OFFICE OF THE
CORRECTIONS
OMBUDS

Monthly Outcome Report
May 2024

Unexpected Fatality Reviews: 1

Case Investigations: 235

Assistance Provided: 41
Information Provided: 83
DOC Resolved: 28
Insufficient Evidence to Substantiate: 19
No Violation of Policy: 64
Substantiated: 0

Intake Investigations: 17

Administrative Remedies Not Pursued: 8
Declined: 0
Lacked Jurisdiction: 0
Person Declined OCO Assistance: 5
Person Released from DOC Prior to OCO Action: 4

Resolved Investigations:
253
Assistance or Information Provided in
53%
of Case Investigations

OCO Casework Highlights

May 2024

Assistance Provided

Reported Concern: Person reported that when he went to the medication window for medical supplies, staff refused to give him those supplies. Person said he was told he would be put on the medical callout but that never happened.
OCO Actions: The OCO reviewed DOC records and reached out to DOC staff about the availability of the needed medical supplies.
Negotiated Outcomes: DOC agreed to schedule this individual for an appointment to pick up his medical supplies, as the supplies he needed are not of the type that are typically available at the medication window.

Assistance Provided

Reported Concerns: Incarcerated individual expressed several concerns regarding a use of force they were involved in. One concern was that they were not allowed a shower for four days, preventing them from washing off the OC spray.
OCO Actions: The OCO reviewed all materials related to the use of force that occurred including video of the altercation and a related grievance. The OCO confirmed with DOC that a 24 hour no move protocol was in place, so showers were not available until four days later per the unit schedule. The OCO expressed concerns to DOC about the individual having to sit with the OC spray on them for several days in the event they refused decontamination.
Negotiated Outcomes: As a result of raising these concerns, DOC directed the Unit CUS to provide individuals with a shower the next day regardless of a no movement day.

Assistance Provided

Reported Concerns: A person reported concern about a strip search and said that because of religious reasons he was uncomfortable with this search. The person said that he was infracted for refusing the search.
OCO Actions: The OCO extensively reviewed this concern and multiple similar concerns at the facility, including reviewing Prison Rape Elimination Act (PREA) records and resolutions requests, and met with facility leadership multiple times.
Negotiated Outcomes: As a result of OCO outreach, DOC released a staff memorandum on February 26, 2024 stating when a staff member changes their gender identity, they must receive approval from the Superintendent to conduct strip searches of individuals whose gender aligns with their new gender identity. Additionally, the OCO was able to negotiate for this individual's infraction to be removed.

Assistance Provided

Reported Concerns: A patient reports concerns about being discharged from residential treatment unit (RTU) level of care and wants to stay in RTU for mental healthcare access.
OCO Actions: The OCO elevated this concern through DOC mental health services leadership.
Negotiated Outcomes: After OCO outreach, the patient was approved and transferred to an RTU.

Assistance Provided

Reported Concerns: Incarcerated individual relayed concerns regarding a grievance being removed for another review process but not hearing anything further.
OCO Actions: The OCO spoke with DOC staff regarding this concern and confirmed that appropriate action was taken regarding the staff's conduct that the individual expressed concerns about. This office also spoke with DOC headquarters about grievances being pulled for administrative review and individuals not being notified of what the outcome of that investigation is. Per page 17 of the Resolution Program Manual, DOC staff should be providing individuals with notification that the concern has been removed from the grievance program for an administrative review.
Negotiated Outcomes: DOC headquarters agreed to meet with the Superintendents and Associate Superintendents to clarify this process.

Unexpected Fatality Review

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

UFR-24-002: The Unexpected Fatality Review Committee reviewed the unexpected death of a 45-year-old person in July 2023. The Unexpected Fatality Review Committee Report dated May 16, 2024 is a publicly available document.

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

Monthly Outcome Report: May 2024

	Complaint Summary	Outcome Summary	Case Closure Reason
Unexpected Fatality Reviews			
Coyote Ridge Corrections Center			
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-24-002 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The following consultative recommendations were included in the report: 1. DOC should explore using a multi-pronged, creative approach to positively impact vaccination rates. 2. DOC should start advanced care planning conversations during intake for incarcerated individuals and revisit annually regardless of age.	Unexpected Fatality Review
Case Investigations			
Airway Heights Corrections Center			
2.	External individual reports concerns about their incarcerated loved one not transferring to a Reentry Center after they were approved.	The OCO provided assistance. The OCO spoke with DOC staff who recognized a delay on their part in finalizing the transfer order. After OCO outreach DOC staff finalized the transfer and the individual will transfer to a Reentry Center soon.	Assistance Provided
3.	Patient received a consult and is concerned his shoulder surgery is not scheduled.	The OCO provided assistance by elevating the concern through DOC health services leadership. After OCO outreach, this office confirmed the patient was scheduled for pre-op and surgery appointments.	Assistance Provided
4.	Person reports DOC staff took an excessive amount of time to respond to a medical emergency then transported him incorrectly for the injury he sustained.	The OCO provided assistance. OCO staff noted the response time for the emergency was outside of the facility's goal response time. OCO staff discussed the issue of response time with DOC health services staff. DOC staff agreed to address the concerns with floor staff. The distance and security measures between the medical unit and the patient's living unit were also a factor in the extended response time. OCO staff reviewed the emergency response documentation and were unable to substantiate that the patient was transported incorrectly.	Assistance Provided
5.	Person reported that when he went to the medication window for medical supplies, staff refused to give him his medical supplies.	The OCO provided assistance. The OCO reviewed DOC records and reached out to DOC staff, who agreed to schedule this individual for an appointment to pick up his medical supplies, as the supplies he needed are not of the	Assistance Provided

	Person said he was told he would be put on the medical callout but that never happened.	type that are typically available at the medication window.	
6.	Person reported safety concerns in the unit.	The OCO provided assistance. The OCO spoke with DOC staff, who spoke with this individual about his concerns upon the OCO's request. DOC staff told the OCO they are watching the situation and have informed the individual to report any further concerns to DOC staff.	Assistance Provided
7.	Person reports that he has a food allergy that DOC is unable to accommodate. The person states that he was instructed to self-select food that would not impact him. The person is requesting to be placed on a special diet.	The OCO provided assistance. OCO staff contacted DOC health services staff to request that the patient be scheduled with the DOC dietician. OCO staff noted that the patient's dietary needs conflict with the special diets currently available. DOC staff agreed to get the patient scheduled with their provider who is able to make the requested referral. Currently, DOC is only accommodating one special diet request at a time. The OCO has noted a pattern of this limitation impacting multiple individuals statewide and is in ongoing discussions with health services to address this conflict.	Assistance Provided
8.	Anonymous person reported that an individual was bullying other incarcerated individuals and attempting to push their security threat group (STG) politics.	The OCO contacted the facility upon receipt of this concern and asked for a review of this information. After facility leadership reviewed this information, the individual reported in this concern admitted to STG activity. The individual will be transferred out of this facility and placed in more appropriate housing.	Assistance Provided
9.	Person reported that he has minimum points and was transferred from one medium unit to another medium unit.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and found that he has been moved to a minimum unit.	DOC Resolved
10.	Person reported that he has not gotten dental work done in years, his teeth are deteriorating, and he is in significant pain.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records regarding this individual's dental concerns and reached out to DOC staff, who confirmed that he has had two dental appointments since reaching out to the OCO.	DOC Resolved
11.	Person reports medical has not continued his medications and related health status report (HSR). The person also requested information about DOC optical policy because he was told he was too close to release to get glasses.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff contacted health services management and were informed that the patient's medications had been restarted. OCO staff reviewed the patient's records and confirmed the HSR was also renewed prior to OCO action.	DOC Resolved
12.	Person reported that incarcerated individuals are having to stand outside in inclement weather at mealtimes due to long lines. Person said that this is avoidable and is caused by the way that custody staff are calling units for meals.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed this individual's resolution request, which was reviewed by DOC headquarters, and reached out to Correctional Industries staff. They stated that they had a meeting with custody staff to address how custody staff can call mainline in a way that avoids long lines and stated that they have not received further complaints since that meeting.	DOC Resolved
13.	Person reports he has not received	The OCO provided information to the patient regarding his	Information

