delays in process for gender affirming surgery.	The OCO provided assistance by elevating the concerns through the DOC gender affirming medical (GAMs) leadership. This office confirmed the surgery was reviewed by the gender dysphoria care review committee (GD-CRC) and the patient was approved for a consult. The OCO confirmed the procedure is not offered in Washington State, and a telehealth consult was requested. The clinic estimated a wait time of 1-2 years, and OCO confirmed DOC has completed their portion of the scheduling paperwork and the appointment is pending clinic scheduling. The OCO provided information about next steps to the patient.	Assistance Provided
105.	Person reports that he is still not receiving care that was agreed to in a prior OCO case.	The OCO provided assistance. OCO staff reviewed the person's consultations and noted an administrative mistake that resulted in a consultation being closed in error. OCO staff contacted DOC health services staff and a new consultation for specialist evaluation and treatment was opened.	Assistance Provided
106.	Person reported that he was told he could order tarot cards from approved vendors outside of Union Supply, but when he ordered tarot cards, they were rejected by property. Person said they were not reviewed by the religious coordinator, and he was not given the opportunity to appeal.	The OCO provided assistance. The OCO reached out DOC headquarters about this situation and reached out to the facility about the process. After OCO outreach, DOC headquarters sent out an email to mailrooms and religious coordinators statewide, changing the process for tarot cards. Previously, Union Supply was the only allowed vendor for tarot cards or tarot cards could only be received as a donation. Tarot cards can now be purchased and received as publications via allowable vendors and publishers as noted in DOC policy 450.100. Tarot cards will not be forwarded or rejected by the mailroom but will be sent to the religious coordinator for approval. Upon OCO request, DOC staff spoke with this individual about this statewide change in the process for tarot cards.	Assistance Provided

107.	Person reported that his medical care has been delayed and reported that staff harassed him about using Durable Medical Equipment (DME) for accessibility needs. Person also reported that he received a negative Behavioral Observation Entry (BOE) for kiting property about other DME.	The OCO provided assistance by speaking with facility leadership, who found that his Accessibility Status Report (ASR) was not up to date in his file. DOC staff updated it to reflect his current ASRs, which the OCO confirmed. Facility leadership also agreed to speak with the staff that the individual said harassed him. The OCO reviewed DOC records and found that this individual received the medical treatment he was seeking. The OCO reviewed his negative BOE and found that it was not appealed and is now outside of the appeal timeframe.	Assistance Provided
108.	Patient reports concerns about electrolysis access.	The OCO provided assistance by elevating this concern through DOC gender affirming medical (GAMs) leadership. This office provided information to the patient regarding surgery prep related electrolysis. The OCO substantiated facial electrolysis was paused to prioritize patients preparing for surgery, and this patient is now on the list for scheduling facial electrolysis.	Assistance Provided
109.	Person reports not having access to their mental health provider. The person requests to have an appointment scheduled.	The OCO provided assistance. OCO staff reviewed the person's appointments and noted that multiple follow up appointments had been canceled. OCO staff contacted DOC Health Services staff and requested the patient be scheduled with their mental health provider. DOC Health Services staff agreed and verified that the patient had been scheduled.	Assistance Provided
110.	A loved one shared concerns on behalf of an incarcerated individual regarding DOC staff ignoring safety concerns and refusing to assist them in transferring facilities.	DOC staff resolved this concern prior to the OCO taking action on this complaint. After review of DOC records, this office was able to confirm that DOC transferred this individual due to the substantiated safety concerns.	DOC Resolved
111.	Incarcerated individual relayed concerns about a behavior observation entry (BOE).	Per the individual's request, the OCO closed this case as the issue was resolved by DOC.	DOC Resolved
112.	Patient reports that he was in a holding cell and was not provided with the necessary assistance with activities of daily living (ADL) as required. The person is requesting placement in a living unit.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff reviewed the person's records and noted that he is being housed in the medical unit. Health Services staff are available on the medical unit to assist with ADLs as necessary.	DOC Resolved
113.	Family member reports concerns about visitation with their incarcerated loved one as their condition is terminal.	The OCO elevated this concern through DOC Health Services and found that the patient was not on seriously ill status, however, DOC confirmed that when the patient's condition progresses and he is moved to seriously ill status, that the family will be approved for visitation and this has already been discussed with headquarters leadership. The OCO provided information to the patient directly.	Information Provided
114.	An external party reported concern about the facility not providing an ADA accommodation.	The OCO provided information about the timeline of this situation and the DOC policies which were followed. The OCO reviewed DOC records and spoke with facility leadership. The OCO found that the Accommodation Review Committee reviewed his accommodations per policy and that he went through the appeals process.	Information Provided
115.	Person reports sustaining an injury a couple of years ago in class due to not having the proper equipment and instructions. The person is requesting	The OCO provided tort claim information to the person. OCO staff contacted DOC health services staff who informed this office of the most recent care provided for this injury as well as reoccurring appointments with his medical provider. OCO staff confirmed that the activity that was being performed is a	Information Provided

	medical treatment and for that class to have better safety equipment.	normal part of the class and students are trained in how to do it safely before the activity. Individuals who have been harmed or who have suffered a loss as a result of negligent actions by a state employee or agency can submit a tort claim to the Office of Risk Management (ORM). ORM is required by law (RCW Chapter 4.92) to receive these claims.	
116.	Loved one relayed concerns regarding an inability to obtain medical information from DOC about an incarcerated individual in addition to seeking clemency paperwork.	The OCO confirmed with DOC that the individual now has a release of information (ROI) on file that should allow the loved one to obtain the desired medical information through DOC. The OCO informed the individual that they can get the clemency paperwork from the law library or if they have an attorney assisting with the clemency, they can mail in the paperwork.	Information Provided
117.	Person reported concern about the facility not providing an ADA accommodation.	The OCO provided information about the timeline of this situation and the DOC policies which were followed. The OCO reviewed DOC records and spoke with facility leadership. The OCO found that the Accommodation Review Committee reviewed his accommodations per policy and that he went through the appeals process.	Information Provided
118.	Person states that they have not received treatment for a sleep condition. They are requesting that OCO verify they are scheduled for an appointment with the specialist.	OCO staff provided information to the patient regarding the status of his requested specialist consult. OCO staff contacted DOC staff and confirmed that recommended equipment had been ordered, and the person would be scheduled for follow-up after the equipment was received.	Information Provided
119.	Incarcerated individual relayed concerns about a job termination.	The OCO reviewed the individual's records and spoke to DOC about this and confirmed that they have open job referrals at this time.	Information Provided
120.	External person reports their loved one is suffering from an infection and DOC staff are not providing medical care. The person requested the release of the patient from DOC custody so they can get medical care in the community.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff reviewed the patient's records and verified that the person was transferred for medical care in the community at the time of injury. The resolution requested by the external person is not within the authority of the OCO.	Insufficient Evidence to Substantiate
121.	Incarcerated individual relayed concerns about their custody score and how it is impacting their placement in segregation.	The OCO spoke with DOC and confirmed that their custody score is correctly calculated.	No Violation of Policy
Washington Corrections Center			
122.	Incarcerated individual shared concerns regarding their cell being without power and DOC staff refusing to move them or fix the concern.	The OCO provided assistance. After OCO outreach, DOC confirmed that they will be actively working to fix the concern. This office was able to confirm that this individual's cell still has power, but the outlets have lost power.	Assistance Provided
123.	Person reports attempting to access reentry services but being denied. The person was told by staff that they should qualify for services.	The OCO provided assistance. OCO staff contacted DOC Health Services staff regarding the reason for denial. OCO staff contacted the program administrator to verify that the person's follow up request was reviewed in a timely manner after additional information was acquired by DOC.	Assistance Provided
124.	Patient reports concerns about a dental emergency and kites at the facility not coming with a pink receipt copy.	The OCO provided assistance by elevating these concerns through DOC health services leadership. After OCO outreach, this office confirmed the dentist assessed for urgent/emergent care needs and identified the patient's dental needs fall under	Assistance Provided