	follow up after receiving a diagnosis. The person is requesting to see a specialist for a treatment plan.	consultation status and treatment plan.	Provided
14.	An incarcerated person reported that the Department of Corrections has acknowledged that they lost an item of their property.	The OCO provided information to the incarcerated individual regarding filing a tort claim.	Information Provided
15.	Incarcerated individual relayed concerns that DOC never paid their legal financial obligations (LFOs).	The OCO reviewed the level 1, 2 and 3 responses to the grievance the individual filed. DOC provided them with records to show all money taken from them for LFOs has been sent directly to the County and DOC spoke directly with the County clerk to confirm that the County has received the LFO payments from DOC. The OCO informed the individual that if they are still unhappy with this outcome, they will need to file a tort claim.	Information Provided
16.	Person reported needing hearing aids, and later contacted the OCO again and stated he was approved for one hearing aid but needs the second hearing aid.	The OCO provided information. The OCO reached out to DOC staff, who confirmed that this individual was assessed for hearing aids, approved for one hearing aid, but does not meet the criteria for both hearing aids. The DOC Criteria for Hearing Aids states, "binaural hearing aids can be considered for the following special populations: 1. Those younger than 21 years of age 2. Those who have corrected vision loss of 20/200 or greater; or 3. Those who have other sensory deprivation disorders, i.e. autism spectrum or sensory processing disorder." The OCO provided information about getting the second hearing aid through the Patient Paid Durable Medical Equipment process.	Information Provided
17.	Incarcerated individual relayed concerns regarding allegations staff made that have resulted in concerns about their facility placement as well as a desire to file charges against DOC for these allegations.	The OCO reviewed the individual's in-review custody facility plan and saw that the individual is being placed at an appropriate facility. DOC has resolved this concern. Regarding the desire to file charges, the OCO informed the individual that this office cannot aid in reporting the alleged crimes to police as requested.	Information Provided
18.	Incarcerated individual relayed concerns regarding having a metal knee brace that is impacting their access to their job in the food factory as staff are saying it has to be worn on the outside of their clothing.	The OCO reviewed the grievance related to this concern and per the agreement medical made with custody regarding knee braces, any brace with metal must be worn with the metal visible. OCO informed the individual that if they would like a brace that could be worn under their clothing without metal while they are at work, they will need to kite medical as medical is happy to work with them. The individual’s HSR allowing it to be worn under the clothing has been rescinded because of this.	Information Provided
19.	Patient reports custody staff reported false information in behavior observation entries (BOEs) that medical staff used to take away his health status reports (HSRs). The patient requested the HSRs be renewed and he be	The OCO confirmed the patient's HSRs were updated and provided prior to OCO outreach. This office provided information about how to request a different provider and follow up with the OCO if additional issues arise.	Information Provided

	assigned to a different provider.		
20.	Incarcerated individual reported the DOC failed to provide adequate information regarding an unsubstantiated incident where the individual slipped and fell.	The OCO provided information to the individual about why DOC did not substantiate their claim. DOC stated the claim was unsubstantiated because there are clear designated walkway borders. DOC staff visited the site in question and deemed the walkway borders adequately painted. DOC staff also agreed to have food factory staff work in maintaining the walkway in which the incident took place.	Information Provided
21.	An incarcerated person reported that they were not being given information that they have requested from DOC.	The OCO provided information regarding additional administrative remedies available to the person through DOC to gain access to materials needed to access the legal system and provided information on legal resources that are publicly available.	Information Provided
22.	Incarcerated individual relayed concerns regarding being infracted and terminated from a job due to a hearing impairment.	The OCO was unable to identify evidence to substantiate the individual's concern. The OCO reviewed each of the infractions the individual expressed concerns about and found that while two infractions due to failing to attend a callout were related to a hearing impairment, they have been addressed by the issuance of a health status report (HSR) for a hearing aid and battery. The OCO also reviewed the individual's job termination and found it was due to inappropriate behavior, not due to a hearing impairment.	Insufficient Evidence to Substantiate
23.	Incarcerated individual relayed concerns regarding staff telling them they are under investigation but not providing any further details.	The OCO reviewed the individual's grievance history and see that they did not file any grievances about this, without a grievance filed to a level 2, there is no further information for this office to investigate as there is insufficient evidence to substantiate.	Insufficient Evidence to Substantiate
24.	An individual was terminated from his recycling job because he was accused of aiding another incarcerated individual who was sneaking bags of stolen food items into the facility. The individual reports he did not know there were food items in the trash bags and handed them to the other person thinking it was trash.	The OCO was unable to identify evidence to substantiate there was a violation of policy. DOC policy 700.000 (B) states assignment to a work program may be suspended/terminated based on security/disruption concerns resulting from, but not limited to, an alleged violation or pending investigation.	No Violation of Policy
25.	Person reports being denied access to the Medicated Assisted Therapy (MAT) program when he returned to Washington DOC after being out of state. The person is requesting to be placed back on the medication and have his provider changed.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed available documentation and were unable to verify that the person meets current criteria to be on the Washington DOC Medicated Assisted Therapy program. The person can request assessment for the program closer to his release date or when the protocol is updated.	No Violation of Policy
26.	Incarcerated individual relayed concerns regarding an infraction with a delayed appeal response.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements. The OCO informed the individual that WAC 137-28-400 states “the time limitations expressed in these regulations are not jurisdictional and	No Violation of Policy

		failure to adhere to any particular time limit shall not be grounds for reversal or dismissal of a disciplinary proceeding."	
27.	Incarcerated individual relayed concerns regarding an infraction sanction that resulted in the taking away of all communication avenues.	The OCO reviewed the infraction materials and confirmed that the individual's sanctions are the mandatory sanctions per DOC policy 460.050. The OCO informed the individual that they are still able to write to their loved ones, they are just not able to place phone calls or send electronic messages.	No Violation of Policy
28.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
29.	Incarcerated individual reports concerns regarding their custody facility plan and reports DOC staff are not starting the planning at the date previously agreed upon.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the individual's custody facility plan and found that it was completed per DOC policy 300.380. The date mentioned in the previous plan was a target date and did not dictate a directive to begin the planning.	No Violation of Policy
30.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
31.	Incarcerated individual reports concerns regarding DOC's decision to terminate his employment. The individual requests the OCO review the termination to substantiate any DOC staff misconduct which resulted in his job termination and get his job back.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the job termination decision and clarified the termination reasons with DOC. The OCO found that the job termination was completed per DOC policy 700.000.	No Violation of Policy
Cedar Creek Corrections Center			
32.	External person reports concerns about an incarcerated individual's access to medical care.	The OCO confirmed testing, treatment and follow up scheduled for this patient. Since the person requested early release for medical care, the OCO provided information about the process to request Extraordinary Medical Placement (EMP). The incarcerated patient also mentioned issues with accessing medical records since he is indigent, and the OCO provided information about the medical records request process through DOC policy 640.020 that states "for individuals who are indigent, copies from the previous 6 months will be provided at no charge. Individuals will be charged for duplicate copies."	Information Provided
33.	Incarcerated individual reports concerns about access to a work crew job. The individual reports that he was not allowed to join the crew due to a health condition, and he thinks that is unfair.	The OCO provided information about how to appeal this decision. The OCO reviewed this concern and found that the decision not to allow the individual to work on a crew was a medical decision. The individual can appeal this decision and the OCO shared with the individual how to appeal the decision.	Information Provided

Clallam Bay Corrections Center			
34.	Incarcerated individual expressed several concerns regarding a use of force they were involved in.	The OCO reviewed all materials related to the use of force that occurred including video of the altercation and a related grievance. The individual raised four concerns regarding the use of force that this office investigated. The first concern was that they were not allowed a shower for four days, preventing them from washing off the OC spray. The OCO confirmed with DOC that a 24 hour no move protocol was in place, so showers were not available until four days later per the unit schedule. The OCO expressed concerns to DOC about the individual having to sit with the OC spray on them for several days in the event they refused decontamination. As a result of raising these concerns, DOC directed the Unit CUS to provide individuals with a shower the next day regardless of a no movement day. The second concern was that the individual needs medical attention. The OCO reviewed the related grievance that states the decontamination process was followed and the individual was seen by medical on the day of the incident. There was insufficient evidence to show that they were not given proper medical attention. The third concern is that their head was split open as a result of the altercation. The OCO reviewed the video, photos, and other records of the incident and saw that the individual did not sustain any major injuries. The fourth concern is that the individual's glasses were broken as a result of the altercation. The OCO reviewed the photos of the incident which shows that their glasses were broken. However, the person has not yet filed any grievances about getting their glasses repaired or getting a new pair.	Assistance Provided
35.	Person reports that he has been dealing with a medical problem for a long time but has not received information on what is happening with his treatment plan.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff reviewed the patient's care and found the patient already had a specialist consult for this issue. OCO staff monitored the appointment on the health services tracker until it was completed.	DOC Resolved
36.	Incarcerated individual relayed concerns regarding a desire to get to level 2 in IMU.	The OCO provided the individual with information related to their concern. The OCO reviewed the individual's custody facility plan that states they are to maintain IMU level 1 due to refusing available general population housing options.	Information Provided
37.	Person reports they do not understand why they are in the receiving units as he states he has been there for two months without an explanation and his grievances are not accepted.	The OCO confirmed that this individual has now been moved to a facility and was able to file a resolution request and the DOC provided a response per policy.	Information Provided
38.	Individual reports they have safety concerns at the facility they have been transferred to and DOC will not talk to him about his concerns.	The OCO verified that this individual was transferred and refused housing due to safety concerns. He has a new custody facility plan (CFP) that the DOC has not completed yet. If he does not agree with the new CFP once it is complete, this office told the individual he can appeal.	Information Provided
39.	Incarcerated individual relayed	The OCO reviewed the individual's custody facility plan that	Insufficient

	concerns regarding safety concerns surrounding a possible transfer.	states there are no safety concerns. Without verifiable safety concerns, there is insufficient evidence to substantiate the concern.	Evidence to Substantiate
40.	A loved one expressed concerns about an incarcerated individual being transferred to the other side of the state, and that it would make it more difficult for them to visit him.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed DOC records and found that this individual was transferred due to safety and security concerns. The OCO could not find a violation of DOC policy 300.380.	No Violation of Policy
41.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and was unable to find a violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
42.	Incarcerated individual relayed concerns regarding getting an infraction for pens that their cellmate had.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the pens were found in the common area of the cell, resulting in a cell tag infraction, and a Captain's Memo was issued in 2018 and 2022 that stated items over 5 inches in length that are in close custody will result in an infraction as they are prohibited.	No Violation of Policy
43.	Incarcerated individual relayed concerns regarding being told by DOC staff that a tablet cannot be taken as an infraction sanction, yet having their tablet taken.	The OCO was unable to identify a violation of policy. The OCO reviewed the individual's concern and confirmed that DOC policy 460.050 allows for tablet restrictions as an infraction sanction.	No Violation of Policy
44.	Incarcerated individual relayed concerns regarding extended placement in IMU.	The OCO reviewed the individual's custody facility plan and confirmed that their current housing is appropriate as there is no violation of DOC policy 300.380(VI)(A)(1) that states the Department will determine facility placement by addressing safety and security concerns including separation and facility prohibitions.	No Violation of Policy
45.	Incarcerated individual relayed concerns regarding being transferred facilities due to alleged security threat group (STG) involvement.	The OCO reviewed the individual's custody facility plan that states they are to transfer facilities due to continued STG activities and being an influential member of an STG. Thus, there is no violation of DOC policy 300.380 as there is evidence to support the facility transfer.	No Violation of Policy
46.	Incarcerated individual relayed concerns regarding safety concerns and an infraction.	The OCO reviewed the individual's custody facility plan that properly addressed their safety concerns and reviewed the infraction materials and found that the individual's behavior met the infraction elements. As a result, the OCO was unable to identify a violation of DOC policy 300.380 regarding the safety concerns and DOC policy 460.000 regarding the infraction.	No Violation of Policy
47.	Incarcerated individual relayed concerns regarding extended placement in IMU and being sent out of a facility with no reason as to why.	The OCO reviewed the individual's in-effect custody facility plan and saw that they were placed at an appropriate facility due to being placed on a MAX program. Thus, there is no violation of DOC policy 320.250.	No Violation of Policy