		routine care. The OCO confirmed the patient is on the list to be scheduled for a dental appointment and provided information about criteria for urgent, emergent, and routine dental scheduling. This office also added this case to the OCO appointment tracker to confirm the appointment is scheduled and occurs. The OCO also confirmed kites are supposed to come along with a pink receipt copy and elevated this concern to DOC headquarters who is working to ensure compliance with this.	
125.	While onsite, an incarcerated individual relayed concerns regarding individuals housed in IMU not having their own personal coats, rather, individuals are having to share dirty coats.	The OCO spoke with DOC about this concern and confirmed that it is the normal protocol for jackets to be shared, the only exception to this protocol was during COVID and jackets are laundered on non-yard days. At OCO request, DOC further investigated this concern to ensure that the coats are being cleaned regularly.	Assistance Provided
126.	While onsite, an incarcerated individual relayed concerns regarding individuals housed in IMU not having access to cleaning supplies to clean the dayroom phones.	The OCO spoke with DOC about this concern and confirmed that spray bottles and towels are provided at the yard door for use upon request. At OCO request, DOC further investigated this concern to ensure that these are being offered.	Assistance Provided
127.	Person reports that DOC did not provide medical care after he was injured by a door. The person states that imaging orders were delayed and he has not received follow-up since getting the imaging done.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff contacted DOC Health Services staff and were informed the patient was already scheduled for follow up to discuss the imaging that took place and returned unremarkable results. OCO staff verified this person's scheduled appointment is before the expiration of their related Health Status reports.	DOC Resolved
128.	Incarcerated individual relayed concerns regarding placement in segregation and concerns about transferring to a particular facility due to safety.	The OCO reviewed the individual's placement and spoke to DOC about this concern. The OCO confirmed that the individual has been released from segregation and transferred facilities. The OCO found no violation of DOC policy 300.380 in the individual's placement and informed the individual that for their safety concerns to be validated, they must provide all details to the intelligence and investigations unit so that they can be verified.	Information Provided
129.	Anonymous incarcerated person reported people are not receiving tennis shoes and other clothing upon entering the DOC receiving units.	The OCO spoke with facility leadership who explained there was an issue filling the order for more clothing, which caused a delay in issuing many people clothing items. The OCO then spoke with DOC staff about the ordering concerns and received information about how DOC is addressing the backlog and how they plan to prevent the issue from occurring again. The OCO also verified the orders for shoes were received by the facility and will be processed and issued to people who did not receive them.	Information Provided
130.	Patient reports concerns about staff conduct and access to mental healthcare.	The person transferred facilities and the OCO provided information about accessing mental health care at the new facility.	Information Provided
131.	Incarcerated individual shared concerns regarding wanting to access programming since they are close to their ERD (earned release date).	The OCO provided information regarding the programming this individual is interested in.	Information Provided

132.	Incarcerated individual relayed concerns about their upcoming release and not feeling prepared for it.	The OCO reviewed the individual's records and confirmed that they are in a unit that is focused on helping people release successfully and confirmed that they have attended the reentry workshop. The OCO suggests that the individual continue to attend any informational sessions that are offered in their unit.	Information Provided
133.	Incarcerated individual shared concerns regarding DOC staff not turning up the heat in their unit despite it being excessively cold.	The OCO provided information regarding why the temperature has been lower. After speaking with DOC staff, this office was able to confirm that DOC staff have placed numerous work orders to repair the heating unit. DOC confirmed to this office that temperatures are currently regulated within the unit.	Information Provided
134.	Incarcerated person reported people are not receiving tennis shoes and other clothing upon entering the DOC Receiving units.	The OCO spoke with facility leadership who explained there was an issue filling the order for more clothing, which caused a delay in issuing many people clothing items. The OCO then spoke with DOC staff about the ordering concerns and received information about how DOC is addressing the backlog and how they plan to prevent the issue from occurring again. The OCO also verified the orders for shoes were received by the facility and will be processed and issued to people who did not receive them. The OCO shared this information with the reporter of this concern.	Information Provided
135.	Incarcerated individual relayed concerns about their facility placement due to safety reasons.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that they did not raise any safety concerns during their FRMT. The OCO informed the individual that they will need to contact the intelligence and investigations unit to express any safety concerns so that they can be validated.	Information Provided
136.	Person reports that he received an infraction but has never used illegal drugs and was denied an interpreter.	The OCO confirmed that the individual received an infraction and has no health status report (HSR) for additional time to provide a urine analysis (UA) sample. The OCO also confirmed that the individual initially told DOC that he could understand English. However, DOC staff report he can still access language services if he needs help. The OCO provided information regarding how to establish an HSR and who to contact at his facility for interpretation services.	Information Provided
137.	External person reports concerns about a patient not being able to access the level of medical care needed if transferred and mentioned a need for further physical therapy but has not received follow up.	The OCO elevated the concern through DOC Health Services clinical leadership. The OCO confirmed there is a medical hold for the patient to stay at their facility to complete their current round of treatment. After review, DOC did not identify a clinical reason that would prevent the patient from accessing medical care if transferred to another facility at this time. After the current round of testing and treatment, another clinical assessment will occur based on the updated diagnosis and treatment plan. The OCO also confirmed the patient was referred for additional PT sessions.	Information Provided
138.	Incarcerated individual shared concerns regarding DOC staff mistreating them and causing them to wrongfully lose their job.	After reviewing DOC records, the OCO was able to confirm that this individual requested their submitted resolution request regarding this concern be withdrawn. Additionally, this office was able to confirm that this individual has been provided with a job. The OCO provided the individual with information regarding the DOC internal administrative processes that need to be fulfilled before contacting the OCO.	Information Provided
139.	Incarcerated individual shared concerns regarding the heaters being	The OCO provided information regarding temperatures within the unit. After speaking with DOC staff, the OCO was able to	Information Provided