Coyote Ridge Corrections Center			
48.	Person reports concerns about DOC staff not following transgender strip search policies in visitation and dismissing their DOC resolution request.	The OCO provided assistance by elevating this concern through DOC leadership. After OCO outreach, the related DOC grievance investigation was substantiated at level 3. This office reviewed the full investigation and substantiated a violation of DOC policy 420.310.	Assistance Provided
49.	Person reports ongoing issues accessing dental care at his facility. The person is requesting to have an appointment with the dentist and receive treatment.	The OCO provided assistance. OCO staff contacted the patient's new facility when he was in transit and requested he be placed on the dental list. OCO staff monitored the appointment on the health services tracker until the appointment was completed.	Assistance Provided
50.	Person states his provider declined to renew a Health Status Report (HSR) because it was believed the issue had resolved.	The OCO provided assistance. OCO staff contacted DOC health services staff to request a review of the criteria and the patient's current status. DOC staff agreed to schedule the patient with his provider.	Assistance Provided
51.	Incarcerated individual relayed concerns regarding safety concerns around a potential transfer.	The OCO spoke with DOC and confirmed that this situation is being properly addressed.	DOC Resolved
52.	Incarcerated individual relayed concerns regarding DOC not allowing the Veteran's Pod to have fundraisers.	The OCO reviewed the level 1, 2 and 3 grievance responses which states the facility made this decision to not have fundraisers specifically for the Veteran's Pod because the facility already conducts 12 facility fundraisers per year which the Veteran's units are part of. Additionally, there were concerns raised about the frequency/amount of fundraisers already established, time spent and unfair advantage cited with other cultural and religious groups. DOC substantiated the concern, but at this time, Veteran's Pod fundraisers will not be reinstated, however, Veteran's units can participate in the 12 other fundraisers that occur, as appropriate.	Information Provided
53.	An incarcerated person reports they had a package of food purchased by their family shipped to them and never delivered, they also report that the money spent was eventually refunded. They ask for an apology from Union Supply.	The OCO provided information regarding additional administrative remedies available to the individual through DOC.	Information Provided
54.	Incarcerated individual relayed concerns regarding a dental procedure that resulted in nerve damage and a desire to file a claim against dental.	The OCO informed the individual that they will have to file a tort claim through DES for the compensation they are seeking,	Information Provided
55.	Individual reported concerns regarding long-term placement in the IMU for non-violent infractions.	The OCO reviewed the custody facility plan and found it was completed per DOC policy 300.380. This office verified that this individual has been living in medium custody, but due to multiple infractions, the DOC is unwilling to give them another override to stay in medium custody. The individual has no close custody options, and has been approved for a MAX program.	Information Provided

56.	Patient reports concerns about access to dental care and says he is being illegally detained.	The OCO reviewed the related DOC grievance investigation and the outcome was that the patient will be scheduled with dental. Medical records indicate the patient signed a form for refusing dental treatment plan at a previous appointment. If the patient has changed his mind and wants to pursue his dental treatment plan, he can discuss this with a dental provider at the scheduled appointment. The OCO cannot grant release from DOC custody or review underlying convictions. The OCO provided information to the patient about his pathway for dental care and how to follow up if they do not receive their appointment.	Information Provided
57.	Incarcerated individual relayed concerns regarding the sanctions from a WAC 603 drug introduction that are negatively impacting their mental health.	The OCO informed the individual that this office reviewed this infraction in a previous OCO case as the WAC 603 sanctions are mandatory. The OCO informed the individual that if they are having concerns about their mental health, they will need to work with their mental health counselor.	Information Provided
58.	Incarcerated individual reported a concern about DOC not repairing his glasses, hot trashing them, and not providing a new pair.	The OCO provided information regarding the tort claim process. DOC does not directly provide monetary compensation themselves and the tort claim process is the way to be considered for compensation so he may purchase new glasses himself.	Information Provided
59.	Incarcerated individual relayed concerns regarding the denial of extended family visits (EFVs).	The OCO found no violation of DOC policy. The OCO spoke with DOC and confirmed that the denial is based on the nature of the crime and serious safety concerns per DOC policy 590.100.	No Violation of Policy
60.	Person reported that while in the Receiving Units at Washington Corrections Center, a doctor prescribed him the diabetic diet because he is prediabetic, but when he arrived at his current facility, they took him off of the diabetic diet. Person wanted to go back to being on the diabetic diet.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed this individual's resolutions request, which said that he does not qualify for the diabetic diet because he has not been diagnosed with diabetes and is not currently prescribed insulin. DOC staff consulted with the DOC nutritionist, who said that a nutrition consult can be added for him for his provider and recommended the lighter fare diet. They also cited the facility orientation manual which states that "HSRs issued at another facility will be subject to review. HSRs will only be issued for needs that are Health Services necessary as defined by the Washington DOC Health Plan. Having an HSR from another facility does not guarantee that an HSR will be issued at CRCC." The OCO encourages this individual to follow up with his provider. The OCO is aware of this systemic concern regarding the diabetic diet.	No Violation of Policy
61.	Incarcerated individual reports concerns regarding being classified as maximum custody.	The OCO was unable to substantiate a violation of policy by DOC as the custody facility plan review was done per DOC policy 300.380.	No Violation of Policy
Mission Creek Corrections Center for Women			
62.	Incarcerated individual relayed concerns that a camp facility is not an appropriate placement for them given that they have health conditions.	The OCO spoke to DOC and confirmed that the facility is a suitable location for them as they are a "P2" (indicating the severity of their medical needs) and all the standalone camps have multiple patients with P2 codes. The P2 definition states "a condition or disease that needs health	Information Provided

		services available onsite." As the only standalone camp with a pill line, Mission Creek has a clinic and health services staff on site 7 days a week, more than any of the other camps. Before the transfer, the individual was reviewed by the medical providers at Mission Creek and was deemed camp appropriate.	
Monroe Correctional Complex			
63.	A loved one reports that an incarcerated individual has undergone two disciplinary hearings for the same incident. The loved one is concerned that the individual is being disciplined for the same incident twice and the DOC has given him unjust sanctions including a custody demotion.	The OCO provided assistance by speaking with the incarcerated individual and confirming that he submitted appeals for both infractions. This office contacted the facility who verified they received one appeal from the individual and are willing to accept a resubmission for that infraction.	Assistance Provided
64.	Person reported concern about a strip search and said that he was threatened with infractions for refusing the search.	The OCO provided assistance. The OCO verified that this individual was not infracted for this incident. The OCO extensively reviewed this concern and multiple similar concerns at the facility, including reviewing Prison Rape Elimination Act (PREA) records and resolutions requests, and met with facility leadership multiple times. As a result of OCO outreach, DOC released a staff memorandum on February 26, 2024 stating when a staff member changes their gender identity, they must receive approval from the Superintendent to conduct strip searches of individuals whose gender is the same as their new gender identity. The OCO will continue to investigate concerns as they arise on an individual basis.	Assistance Provided
65.	Person reported concern about a strip search and said that because of his religion he was uncomfortable with this search. Person said that he was infracted for refusing the search.	The OCO provided assistance. The OCO was able to negotiate for this individual's infractions to be removed. The OCO extensively reviewed this concern and multiple similar concerns at the facility, including reviewing Prison Rape Elimination Act (PREA) records and resolutions requests, and met with facility leadership multiple times. DOC released a staff memorandum on February 26, 2024, stating when a staff member changes their gender identity, they must receive approval from the Superintendent to conduct strip searches of individuals whose gender is the same as their new gender identity. The OCO will continue to investigate concerns as they arise on an individual basis.	Assistance Provided
66.	Patient reports their Health Status Report (HSR) for wet wipes was discontinued.	The OCO provided assistance by elevating the concern through health services leadership. DOC agreed to re-review the HSR through the Care Review Committee (CRC) with updated medical information and mobility considerations. Person can appeal the CRC and follow up with the OCO if this is not resolved.	Assistance Provided
67.	Person reported concern about a strip search and said that he received a general infraction for	The OCO provided assistance. The OCO was able to negotiate for this individual's infraction to be removed. The OCO extensively reviewed this concern and multiple similar	Assistance Provided