	off within the unit despite the temperature being cold.	confirm that facility staff are actively working to mitigate the concern.	
140.	Incarcerated person reported a concern regarding DOC staff using force on them as a result of an interaction. The person wants to stay in the unit they were housed in prior to the interaction with staff.	The OCO provided information regarding the force DOC staff used during the incident and information about the policy DOC followed to transfer him to another facility. The OCO reviewed DOC documentation related to the force used and substantiated that video evidence was not properly captured. After viewing the documentation available, there was insufficient evidence to substantiate that the use of force violated DOC policy. The OCO spoke with facility leadership about the concerns the OCO found related to video retention and continue to have conversations with DOC leadership about the importance of video collection and retention in many scenarios but especially uses of force. The OCO reviewed the person's classification and found DOC transferred them per DOC policy 300.380.	Information Provided
141.	Person reported severe dental concerns and said that he filed a dental emergency, but that the dentist did not see him.	The OCO provided information about the Health Services Orientation Handbook and the OCO's ongoing work on systemic issues involving delays in dental care. The OCO substantiated a delay in this individual's care and found that the care he needed qualified as urgent care. The OCO reviewed DOC records and reached out to DOC staff, who confirmed that after a delay, he received the dental care that he needed. Per the Health Services Orientation Handbook, exposed nerves, abscessed teeth, cracked/broken teeth, cavities, loose teeth, and fillings falling out qualify as requiring urgent care.	Information Provided
142.	Incarcerated individual relayed concerns about wanting to go to general population or safe harbor.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that during their CFP, they requested to be put in IMU and said they would refuse all other housing until their release.	No Violation of Policy
143.	Incarcerated individual relayed concerns about wanting to get access to their levels and tablet.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that per their CFP, they are to maintain level 1 only due to refusing housing as they said they will continue to refuse housing if they must leave segregation.	No Violation of Policy
144.	Incarcerated individual relayed concerns about being in segregation beyond the initial investigation time and not getting any extensions.	The OCO reviewed the individual's administrative segregation (ad seg) placement and confirmed that per their ad seg placement, they are to retain ad seg status while pending an infraction as the investigation was completed.	No Violation of Policy
145.	Incarcerated individual relayed concerns about accessing their levels.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that they are to maintain level 2 only.	No Violation of Policy
146.	Incarcerated individual relayed concerns regarding an infraction from a previous incarceration impacting their custody level.	The OCO reviewed the individual's custody facility plan (CFP) and spoke to DOC about this concern and confirmed that the individual is losing points per DOC 310.150 Section II. C. (initial classification) for their crime category, past institutional violence, and history of violence, not just the previous incarceration's infraction.	No Violation of Policy
147.	Person reported concerns about mainline meals not containing pork and said that this violates his religious freedoms.	The OCO was unable to substantiate a violation of policy by DOC. DOC Food Services Program 240.100 Attachment 1 states that mainline meals will be pork free. The OCO reviewed this individual's resolution request, which was reviewed by DOC headquarters who stated that this individual said pork is not on the menu for religious reasons, but policy does not state a reason for pork being excluded from the menu. DOC	No Violation of Policy

		headquarters stated that the mainline menu is reviewed by the statewide dietician and meets nutritional guidelines.	
148.	Incarcerated individual relayed concerns about being in segregation beyond the original investigation timeframe and not getting any extension paperwork.	The OCO reviewed the individual's administrative segregation (ad seg) placement and confirmed they remain in segregation due to a new custody facility placement being initiated.	No Violation of Policy
Washington Corrections Center for Women			
149.	Person reports that she was negatively impacted by a medication error. The person stated that DOC staff had no way of proving her dose was incorrect after it was given.	The OCO provided assistance. OCO staff reviewed the patient's records, contacted DOC Health Services staff and leadership regarding the substantiated medication error. OCO requested that the administration process for that medication be changed to prevent this issue from happening again. DOC agreed and the process was changed.	Assistance Provided
150.	Incarcerated individual relayed concerns regarding hearing and seeing things as well as concerns about the individual housed in the adjacent cell.	The OCO spoke with DOC about this concern. At OCO request, DOC came to speak to the individual and offered them follow up with the psychiatrist as well as support from mental health, in addition to a room move which successfully occurred.	Assistance Provided
151.	Incarcerated individual relayed concerns about placement in segregation.	The OCO reviewed the individual's placement and confirmed that they have been released from segregation.	DOC Resolved
152.	Incarcerated individual shared concerns regarding DOC staff lying about the medication they are taking.	The OCO provided information to this individual regarding how to access the medication they wish to take. The OCO encouraged the individual to continue working with their provider to take care of concerns as they arise.	Information Provided
153.	Person reports that her medical provider did not provide any options for pain relief while she was dealing with a serious medical condition. The person is requesting sanctions be brought against the medical provider and to be switched to a different provider.	The OCO provided the requested information regarding how to report a medical provider to the Washington Medical Commission. OCO staff reviewed the patient's records and were not able to substantiate a delay in the specialist consultations being caused by DOC action. OCO staff noted that the specialist did not support the claim that the condition they were asked to treat would be a cause of the pain reported by the patient. OCO staff also verified the patient had access to multiple medications for pain management during that time.	Information Provided
154.	Person reported concerns regarding her mental health treatment being changed once she came into DOC custody. She is requesting to be returned to the treatment plan she came into prison with.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed the patient records and contacted DOC Health Services staff who provided the clinical rationale for the changes to the person's treatment plan. OCO staff confirmed that the patient's reported concerns are being addressed with the current treatment plan that is supported by the DOC formulary. OCO staff verified that the prior treatment plan was not supported by the DOC formulary.	No Violation of Policy
155.	Person wants tablet access to be able to call her family, friends and attorneys. She wants her tablet as an ADA accommodation and DOC is denying the tablet as an accommodation. She appealed the decision but never heard back.	The OCO confirmed that this individual was given a tablet and then broke it the next day. The facility will not issue another one.	No Violation of Policy
156.	Patient reports multiple concerns: Health Status Reports (HSRs) were removed when she transferred	The OCO elevated the concerns about changes in HSRs and medication after transferring facilities. The OCO elevated these concerns throughout DOC health services leadership, however,	Substantiated

	facilities, her prescription was discontinued, and her grievance appeals are not being processed.	DOC did not agree to resolve the concerns. The OCO substantiated the HSRs were changed and the medication was discontinued.	
Washington State Penitentiary			
157.	Incarcerated individual shared concerns regarding their cell power being out for multiple days and DOC staff not working to fix it.	The OCO provided assistance. After this office's outreach, DOC staff assured this office that they will be actively working to fix the concern. This office was able to confirm that this individual's cell still has power but the outlets have lost power.	Assistance Provided
158.	The incarcerated individual reports that there are a lot of drugs and contraband in his unit.	The OCO provided assistance by contacting IIU and reporting this concern.	Assistance Provided
159.	Incarcerated individual was placed on administrative segregation pending the outcome of a number of serious infractions.	The OCO provided assistance through a series of requests to the DOC. OCO staff met with the incarcerated individual while he was on administrative segregation after being transferred to a different facility. After meeting with the incarcerated individual, the OCO requested that DOC HQ leadership review the pending infractions and the ongoing administrative segregation placement. After discussions with the OCO, the DOC dismissed most of the infractions and the person was quickly released to general population at a third facility.	Assistance Provided
160.	Patient reports that they never received their medical shoes.	The OCO provided assistance by elevating the concerns through DOC health services leadership. After OCO outreach, DOC ordered the shoes, confirmed they arrived and delivered them to the patient.	Assistance Provided
161.	Incarcerated individual was placed on administrative segregation pending the outcome of a number of serious infractions.	The OCO provided assistance through a series of requests to the DOC. OCO staff met with the incarcerated individual while he was on administrative segregation after being transferred to a different facility. After meeting with the incarcerated individual, the OCO requested that DOC HQ leadership review the pending infractions and the ongoing administrative segregation placement. After discussions with the OCO, the DOC dismissed most of the infractions and the person was quickly released to general population at a third facility.	Assistance Provided
162.	Incarcerated individual shared concerns regarding not being provided with their medication for an extended period of time.	The OCO provided assistance. After this office's outreach, DOC medical staff shared that they will discuss a process where this individual can safely receive their medication. DOC staff shared that after an incident, they had to take the medication for the individual's safety.	Assistance Provided
163.	Patient reports concerns about ongoing placement in Close Observation Area (COA) and requested access to mental health treatment and a placement referral that includes his mental health needs.	The OCO provided assistance by elevating the concerns through DOC health services leadership. After OCO outreach, the OCO confirmed the patient met with a mental health provider multiple times to discuss treatment and medication was prescribed. Once the patient was stabilized and discharged from COA, he transferred to another facility, which was approved through a Custody Facility Plan (CFP) with input from mental health.	Assistance Provided
164.	Person reported that he received Durable Medical Equipment (DME) as the result of a previous OCO case, but he never received the medical care associated with that injury he needed the DME for.	The OCO provided assistance. The OCO reached out to DOC staff and continued to follow up and confirm in DOC records that this individual received follow-up care and that cancelled appointments were rescheduled.	Assistance Provided

165.	Patient reports concerns about the size and number of catheters provided.	The OCO reviewed the concern and discussed with DOC Health Services leadership and could not identify evidence to substantiate that patient was told to re-use old catheters. The OCO did find that the patient's preferred size catheter was on order and he was provided an alternative size (smaller) in the meantime. After OCO outreach, DOC agreed to review the number of catheters ordered for the patient, and the number was increased.	Assistance Provided
166.	External person reports concerns about their incarcerated loved one's access to therapeutic community programming.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The person requested to be moved back to camp and the individual was transferred.	DOC Resolved
167.	Incarcerated individual relayed concerns about an infraction.	The OCO reviewed the individual's records and confirmed that the infraction is no longer on their record.	DOC Resolved
168.	Incarcerated individual shared concerns regarding DOC failing to provide adequate medical care.	DOC staff resolved this concern prior to the OCO taking action on this complaint. After review of DOC records and speaking with DOC staff, this office was able to confirm that this individual is being provided with continuous care regarding their concern.	DOC Resolved
169.	The person reports that they are not getting the correct meals, and the kitchen has messed up his tray multiple times. This individual also reports that his tray has been shorted food items, and DOC staff lie, saying they checked all the trays to ensure they are the same.	The DOC resolved this concern by providing the mainline's menu and encouraging this person to let custody staff know when his meal is wrong so they can notify the kitchen. The DOC also encouraged the individual to contact their medical provider so they could be approved for a yellow snack in addition to dinner.	DOC Resolved
170.	External person reports concerns about their incarcerated loved one's access to therapeutic community programming.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The person requested to be moved back to camp and the individual was transferred.	DOC Resolved
171.	Incarcerated individual relayed concerns about having an HSR for medical shoes but not getting them.	The OCO spoke to DOC about this and confirmed that they have been seen for this issue.	DOC Resolved
172.	External person reports concerns regarding DOC Health Services staff not documenting medication administration errors. the person requested that the OCO investigate if DOC staff recorded medication errors.	The OCO provided information to the patient regarding the DOC's established process for recording medication errors. OCO staff reviewed records and verified that each of the medication administration errors reported by community member had been documented through the established quality assurance process created by the DOC. This process ensures that all medication errors are reviewed by a DOC pharmacist and the supervisors of line staff for process improvement and corrective action.	Information Provided
173.	Patient reports concerns about Residential Treatment Unit (RTU) placement.	The OCO provided information about how to appeal RTU decisions by submitted an appeal in writing through the facility Health Services Manager. There is no timeline limitation or official DOC form for these types of appeals.	Information Provided
174.	Person is requesting to see a specialist about an issue he has been dealing with for several years.	The OCO provided the person with information regarding the steps to establish care with a new specialist. OCO staff confirmed the patient had refused all specialist consults and will need to establish care with a new provider at his new	Information Provided

		facility. OCO staff also provided information about using the local resolution program.	
175.	Incarcerated individual relayed concerns about difficulties filing resolution requests.	The OCO reviewed the individual's records and confirmed that they were able to successfully file grievances since opening this case. The OCO informed the individual that if the issue still persists, they can open a new case.	Information Provided
176.	Incarcerated individual shared concerns regarding DOC failing to provide them with adequate accommodation.	The OCO provided information why their requested accommodation hasn't been provided. After review of DOC records, this office was able to confirm that DOC staff have provided this individual with numerous HSRs (health status report) and DME (durable medical equipment) to accommodate them.	Information Provided
177.	Person reported having mental health concerns and told the OCO he wanted to remain in solitary confinement.	The OCO provided information about accessing mental health care. The OCO reviewed DOC records and found that this individual was released from solitary confinement. The OCO could not find a violation of DOC Restrictive Housing 320.255. This office also could not find that this individual filed resolution requests regarding needing mental health care or any notes from classification regarding mental health concerns.	Information Provided
178.	Incarcerated individual shared concerns regarding DOC medical staff refusing to provide them with an HSR.	The OCO provided information regarding steps they can take to attempt to obtain an HSR. After review of DOC records, this office was able to confirm that this individual has not attempted resolve their concern at the facility level.	Information Provided
179.	Incarcerated individual relayed concerns about the BAR kitchen workers being cut from 7 to 3 days of work per week.	The OCO reviewed the individual's grievance response and confirmed that due to a declining number of BAR unit workers DOC had to make modifications to the way food production was done including cutting the hours.	Information Provided
180.	Incarcerated individual relayed concerns about accessing their levels and mental health access.	The OCO reviewed the individual's records and provided information on how to see mental health and confirmed per their custody facility plan (CFP), they are to maintain level 1 only due to their refusal of housing.	Information Provided
181.	Incarcerated Individual requested access to a rabbi.	The OCO provided information to the incarcerated individual on how to make this request through the religious coordinators at the facility. OCO staff discussed the concern with facility leadership and provided the incarcerated individual with step by step instructions. Subsequent to the in-person conversation where the OCO provided the information, the person transferred to a different facility where access to a rabbi is more readily available.	Information Provided
182.	Person reports concerns about access to legal assistance and release from prison. The incarcerated individual also reported concerns about hearing voices.	The OCO provided information about how to report symptoms and access mental health services. The requested resolution was not within the OCO's statutory power and authority, and this office provided information about accessing legal services.	Information Provided
183.	Incarcerated individual relayed concerns about not being able to make legal calls when they are on a one-to-one watch.	The OCO spoke to DOC about this and confirmed that their conditions of confinement are placed by their Mental Health team which may result in the inability to use the yard to make phone calls for safety reasons, however if there is a pending court deadline or an attorney needs to set up a phone call, exceptions can be made.	Information Provided