	refusing the search.	concerns at the facility, including reviewing Prison Rape Elimination Act (PREA) records and resolutions requests, and met with facility leadership multiple times. DOC released a staff memorandum on February 26, 2024 stating when a staff member changes their gender identity, they must receive approval from the Superintendent to conduct strip searches of individuals whose gender is the same as their new gender identity. The OCO will continue to investigate concerns as they arise on an individual basis.	
68.	Person reported concern about a strip search and said that he received serious infractions for refusing the search.	The OCO provided assistance. The OCO was able to negotiate for this individual's serious infractions to be reduced to a general infraction. The OCO extensively reviewed this concern and multiple similar concerns at the facility, including reviewing Prison Rape Elimination Act (PREA) records and resolutions requests, and met with facility leadership multiple times. DOC released a staff memorandum on February 26, 2024 stating when a staff member changes their gender identity, they must receive approval from the Superintendent to conduct strip searches of individuals whose gender is the same as their new gender identity. The OCO will continue to investigate concerns as they arise on an individual basis.	Assistance Provided
69.	The individual reports that his toilet overflowed and there were feces and urine all over the floor and that he is still in the same cell and the DOC has not given him any cleaning supplies to clean his cell.	The OCO traveled to the facility to check on this individual in person. The OCO observed that his cell was clean, however the OCO cannot substantiate that the DOC cleaned his cell in a timely manner. This individual has called the OCO multiple times regarding his conditions in restrictive housing. The OCO contacted DOC leadership to gather more information on his placement and will continue to monitor the restrictive housing unit.	Assistance Provided
70.	Person reported concern about a strip search and said that he received a negative Behavioral Observation Entry (BOE) for refusing the search.	The OCO provided assistance. The OCO was able to negotiate for this individual's BOE to be reduced from a negative to a neutral. The OCO extensively reviewed this concern and multiple similar concerns at the facility, including reviewing Prison Rape Elimination Act (PREA) records and resolutions requests, and met with facility leadership multiple times. DOC released a staff memorandum on February 26, 2024 stating when a staff member changes their gender identity, they must receive approval from the Superintendent to conduct strip searches of individuals whose gender is the same as their new gender identity. The OCO will continue to investigate concerns as they arise on an individual basis.	Assistance Provided
71.	Incarcerated individual relayed concerns regarding excessive loss of good conduct time (GCT) for an infraction.	The OCO reached out to DOC regarding the loss of good conduct time for the infraction. Due to a lack of clarification of where each loss of GCT came from, DOC is remanding the individual for a secondary hearing to seek clarification regarding the issuance of the GCT loss. The OCO informed the individual that if they believe the GCT loss is still improper after the remanded hearing, to please contact this office so that the information can be further reviewed.	Assistance Provided

72.	Person reports continued issues accessing the DOC Medication Assisted Therapy program despite OCO assistance. The person is concerned he will not be able to start the medication before release.	OCO provided assistance. The concern was resolved as a result of previous discussions with DOC. The patient was started on the medication shortly after re-reporting the issue, within the timelines set by the MAT protocol.	Assistance Provided
73.	Incarcerated individual relayed concerns regarding not being able to have a tablet.	DOC resolved this concern prior to OCO involvement as the individual was given their tablet.	DOC Resolved
74.	Incarcerated individual relayed concerns regarding access to their property.	DOC resolved this concern prior to OCO involvement. The OCO spoke with DOC and confirmed that their property inventory compliance has been completed and they have received the remainder of their allowable property.	DOC Resolved
75.	Person reported that in the middle of the night, a toilet overflowed due to a plumbing issue and created unsanitary conditions in his cell. Person reported that he had to wait until the morning to receive cleaning supplies so he could clean his cell.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed the resolutions request investigation for this concern, which was substantiated at the facility level, who found that a toilet did overflow, and that no one was available to clean his cell. The concern was deemed unfounded at the facility leadership level, which stated that this individual was offered cleaning supplies and refused them. This concern was appealed to DOC Headquarters, who substantiated the concern and said that unit custodians who are trained in cleaning up biohazard and bodily fluids need to be available in such situations. DOC Headquarters contacted the unit sergeant, who agreed that trained custodians will be used for such situations in the future.	DOC Resolved
76.	Incarcerated individual relayed concerns regarding a delay in dental care.	The OCO confirmed that DOC resolved this concern prior to OCO involvement as the individual is scheduled for a dental appointment to discuss these concerns.	DOC Resolved
77.	Individual reports that they have been housed in the IMU for an extended amount of time after a fight they were not involved in.	When OCO reviewed this concern, this individual had been moved back to their living unit.	DOC Resolved
78.	Patient reports concerns about delayed access to a medical provider, medication refills, blood pressure monitoring, health status reports (HSRs), and specialized medical shoes.	The OCO confirmed the HSR for no upper bunk was renewed, the patient was scheduled and seen for diabetes and hypertension, and medications were updated and refilled. Since the patient declined the shoes and expressed interest in purchasing his own, the OCO provided information about the patient paid healthcare policy.	Information Provided
79.	An incarcerated individual reports that he wants a keep separate between himself and a couple of other individuals.	The OCO provided information about how to kite the internal investigations unit (IIU). This office encouraged the individual to write a statement to IIU so they may investigate his safety concerns.	Information Provided
80.	Incarcerated individual relayed concerns regarding time calculations.	The OCO informed the individual that they will first need to file a grievance about this concern and discuss the issue with records before this office is able to investigate.	Information Provided
81.	Incarcerated individual relayed concerns regarding an infraction.	The OCO provided the individual with information. The OCO reviewed the infraction materials but because they did not	Information Provided

		appeal the infractions, there were no further steps for this office to take at this time.	
82.	Incarcerated individual relayed concerns regarding placement in IMU.	The OCO provided the individual with information regarding this concern. The OCO reviewed the individual's record and confirmed that they were initially placed in IMU for an infraction and that they remain in IMU as their custody facility plan is currently being finalized.	Information Provided
83.	Incarcerated individual relayed concerns regarding an infection in the skin of their feet.	The OCO reviewed the associated grievance which states the individual was seen and no infection was noted, just that they have dry skin and ointment was given to them. The OCO informed the individual that if they disagree with this medical decision, they will need to continue to pursue the concern through the grievance process.	Information Provided
84.	Person reports concerns about DOC not being able to provide safe housing for transgender women currently housed in prison facilities for men.	The OCO provided information about pathways for reporting individual safety concerns. The OCO regularly meets with the DOC Transgender Settlement Administrator to elevate concerns and negotiate individual resolutions. This office also meets with LGTBTQ groups in prison to hear feedback about ongoing issues. The person can report safety concerns to their Corrections Unit Supervisor (CUS) and Sergent and if unaddressed, follow up with the OCO. The OCO reviews transgender safety concerns on an individual basis and anyone can report to this office if their issues are unaddressed via DOC.	Information Provided
85.	Incarcerated individual shared concerns regarding DOC taking earned time away from them.	The OCO provided information regarding why DOC took their earned time. The individual had received a serious infraction and did not appeal the infraction. The OCO viewed the infraction and found the incident met the infraction thresholds. Earned time lost was appropriate per DOC policy 460.050. The OCO shared this information with the individual.	Information Provided
86.	Incarcerated individual relayed concerns regarding a desire to have access to the IMU levels system.	The OCO provided the individual with information regarding this concern. The OCO reviewed the individual's record and confirmed that the headquarters' MAX committee decided to maintain them at IMU level 1 due to refusing available custody appropriate housing.	Information Provided
87.	Person states that DOC changed her information after she had gone though the process to have it amended to match her documentation.	The OCO provided information to the person. OCO staff confirmed the information was changed by DOC due to a system issue that could only be resolved by changing the information back. OCO brought the issue to DOC leadership who informed the OCO that a solution was in process, but would take a significant amount of time. The OCO will continue to track this system issue until it is resolved.	Information Provided
88.	Person reports that a DOC staff member is refusing to make an order for him to stay at his current facility.	The OCO provided information to the person. A medical provider cannot make the final decision in a person's facility assignment. OCO staff reviewed the person facility plan and confirmed that health services was involved in the review. OCO staff noted the patient is housed appropriately for his custody level and access to medical care. The OCO provided information to the person regarding how to report licensure concerns to the Washington Medical Commission.	Information Provided