184.	External person and patient reported concerns about access to a medical provider related to a leg injury.	The OCO confirmed the patient was seen by a provider, HSRs were ordered for crutches and ice, testing occurred and follow up appointment occurred. DOC also put in a request for a second opinion appointment. The OCO provided information directly to the patient about next steps and to follow up with the OCO if second opinion not provided.	Information Provided
185.	An external person reported concerns about an incarcerated loved one regarding his facility placement and issues with legal filings. The person wants their loved one to be transferred closer to familial support and requests the OCO review the issues the person was having with filing legal documentation with the courts.	The OCO provided information about to the incarcerated person regarding facility transfers and the status of their legal filings. The OCO shared with the incarcerated person the process and protocols for requesting a transfer to a different facility. This office shared that DOC will make the final placement determination and that housing is decided by multiple factors. The OCO reviewed the issue with the person's legal fillings and found DOC substantiated that there was an issue with the legal filing due to staff error. DOC also shared with the person that the legal filing can continue as the court appeal is still active. The OCO shared this information with the incarcerated person and provided details about how to address the courts and continue the filing if they choose to continue the legal process.	Information Provided
186.	Incarcerated individual shared concerns regarding DOC taking an extended period of time to provide them with equipment that is medically necessary.	The OCO provided information regarding why there has been such a delay in receiving their requested equipment. After speaking with DOC staff, this office was able to confirm that DOC medical staff have placed an order for their equipment. Due to a variety of factors, it has been delayed or required reordering.	Information Provided
187.	Incarcerated individual relayed concerns about the BAR kitchen workers being cut from 7 to 3 days of work per week.	The OCO reviewed the individual's grievance response and confirmed that due to a declining number of BAR unit workers DOC had to make modifications to the way food production was done including cutting the hours.	Information Provided
188.	Incarcerated individual relayed concerns about behavior observation entries (BOEs), placement in segregation and inability to access levels.	The OCO reviewed the individual's records and confirmed they are not eligible for a level promotion due to their behavior in IMU. The OCO informed the individual that they will need to appeal the level assignment and BOEs.	Information Provided
189.	Incarcerated individual relayed concerns about facility placement.	The OCO reviewed the individual's custody facility placement (CFP) and confirmed that they did not express any safety concerns during their FRMT and informed them that they will need to speak to the intelligence and investigations unit to have their safety concerns validated.	Information Provided
190.	The incarcerated individual is requesting telehealth sexual deviancy treatment via Microsoft Teams.	The OCO reviewed the individual's resolution request regarding this concern and spoke with DOC staff. The OCO was unable to negotiate telehealth appointments for this individual due to the guidelines DOC must follow to provide sex offender treatment. This office provided the individual with a list of workbooks and self-help books they can utilize until they begin SOTAP.	Information Provided
191.	Person reports that they were terminated from the therapeutic community (TC) program despite having a reasonable accommodation to miss class.	The OCO reviewed this person's electronic file and spoke with DOC staff regarding this concern. The OCO could not confirm this individual had a health status report (HSR) for lay-ins from TC programming. Additionally, DOC reported that a lack of progress and engagement, as well as attendance issues, are why the individual was terminated from the program. This	Insufficient Evidence to Substantiate

		office could not substantiate this concern due to insufficient evidence.	
192.	Incarcerated individual relayed concerns about DOC throwing away their grievances.	The OCO asked the individual to provide more details about these grievances such as topics or dates they filed them. The OCO never received this clarifying information from the individual and were unable to investigate further.	Insufficient Evidence to Substantiate
193.	Person reports concerns about their transgender preference form being revoked.	The OCO elevated this concern through DOC Headquarters and confirmed the preference form was revoked. The OCO was unable to substantiate a violation of policy by DOC; the preference form was revoked due to the individual's inappropriate sexual behavior during strip searches.	No Violation of Policy
Intake Investigations			
Airway Heights Corrections Center			
194.	An external friend or family member reported concerns on the incarcerated person's behalf that the unit counselor is creating a hostile environment and is not working with him to meet his 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
195.	An external person reported concerns on their loved one's behalf about being harassed by a DOC staff member.	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
196.	An external person reported concerns on their loved one's behalf about being harassed by a DOC staff member.	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
197.	Incarcerated individual shared concerns regarding DOC not providing them with their early release credits.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
198.	Incarcerated individual shared concerns regarding not receiving a response to their infraction appeal.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
199.	Incarcerated individual shared concerns regarding DOC staff not assisting them with their release planning.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
200.	Incarcerated individual shared concerns regarding not having access to the statewide housing directory despite being imminent to release.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
201.	A friend or family member reported on their loved one's behalf that they received an infraction and deduction in	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution	Technical Assistance Provided

	custody points, however, the Department of Corrections staff did not properly complete the infraction packet.	Program. The OCO provided technical assistance about appealing an infraction and using the resolution program.	
202.	A friend or family member submitted a complaint on their loved one's behalf that the DOC violated their policy to conduct a post-Extended Family Visit urine analysis (UA) test within 72 hours. Their loved one's UA test was not conducted until 110 hours after the extended family visit had concluded.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program.	Technical Assistance Provided
203.	Person reported that he has health conditions that make it difficult to provide a urine analysis (UA) sample and his provider has refused to issue him a Health Status Report (HSR). This person was woken up in the middle of the night recently for a UA test, was unable to provide a sample and was then infracted for being unable to provide.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about appealing an infraction and obtaining HSR documentation.	Technical Assistance Provided
204.	Person called the OCO hotline and asked for legal resources.	The OCO gave technical assistance by providing a guide about legal resources access.	Technical Assistance Provided
205.	Person reported that a DOC staff member separated them and their roommate for no reason.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns and information on a courtesy cell move.	Technical Assistance Provided
206.	An incarcerated person reports that a religious group is having difficulty coordinating with the chaplain at the facility.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to utilize the resolution program.	Technical Assistance Provided
207.	Person reported that he was transferred to another facility by the wheelchair van but his property was not moved with him and he needs his legal documents for a case with an upcoming deadline.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about property concerns and using the resolution program.	Technical Assistance Provided
208.	Person reported a concern that he did not have enough funds to ship his TV when he transferred to another facility. When he did have enough funds to cover the shipping costs, he was overcharged but the funds have not been deducted from his trust account.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program.	Technical Assistance Provided
209.	Person reported that they are being retaliated against by DOC staff members for filing a PREA complaint against them.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided

210.	An incarcerated person reported a concern related to the behavior of a DOC staff member.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about filing the resolution request process and how it relates to staff behavior concerns.	Technical Assistance Provided
211.	Person reported that they are being retaliated against by DOC staff for trying to file a staff conduct grievance.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
212.	Person reports that he was moved across the facility for medical reasons but has not been given his 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 about the resolution program.	Technical Assistance Provided
213.	Person reported that some of their property was left behind when they transferred to another unit and was never returned to them.	The OCO provided technical assistance about utilizing the tort claim process.	Technical Assistance Provided
214.	An incarcerated person reports their property was lost at a recent facility transfer.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about tort claims. The OCO also reviewed the DOC's responses and verified that the property could not be located.	Technical Assistance Provided
215.	Person reported a concern about being infracted and losing his job for allegedly covering up evidence from a physical altercation.	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
216.	Person reported a concern about receiving a infraction and DOC staff not following the UA policy.	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
217.	Person reported that they were having trouble with their Securus tablet and when they asked for help, the staff member was rude to them.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns and Securus.	Technical Assistance Provided
218.	Person reported that their good conduct time credit was not applied correctly to their early release date (ERD).	The OCO provided technical assistance about the records process.	Technical Assistance Provided
219.	Person reported that they received an infraction after receiving a negative behavior observation entry (BOE) for the same issue.	The OCO provided technical assistance about appealing a BOE.	Technical Assistance Provided
220.	The individual reports that his counselor and other DOC staff are not following the classification policy.	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 staff conduct concerns.	Technical Assistance Provided
Cedar Creek Corrections Center			
221.	Person reports concerns about not being given credit for therapeutic community programming.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
Clallam Bay Corrections Center			

222.	Incarcerated individual relayed concerns regarding them and their loved one being banned from Union Supply.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
223.	Incarcerated individual relayed concerns regarding them and their loved one being banned from Union Supply.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
224.	Incarcerated individual relayed concerns regarding the inability to get medical records from a county jail.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
225.	A friend or family member reported that an incarcerated person's tort claim was denied and asked the OCO to assist.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about tort claims and how to contact the Department of Enterprise Services.	Technical Assistance Provided
226.	Person reported that they received an infraction for being attacked and defending themselves.	The OCO provided technical assistance about appealing an infraction.	Technical Assistance Provided
Coyote Ridge Corrections Center			
227.	An external person reported concerns about not being allowed to take home photos from recent visits with their loved one because the pose in the photos was not on the approved pose list, however, they were allowed to take home previous photos with the same pose.	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
228.	An external person reported concerns on their loved one's behalf about an infraction they received recently and being sanctioned excessively.	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
229.	Incarcerated individual shared concerns regarding DOC wrongfully withholding their mail.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
230.	An external person reports issues with her husband's property and delayed tort claim.	The OCO provided technical assistance regarding the tort claims process.	Technical Assistance Provided
231.	Person reported that their incarcerated loved one is not receiving their medications in a timely manner for a serious health condition.	The OCO provided technical assistance about utilizing the health services process.	Technical Assistance Provided
232.	An incarcerated person reported a concern related to SecurUs.	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 reach out to SecurUs.	Technical Assistance Provided

233.	A loved one requests that the OCO assist with a serious infraction that an incarcerated person has received.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal infraction and contact the OCO after the appeal has been completed.	Technical Assistance Provided
234.	Incarcerated individual shared concerns regarding wanting to obtain a health status report (HSR).	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 obtaining an HSR.	Technical Assistance Provided
235.	Person reports that DOC staff removed the chairs from their cell.	The OCO provided technical assistance about the resolution program.	Technical Assistance Provided
236.	An incarcerated person requests that the OCO assist with a serious infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal infraction and contact the OCO after the appeal has been completed.	Technical Assistance Provided
237.	Person reported that he had surgery and was not able to access adequate post-operative medical treatment.	The OCO provided technical assistance by mailing information guides to help assist in obtaining medical appointments and emergencies.	Technical Assistance Provided
238.	Person reported that they cannot be released on their early release date (ERD) due to a 35-day notifier to the victim.	The OCO provided technical assistance about the resolution program.	Technical Assistance Provided
Mission Creek Corrections Center for Women			
239.	External person reported concerns regarding an incarcerated person's access to mental health medications.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance
240.	An incarcerated person reports that DOC lost their property at a recent facility move.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about tort claims. The OCO also reviewed the DOC's responses and verified that the property could not be located.	Technical Assistance Provided
Monroe Correctional Complex			
241.	An external person reported on their loved one's behalf that they have been moved to the Intensive Management Unit (IMU) and have not been told why.	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
242.	An external person reported a concern on their loved one's behalf that he was infracted and found guilty for contraband that his cellmate's 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 about appealing an infraction.	Technical Assistance Provided
243.	Person reported a concern about not being able to access an assessment with the Veterans Affairs (VA) provider.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program.	Technical Assistance Provided

244.	An incarcerated person reported several concerns related to accessing healthcare, accessing law library and relating to their facility placement.	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 accessing the resolution program, how medical appointments can be requested, the classification and facility placement process, and OCO jurisdictional limitations.	Technical Assistance Provided
245.	An incarcerated person reports that DOC staff confiscated some of their property at a recent cell search.	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
246.	Person reported that they would like help with not going to solitary confinement as a punishment for an infraction they received.	The OCO provided technical assistance about appealing an infraction.	Technical Assistance Provided
247.	Incarcerated individual shared concerns regarding DOC medical staff not wanting to assist them in receiving medical care.	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 working with medical staff to receive their desired testing.	Technical Assistance Provided
248.	Person reported that they received an infraction but does not know why.	The OCO provided technical assistance about appealing an infraction.	Technical Assistance Provided
249.	An incarcerated person reported a concern related to DOC's use of restrictive housing for non-violent infractions.	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 DOC policy change process, serious infraction processes, and how to utilize the resolution program.	Technical Assistance Provided
250.	Person reported that a DOC staff member was calling them racial slurs and harassing them.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
251.	Person reported that they are being retaliated against by DOC staff members.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
252.	Person reported that DOC did not follow their policy when he was infracted for making pruno that his cellmate admitted to.	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
253.	Person reports that he fell at work, and did not file an incident report initially because he did not know he hurt his neck until several months later.	The OCO provided technical assistance about the tort claims process.	Technical Assistance Provided
254.	Person reported a concern about not being able to access dental services.	The OCO provided technical assistance about accessing dental services.	Technical Assistance Provided
255.	Person reported that DOC medical gave inadequate medical treatment for their foot.	The OCO provided technical assistance about the resolution program.	Technical Assistance Provided
Olympic Corrections Center			
256.	An external person reported concerns on the incarcerated person's behalf about being infracted for refusing to	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this	Person Declined OCO Assistance

	participate in the work crew assignment although there is a statute that says participation is voluntary.	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.	
Other			
257.	Loved one relayed concerns about an induvial returning to jail after prison release.	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
258.	Individual relayed concerns regarding the conduct of a jail corrections officer.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint	Lacked Jurisdiction
259.	Loved one relayed concerns about medication access at a county jail.	The OCO declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
260.	Loved one expressed concerns about the medical attention an individual is getting while in a county jail.	The OCO declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
261.	Individual relayed concerns regarding being placed on community supervision in a county they are not from.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
262.	Incarcerated individual relayed concerns regarding the conduct of a jail corrections officer.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint	Lacked Jurisdiction
263.	Individual relayed concerns regarding a protection order they thought was rescinded.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
Stafford Creek Corrections Center			
264.	An external person reported concerns on their loved one's behalf about being held in segregation and not being told why, only that it is the new protocol.	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
265.	Person provided OCO a copy of a letter addressed to a Legislator, regarding the impacts of solitary confinement, or restrictive housing, on incarcerated individuals.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint. The person's letter was documented and received.	Person Declined OCO Assistance
266.	Someone reported concerns on an individual's behalf regarding staff conduct.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
267.	Incarcerated individual reported that DOC is covering up a conspiracy to silence the individual.	After the OCO met with this individual in person and worked several separate complaints on their behalf, the incarcerated individual requested that the OCO close two of their open cases, including this one.	Person Declined OCO Assistance
268.	Someone reported concerns on the incarcerated individual's behalf regarding gender affirming clothing.	The OCO sent the individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this	Person Declined OCO Assistance