89.	Incarcerated individual relayed concerns regarding a desire for OCO to come and take photos of all of their intellectual property that is being stored in the property room to be used as evidence in a lawsuit.	The OCO informed the individual that this office is not able to come and take photos of the property to be used as evidence in a lawsuit but that this office is investigating the individual's placement concerns in a separate OCO case.	Information Provided
90.	Person reported that health services will not issue him medical shoes and requested an appointment with an outside provider.	The OCO provided information. The OCO reached out to DOC staff and confirmed that this individual was seen by a medical specialist. The OCO reviewed the consultation progress report, which recommended arch supports, and reviewed the resolutions investigation, which stated that he does not meet the medical necessity for the medical shoes. The OCO provided information about asking property for a different shoe size to accommodate the arch support or purchasing tennis shoes from Union Supply.	Information Provided
91.	Incarcerated individual relayed concerns regarding placement in IMU.	The OCO provided the individual with information regarding this concern. The OCO reviewed the individual's record and confirmed that they were originally placed in IMU for an infraction and remain in IMU as their custody facility plan is being finalized.	Information Provided
92.	Person reports concerns that he will be transferred to a facility that cannot meet his medical needs and is too far from the specialist he sees.	The OCO provided information to the person regarding the status of his facility plan. OCO staff confirmed DOC medical staff have been involved in the facility decision making process regarding this person's assignment.	Information Provided
93.	Incarcerated individual reports DOC staff purposefully packed his property in more boxes than needed so that he will have to pay more to ship his property to the new facility he is transferring to.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO spoke with property and confirmed that property was packed per DOC protocol and sent to the facility the person transferred to.	Insufficient Evidence to Substantiate
94.	Incarcerated individual relayed concerns regarding not being able to get hygiene items as the result of an infraction sanction.	The OCO spoke to DOC and confirmed that with the loss of store sanction, individuals are still allowed to order certain items such as envelopes, OTC medicines, and indigent hygiene items. The OCO confirmed that the individual has received hygiene items. As a result, there was insufficient evidence for the OCO to substantiate the individual's claim.	Insufficient Evidence to Substantiate
95.	Incarcerated individual relayed concerns regarding staff having harassed, berated, and used derogatory language towards them.	The OCO reviewed the grievance responses regarding the claims and found insufficient evidence to substantiate the claims. DOC investigated this claim, but no evidence of harassment or derogatory term usage was found. The grievance response states that in the future, relevant staff will work to ensure directions are clearly written and explained to avoid any future issues.	Insufficient Evidence to Substantiate
96.	Incarcerated individual relayed concerns regarding staff and the resolution program being difficult to work with.	The OCO reviewed the individual's grievance history and see that they have not filed any recent grievances that are not being responded to as the last grievance was from several months ago. Additionally, OCO already investigated the staff conduct in a previous OCO case. The OCO informed the individual that the OCO cannot force DOC to prevent the	Insufficient Evidence to Substantiate

		named officers from transporting the individual in the future. There was insufficient evidence to substantiate the individual's concern.	
97.	Person reported that he waited three hours for mental health staff to see him after declaring a mental health emergency. The person states that staff bully him when he asks for mental health assistance.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff reviewed video evidence of the day of incident and were unable to substantiate that staff were acting inappropriately or that mental health staff response was significantly delayed. OCO staff reviewed the resolution request investigation completed by DOC staff and confirmed the response aligned with the video evidence.	Insufficient Evidence to Substantiate
98.	Incarcerated individual relayed concerns regarding not being given LOGID numbers for grievances filed.	The OCO was unable to find evidence to substantiate the individual's concern. The OCO reviewed the individual's grievance record for several months and confirmed that numerous grievances had been filed and all have been responded to. There is no evidence to show DOC is not responding as those responses would include the LOGID numbers.	Insufficient Evidence to Substantiate
99.	Incarcerated individual relayed concerns regarding the IMU yard being dirty with mold and grime.	The OCO was unable to substantiate this concern due to insufficient evidence. The OCO visited the facility and looked at the IMU yard. The yard was clean and free of any visible mold and grime.	Insufficient Evidence to Substantiate
100.	Incarcerated individual relayed concerns regarding a visitation denial.	The OCO found no violation of DOC policy 450.300 after the OCO reviewed the visitation application that was denied due to the current and previous crimes of conviction leading DOC to believe there is a safety risk for minor applicants.	No Violation of Policy
101.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
102.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
103.	Incarcerated individual expressed concerns about future facility placement options.	The OCO spoke with DOC and confirmed that DOC is properly addressing their housing concerns and will discuss options with the individual as the timing gets closer.	No Violation of Policy
104.	Person reports they have been in IMU for three years on the out of state transfer list.	The DOC maintains that due to staff assaults, this individual poses a safety and security threat and cannot be placed in the general population. In DOC policy 330.600, there is no timeline that the DOC must adhere to regarding when the out-of-state transfer must take place. The DOC sends the packet to multiple states and waits for another state to accept the transfer. The OCO has substantiated that many people sit in the IMU waiting to transfer for years.	No Violation of Policy
105.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
106.	Incarcerated individual relayed concerns regarding two infractions.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behaviors met the infraction elements.	No Violation of Policy
107.	The incarcerated individual reports	The OCO was unable to identify evidence to substantiate	No Violation of