		concern was closed without further investigation. The OCO informed the individual that if they believe this was closed in error, to please contact this office to open a new case.	
269.	An external person reported concerns on the incarcerated person's behalf about a request to be housed at another 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
270.	Incarcerated Individual informed the OCO that he believed the DOC was planning to extract him from his cell on a holiday when there were less DOC staff or witnesses around, and when the OCO hotline would be closed.	OCO staff discussed this concern with facility leadership and the DOC agreed to delay the cell extraction to a non-holiday date. However, after the OCO negotiated a new outcome on behalf of this individual, he requested that the OCO close two of their open cases.	Person Declined OCO Assistance
271.	External person reports concerns about their incarcerated loved one's access to medical care.	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 trying to address the issue through the DOC resolution process prior to OCO involvement.	Technical Assistance Provided
272.	Person reported that they were put involuntarily into protective custody and was supposed to go to work release.	The OCO provided technical assistance via hotline regarding how to appeal a facility risk management (FRMT) decision or a custody facility plan (CFP).	Technical Assistance Provided
273.	An incarcerated person requests that the OCO assist with two serious infractions.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal infractions and contact the OCO after the appeals have been completed.	Technical Assistance Provided
274.	Individual reported that they are not receiving a health services appointment at their new facility and would like a follow up appointment sooner than April.	The OCO provided technical assistance regarding health services and how to initiate a medical emergency.	Technical Assistance Provided
275.	External person reports concerns about her incarcerated loved one's medical care and asked for legal assistance.	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 addressing healthcare issues through DOC prior to OCO involvement and information about legal access.	Technical Assistance Provided
276.	An incarcerated person reported that they are not being given a tablet when they should be able to have one.	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
277.	Person reported that the DOC records department calculated their time incorrectly.	The OCO provided technical assistance about the records process and resolution program.	Technical Assistance Provided
278.	Person reports that because of changing case law and court of appeals decisions, DOC audited his sentence, changed his release date and moved 232 credit days to his other cause number which earns less good time.	The OCO provided technical assistance regarding DOC time calculations.	Technical Assistance Provided

279.	An incarcerated person reports that the internal investigation unit (IIU) has confiscated their 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 about how to utilize the resolution program.	Technical Assistance Provided
280.	An incarcerated person reports that their tablet is broken.	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 and information regarding SecurUs.	Technical Assistance Provided
281.	An incarcerated person requested information about how to contact the Office of Crime Victims Advocacy (OCVA).	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 contact the Office of Crime Victims Advocacy (OCVA) and information about the OCO's jurisdictional limitations.	Technical Assistance Provided
282.	Person reported concerns about being targeted by staff and having his property destroyed repeatedly during searches.	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, property information, and filing a tort claim.	Technical Assistance Provided
283.	Person reported a concern about not being able to access the electronic law library.	The OCO provided technical assistance about access to legal resources.	Technical Assistance Provided
284.	An incarcerated person reported a concern related to the behavior of a DOC staff member.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about filing the resolution request process and how it relates to staff behavior concerns.	Technical Assistance Provided
285.	Person reported that they received an infraction for something they did not do.	The OCO provided technical assistance about appealing an infraction.	Technical Assistance Provided
286.	Person reported that they are having issues with their cellmate and does not want to jeopardize their housing placement.	The OCO provided technical assistance about the resolution program.	Technical Assistance Provided
287.	An incarcerated person reported a concern related to the behavior of a DOC contracted staff member.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about filing the resolution request process and how it relates to staff behavior concerns.	Technical Assistance Provided
288.	An incarcerated person reported they were concerned about a possible move to a different facility.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance regarding classification and facility placement.	Technical Assistance Provided
289.	An incarcerated person requests assistance with an infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal infractions and to contact the OCO after the appeal has been completed.	Technical Assistance Provided
290.	An incarcerated person reports that Ramadan meals are being issued at normal mealtime and are cold by the time the person is able to eat them.	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

291.	An incarcerated person reports they were moved to a different cell related to a DOC staff behavior concern.	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 the resolution request process and how it relates to staff behavior concerns.	Technical Assistance Provided
Washington Corrections Center			
292.	Incarcerated individual shared concerns regarding being restricted to their cell for excessive hours within the day.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
293.	Incarcerated individual shared concerns regarding being placed on cell confinement and only allowed limited time out of their cell.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
294.	A friend or family member reported on their loved one's behalf that the Department of Corrections has not amended their loved one's sentencing calculation based on recent court records and they are being held past their release date.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about records correction/time calculations and using the resolution program.	Technical Assistance Provided
295.	A friend or family member submitted a complaint on their loved one's behalf that he is being harassed and targeted by a DOC staff member.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance regarding staff conduct concerns and using the resolution program.	Technical Assistance Provided
296.	A loved one reported a concern related to the behavior of a DOC staff member.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance regarding staff conduct concerns.	Technical Assistance Provided
297.	An incarcerated person reported a concern related to the behavior of a DOC staff member.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about filing the resolution request process and how it relates to staff behavior concerns.	Technical Assistance Provided
298.	An incarcerated person reported an issue with the way DOC has calculated their time.	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 contact DOC records to have their time recalculated, and explained how to utilize the resolution program.	Technical Assistance Provided
299.	An incarcerated person reported that their time calculation is incorrect.	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 contacting DOC records and asking to have their time recalculated.	Technical Assistance Provided
300.	An incarcerated person reported that DOC is limiting their hourly pay rates incorrectly.	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
301.	An incarcerated person reported they are concerned that they are being held at a facility against DOC policy.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution	Technical Assistance Provided

		Program. The OCO provided technical assistance about how to appeal classification and facility placements.	
302.	An incarcerated person reports DOC mail room is holding on to mail unreasonably.	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
303.	Person reported a concern about his community custody sentence not being ran concurrently.	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 records correction, time calculation and using the resolution program.	Technical Assistance Provided
304.	Individual reports that he is a month past his early release date (ERD) and the DOC has not updated his records correctly.	The OCO provided technical assistance regarding DOC time calculations and records correction.	Technical Assistance Provided
305.	Person reported that their time was calculated incorrectly.	The OCO provided technical assistance about utilizing the records correction and time calculation process.	Technical Assistance Provided
306.	An incarcerated person reports their family member is owed money by SecurUs.	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 their family member can contact SecurUs.	Technical Assistance Provided
307.	The person reported that when he was released for the COVID protocol in 2021, his property was not secured as staff said it would be, and it went missing.	The OCO provided technical assistance regarding the tort claim process.	Technical Assistance Provided
308.	Person reported a concern about not being able to access medical and Health Status Reports (HSR) to meet his healthcare needs.	The OCO provided technical assistance regarding how to access medical care.	Technical Assistance Provided
309.	An incarcerated person requests that the OCO assist with a serious infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal an infraction and then contact the OCO after the appeal has been completed.	Technical Assistance Provided
310.	An incarcerated person requests that the OCO assist with a serious infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal an infraction and then contact the OCO after the appeal has been completed.	Technical Assistance Provided
311.	Person reported that a DOC staff member is targeting them and treating them poorly.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
312.	Person reported that they received a sanction during a video visit.	The OCO provided technical assistance regarding the visitation policy.	Technical Assistance Provided
313.	Person reported concerns about the inefficiency of an EKG test they requested and received.	The OCO provided technical assistance regarding health services.	Technical Assistance Provided
Washington Corrections Center for Women			