	that he was transferred from another facility and had a health status report (HSR) for a single-man cell. This person is currently in a two-man cell and would like the DOC to honor his HSR.	there was a violation of policy by DOC. This office could not determine that this person has an HSR for a single-man cell and when he was reviewed for a single-man cell, he was denied because he does not meet the criteria. DOC policy 420.140 says that single-cell assignment decisions may not be appealed.	Policy
108.	Incarcerated individual relayed concerns regarding an infraction that resulted in MAX placement.	The OCO reviewed the individual's custody facility plan and confirmed that the referral to MAX was appropriate given the infractable behavior. Thus, there is no violation of DOC policy 320.250.	No Violation of Policy
109.	Incarcerated individual relayed concerns regarding a desire to move to medium custody.	The OCO was unable to identify a violation of DOC policy. The OCO reviewed the individual's custody facility plan and see that they will maintain close custody due to infraction behavior which is in accordance with DOC policy 300.380.	No Violation of Policy
110.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
111.	Incarcerated individual relayed concerns regarding needing noise cancelling headphones but being denied by the Accommodation Review Committee (ARC).	The OCO found no violation of DOC policy as the OCO spoke to DOC regarding the denial and confirmed that the individual was denied the noise cancelling headphones as they have no diagnosis that requires these.	No Violation of Policy
	Olympic Corrections Center		
112.	Person reported concern about DOC not funding projects that ensure a safe and healthy living environment at the facility. Person reported that the floor in the kitchen has broken tile and is unsafe. Person wants this tile floor to get replaced.	The OCO provided assistance. The OCO visited this facility and took pictures of the broken tile in the kitchen and spoke with the Superintendent multiple times. The Superintendent said that the floors have been fixed with a new, more durable epoxy.	Assistance Provided
113.	Person reports that he needs medical care and accommodations that his facility cannot provide. He is requesting to be transferred to a facility that has a higher level of medical care available.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff contacted DOC staff for a review of any accommodation that the patient might need. During the course of the investigation the patient was transferred to a facility with more medical care available.	DOC Resolved
114.	A loved one reported a concern that an incarcerated individual was denied Reentry Center placement based on an old police report from dismissed charges.	The OCO provided information. The OCO reviewed DOC records and verified that there were validated community victim concerns. DOC policy 300.500 II. states "A. An individual is prohibited from Reentry Center placement and should not be considered if the individual: 7. Has a current local victim safety concern that cannot be mitigated after review with Victim Services." The OCO encourages this individual to work with his counselor for other options.	Information Provided
	Reentry Center - Helen B. Ratcliff - King		
115.	Anonymous individual made a report relating to unsafe food prep practices.	The OCO was unable to substantiate the concern due to insufficient evidence because no contact information or additional details were provided.	Insufficient Evidence to Substantiate

Stafford Creek Corrections Center			
116.	Person reports that his pain issues have not been addressed by medical. The person is requesting follow up from a provider and a treatment plan.	The OCO provided assistance. OCO staff contacted DOC health services staff and requested the person be scheduled for a provider follow up appointment. OCO staff also asked that the Patient Care Navigator assist the patient with his treatment plan concerns. OCO staff monitored the appointment on the Health Services Tracker and verified the patient was able to meet with the provider	Assistance Provided
117.	Person reported that his cell was searched, and that correctional officers confiscated and threw away his legal paperwork. Person stated that his resolutions request was substantiated by DOC headquarters, and that they said that they gave him a new copy of his legal paperwork. Person reported that he never received a new copy of his legal paperwork.	The OCO provided assistance. The OCO reviewed the substantiated resolutions request and verified that DOC headquarters stated they sent him a new copy of his legal paperwork. The OCO spoke with DOC headquarters and informed them that this individual never received the new copy of this paperwork and requested they send him another copy, and they did.	Assistance Provided
118.	Person reports OCO was given incorrect information by DOC. The person states that a procedure which DOC said had occurred did not because of staff error. The person reports this error caused a delay in cancer treatment and the person is requesting to have the procedure rescheduled.	OCO staff provided assistance. OCO staff contacted DOC health services staff and requested a review of the incident. An administrative error was found where specialist orders were not carried over to the patient's medication report. OCO staff verified that a medication incident report was submitted. OCO staff monitored the appointment on the Health Services tracker to confirm completion. OCO staff also followed up with health services staff to confirm that treatment was moving forward.	Assistance Provided
119.	External person reports concerns about an incarcerated individual's medical care.	The OCO provided assistance by scheduling a phone call with the patient and providing self-advocacy information about the DOC Patient Care Navigators. This office elevated the concerns through health services leadership and confirmed updated appointments, prescriptions, and follow up scheduling. The individual was given information about how to contact the OCO directly if new concerns arise.	Assistance Provided
120.	Person reported that a DOC staff he had a history of concerns about wrote a behavioral observation entry (BOE), and he did not receive notice about it. Person said that he also filed a resolution request because this is a staff conduct issue, but it was not accepted.	The OCO provided assistance. The OCO reviewed the BOE and found that after the individual appealed it, it was reviewed by facility leadership and personal opinion was removed. The OCO also found that this was a neutral BOE, which per DOC policy 300.010 does not require staff to notify individuals about the BOE. The OCO spoke to facility leadership about neutral BOEs being used to avoid notifying individuals to make them aware of the concern, and they agreed to speak with all classifications staff about how to use neutral BOEs per policy. The OCO reviewed the resolutions request, which was not accepted because of the appeals process for BOEs. The OCO is in ongoing conversations to address concerns about the resolutions program.	Assistance Provided
121.	Person reported shoulder and neck pain and has been on medication	The OCO provided assistance. The OCO reviewed the Care Review Committee (CRC) decision that deemed further pain	Assistance Provided

	but has not been able to follow up with pain management to review options, or with neurology to address the source of his pain.	management not medically necessary and found that neurology consults had not been scheduled. The OCO met with health services management and substantiated that there was a delay in scheduling the neurology consults. Health services agreed to reach out to patient services about the delay, and then scheduled the neurology consults. The OCO informed this patient that after the neurology consults, he can request that the CRC review his request for pain management again, with the new information from neurology.	
122.	Incarcerated individual relayed concerns regarding needing an ergonomic chair in the resource room.	The OCO confirmed that DOC resolved this concern prior to OCO involvement. The OCO spoke with DOC and confirmed that the committee determined that no action is required on this request as the individual also requested and received an HSR for a cushion to use for work and programming.	DOC Resolved
123.	Patient reports missing an appointment for physical therapy because staff did not provide notification of the appointment.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO confirmed the physical therapy appointment was rescheduled and occurred.	DOC Resolved
124.	Patient reports concerns about not receiving oncology recommended pain management.	The OCO reviewed the related DOC grievance investigation and found the issue informally resolved. This office contacted DOC health services leadership to confirm access to pain management and oncology recommendations.	DOC Resolved
125.	Incarcerated individual relayed concerns regarding a delayed release.	The OCO confirmed that the individual has been released from DOC custody prior to OCO involvement.	DOC Resolved
126.	Incarcerated individual relayed concerns regarding being denied access to an interpreter at an infraction hearing.	DOC resolved this concern prior to OCO involvement. The OCO reviewed the level 1, 2, and 3 responses for the grievance regarding staff being intimidating and unprofessional during an infraction hearing and confirmed that DOC properly resolved the concern by addressing staff about the unprofessional conduct.	DOC Resolved
127.	Person reported that a consult with a specialist was cancelled for the third time, and that this most recent cancellation was due to the specialist not being able to treat his specific kind of injury.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC health services records and found that the specialist in the community made a referral to a different provider and that this individual is scheduled for an evaluation with the new provider. Neither the OCO nor DOC cannot impact specialist scheduling dates, they are chosen by the community clinic by availability.	DOC Resolved
128.	Person reported that his appointment with a medical specialist in the community was cancelled and was not rescheduled.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and reached out to DOC staff, who confirmed that this appointment was rescheduled and that this patient has been seen by the specialist.	DOC Resolved
129.	Incarcerated individual relayed concerns regarding their glasses being broken and having difficulty getting a new pair.	DOC resolved this concern prior to OCO involvement as the OCO confirmed that the individual has been seen by medical and this concern has been addressed.	DOC Resolved