314.	External person reports concerns about their incarcerated loved one's access to medications.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance
315.	Someone reported concerns on the incarcerated person's behalf that they are being targeted by other incarcerated individuals which resulted in them receiving 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
316.	Incarcerated individual shared concerns regarding DOC staff mistreating them.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
317.	Incarcerated individual shared concerns regarding DOC staff ignoring their request for cell movement but acknowledging other requests.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
318.	Incarcerated individual shared concerns regarding their release date being pushed back due to an infraction.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
319.	Incarcerated individual shared concerns regarding being strip searched and told their release has been cancelled.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
320.	Person reported concern about medication while in the Close Observation Area (COA).	This person was released prior to the OCO taking action on the complaint. The OCO reviewed DOC records regarding this person's time in COA and concerns about medication but is unable to conduct a full investigation of this concern because the OCO requires a Release of Information (ROI) from the individual to review mental health records. The OCO cannot get an ROI because this individual is no longer in DOC custody.	Person Released from DOC Prior to OCO Action
321.	Incarcerated individual shared concerns regarding DOC staff mistreating them.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
322.	Person reported a concern regarding two infractions and not being able to work because of mental health complications.	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
323.	Person reported that a confidential informant is relaying false information to DOC staff causing them to receive infractions.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
324.	Person shared concerns about their mental health and receiving an infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance regarding mental health services and appealing an infraction.	Technical Assistance Provided

Washington State Penitentiary

325.	An external person reported concerns on their loved one's behalf about delays in accessing his property and a kiosk unit that is not working.	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
326.	An external person reported concerns about their loved one's safety in a facility that has active gang activity and wanting the Security Threat Group (STG) tag removed.	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
327.	Person reported concerns regarding staff misconduct and bullying.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint.	Person Declined OCO Assistance
328.	Incarcerated individual shared concerns regarding wanting to be provided with a train ticket upon release instead of a bus ticket.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
329.	An individual in restrictive housing wants to be placed on level two to have his commissary. He reports other incarcerated individuals in his unit are high on meth, which prevents him from sleeping and is bad for his mental health.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
330.	Incarcerated individual relayed concerns about the utensils that food is served on.	The OCO confirmed the individual is no longer in Washington DOC custody.	Person Released from DOC Prior to OCO Action
331.	Incarcerated individual shared concerns regarding DOC staff failing to provide them with their property upon IMU placement.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
332.	Incarcerated individual shared concerns regarding DOC staff failing to assist them despite requesting accommodations.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
333.	A loved one expressed concerns about an individual's placement in segregation.	The OCO provided the individual technical assistance about attending the infraction hearing and appealing the infraction outcome prior to OCO involvement.	Technical Assistance Provided
334.	A friend or family member submitted a complaint on their loved one's behalf that his property was not packed and moved with him to a new facility as DOC staff stated it would be. He had to wait over a month to receive his property and when he did, the property had been tampered with, damaged and items were missing.	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 staff conduct concerns and property.	Technical Assistance Provided

335.	A loved one reported that their extended family visits have been terminated.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance, to the incarcerated person, about steps their family member can take to address the termination.	Technical Assistance Provided
336.	Person reported that they are not receiving adequate medical care for their health condition.	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
337.	Person reported concerns that banking took money out of an inheritance they received.	The OCO provided technical assistance regarding DOC banking.	Technical Assistance Provided
338.	An incarcerated person reports educational materials are not being provided on paper which is a barrier to their learning.	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
339.	Person reported that they had a bad toothache, and DOC is doing nothing about it.	The OCO provided technical assistance about the resolution program.	Technical Assistance Provided
340.	Person reported ongoing concerns with the US Torture program.	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
341.	An incarcerated person reports that they are being denied extended family visits (EFVs).	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 EFVs.	Technical Assistance Provided
342.	Person reported that in their unit it is segregated, and DOC staff promote it.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
343.	An individual reported concerns about access to the yard and receiving a health status report (HSR) for a no-fish diet.	The OCO confirmed that this person does have an HSR for a no-fish diet. However, there were no resolutions filed regarding his yard time. The OCO provided technical assistance regarding the resolution program.	Technical Assistance Provided
344.	Person reported concerns about the mandatory deduction from his gratuity pay.	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 banking information and using the resolution program.	Technical Assistance Provided
345.	An incarcerated person reported that their time calculation is incorrect.	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 contacting DOC records and asking to have their time recalculated.	Technical Assistance Provided
346.	The individual reports he was moved to another facility for his own safety, but he wants to go back to the facility that he was transferred from.	The OCO provided the person with information about the DOC housing and classifications process.	Technical Assistance Provided

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-023

Report to the Legislature

As required by RCW 72.09.770

March 23, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Tim Lang, Secretary
tim.lang@doc1.wa.gov

Table of Contents

Unexpected Fatality Review Committee Report

UFR-24-023 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on February 20, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Patricia Paterson, Chief of Nursing
- Dr. Rae Simpson, Director - Quality Systems
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Paige Perkinson, Correctional Operations Program Manager

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Heather Schultz, Associate Medical Director

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

Fatality Summary

Year of Birth: 1962 (62-years-old)

Date of Incarceration: June 2024

Date of Death: November 2024

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

His cause of death was atherosclerotic and hypertensive cardiovascular disease. The manner of his death was natural.

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

Day of Death	Event
1230 hours	• Tier check completed.
1301 hours - 1314 hours	• He is found unresponsive by a custody officer during a routine tier check. • Radio call for medical emergency response including 911 requested. • Lifesaving efforts provided by DOC staff. • Emergency medical services (EMS) enter the cell and assume lifesaving efforts.
1315 hours	• He was pronounced deceased by EMS.

UFR Committee Discussion

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

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

   1. The committee found:

      a. He had been prescribed medication to treat his elevated blood pressure and had not requested a refill.

b. His last blood pressure reading during a nursing chronic care management appointment was at goal and a follow-up nursing visit in six (6) months was planned.

c. He had not requested a medical appointment nor been seen by his primary care provider after transfer to parent facility.

d. Substance use disorder assessment and treatment records were not included in the incarcerated individual's DOC health record.

2. The committee recommended:

a. Referral to the UFR committee for review.

B. Independent of the mortality review, the DOC conducted a critical incident review (CIR) to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operational procedures. The CIR found safety inspections standards were not consistently followed by custody staff when documenting and conducting unit tier checks on the day of the incident. The CIR team recommended the facility utilize supervisors (Sergeants and Correctional Unit Supervisors) to ensure DOC safety inspection standards are followed.

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

1. Substance use disorder (SUD) and medical records:

DOC kept substance use assessment and treatment records confidential and restricted access to SUD treatment providers. Inclusion in the medical record required written consent from the incarcerated individual. In 2024, federal law (42 CFR Part 2) changed to allow for the integration of SUD records for care coordination. DOC confirmed that they are taking steps to integrate substance use records into the medical record.

2. Prescription Refills:

Incarcerated individuals have autonomy to manage prescribed medications that are designated for self-administration including requesting refills, as in the community. For unknown reasons, this incarcerated individual did not request a refill of the medication to treat his elevated blood pressure. Lack of an electronic health record increases the difficulty for primary providers to monitor patient engagement with the recommended treatment plan. The committee acknowledges the community also face similar challenges. DOC is continuing to pursue an electronic health record, and in the interim is building strategies to identify and engage incarcerated individuals.

3. Missed tier checks:

The critical incident review noted that staff were not in compliance with DOC policy 420.370 *Security Inspections*. Staff failed to conduct or document the required 60-minute tier checks earlier in the shift.

Committee Findings

The incarcerated individual died as a result of atherosclerotic and hypertensive cardiovascular disease. The manner of death was natural.

Committee Recommendations

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

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