130.	Incarcerated individual relayed concerns regarding needing to transfer to another facility to get proper chemical dependency treatment.	The OCO reviewed the individual's record and confirmed that DOC is properly working to address this concern.	Information Provided
131.	Incarcerated individual relayed concerns regarding an infraction.	The OCO informed the individual that they will need to appeal the infraction and receive the response from DOC before this office is able to investigate.	Information Provided
132.	Incarcerated individual found that the commissary policy says something about a person being required to speak with the population regularly, or surveys, and states it is not happening.	During the December 2023 policy review cycle, DOC policy 200.210 was up for review and in the submitted OCO policy comments, OCO recommended that DOC provide a publicly accessible explanation of how an incarcerated individual is able to provide input in the selection of commissary items including information about who the input is provided to, who reviews the feedback and what the feedback protocol includes.	Information Provided
133.	Incarcerated individual relayed concerns regarding a medical provider providing them with information no one else previously told them resulting in a desire to continue to see this specific provider.	The OCO informed the individual that this office cannot ensure future scheduling with particular specialists/providers but informed the individual that they can grieve the issue and follow up if they would like this office to review to ensure access to treatment/care.	Information Provided
134.	Person reports that he needs a procedure completed before he can have surgery on a chronic medical issue. He is requesting the procedure be scheduled so his care can move forward.	The OCO provided information to the patient regarding his consult status. OCO staff reviewed the patient's consults and noted that a nonsurgical procedure had been approved. OCO contacted DOC health services staff to confirm scheduling and were informed that the requested surgery was not currently indicated, and the procedure had been scheduled.	Information Provided
135.	Person reports that an injury he had surgery for has returned and he is requesting to see a specialist to be evaluated for another surgery.	The OCO provided information to the patient regarding his consult status. OCO staff reviewed his consultation with the specialist. OCO staff confirmed the patient has established care with the specialist and that DOC medical is pursuing the studies recommended by the specialist prior to scheduling follow up.	Information Provided
136.	Incarcerated individual relayed concerns regarding an infraction for failure to provide a urinalysis (UA) despite having a health status report (HSR) that allowed the individual to have two hours to provide a UA and that this HSR was rescinded.	The OCO reviewed the infractions for the 607 failure to provide a UA as well as medical records related to the HSR. The OCO discussed this concern with DOC and found out that the HSR was rescinded after DOC staff discussed with DOC headquarters the recent rash of requests for shy bladder protocol HSRs. The decision was reached that all requests for approval would be sent directly to health services leadership by the individual's primary mental health therapist. As a result of the HSR being rescinded, there was no violation of policy in issuing the WAC 607 infractions.	Information Provided
137.	Incarcerated individual relayed concerns regarding staff refusing to make copies to send to OCO.	The OCO provided the individual with information regarding this concern. The OCO spoke with DOC and confirmed that copies are made for individuals housed in IMU to be sent to OCO as long as the individual sends the law librarian a kite.	Information Provided

		Once a week the law librarian will make these copies. Staff inside of IMU are not allowed to make any copies for legal work.	
138.	An individual reports concerns that DOC is violating several laws and codes in regard to how the facility conducts a urine analysis (UA) on groups of individuals.	The OCO provided information about how to file a concern with the U.S. Department of Health and Human Services regarding a violation of private information.	Information Provided
139.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the 103 refusing orders infraction when the individual was observed with their ID clipped onto their jacket backwards, officers gave them directives to turn the ID around but ignored them. As the individual was originally given a 663 for intimidation but the decision narrative states video and staff written testimony do not support each other, it appears the 103 is unrelated to the intimidation infraction, thus this office asked DOC if they would be willing to dismiss the infraction. DOC was unwilling to overturn the infraction based on the rationale that the hearings officer may find an individual guilty of a lesser violation and apply the sanction associated with it. In this case DOC states the individual should have obeyed the order to turn their ID around when given the order from the officer and felt the 103 guilty finding is appropriate.	Information Provided
140.	Incarcerated individual relayed concerns regarding having their Securus player unreasonably held by the intelligence and investigations unit (IIU) for several months.	The OCO provided information to the individual regarding this concern. The OCO spoke with DOC and confirmed that the investigation involving the individual's player is still ongoing. Until the investigation is complete, and pending the outcome of said investigation, IIU will continue to be in possession of the player.	Information Provided
141.	Person reports concerns regarding his heart health. The person states that DOC is refusing to send him to a specialist.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff reviewed the patient's consults and found that the patient is scheduled to see a specialist to determine the cause of the issue. OCO staff provided self advocacy information to the patient for accessing answers to treatment related questions.	Information Provided
142.	Person reports he was denied a medical emergency. The person states DOC staff treated him poorly due to bias against people with accents.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff reviewed the emergency response records and related medical records. There was insufficient evidence to substantiate that the patient was not evaluated by medical staff when the emergency was reported. OCO staff noted the person's medications were on the way from the pharmacy at the time of the reported emergency and no urgent stock medication was ordered based on the nursing assessment. OCO staff provided the patient with information to assist in preventing late refills or renewals of his medications. There was insufficient evidence to support that DOC staff were acting inappropriately with the patient.	Insufficient Evidence to Substantiate
143.	Incarcerated individual relayed concerns regarding staff writing numerous infractions.	The OCO was unable to identify information to substantiate this concern. The OCO reviewed the individual's infraction history and saw that the general infraction was dismissed.	Insufficient Evidence to Substantiate

		Additionally, there are no grievances that have been filed regarding the staff conduct.	
144.	Incarcerated individual relayed concerns regarding being released in less than a year and staff not helping with their release.	The OCO was unable to identify information to substantiate this concern as the individual's release date is scheduled for more than a decade from now. The OCO informed the individual that staff would not begin release planning measures until they are much closer to their early release date (ERD).	Insufficient Evidence to Substantiate
145.	External person reports they are worried for their loved one's safety if they are moved to a close custody unit.	The OCO reviewed the custody facility plan and found that it was completed per DOC policy 300.380. This individual was transferred to medium custody earlier this year and has since received multiple infractions. The DOC is declining to override him to keep him in medium based on the infraction behavior. He will transfer to close custody. The OCO explained to the individual how to kite IIU with safety concerns.	No Violation of Policy
146.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
147.	Incarcerated individual expressed concerns about several infractions they received.	The OCO reviewed the infraction materials for each corresponding infraction and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
148.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
149.	Incarcerated individual reported the DOC refused to offer a loaner coat despite the individual having to wash his and go into inclement weather.	The OCO was unable to substantiate a violation of policy by DOC. Per Policy 440.050(a)(1), incarcerated individuals are only allowed to have one coat in their possession at a time. DOC staff stated incarcerated individuals having more than one coat would lead to individuals incurring infractions, as well as applying a strain on facility logistics.	No Violation of Policy
150.	Person reported concerns regarding a demotion to close custody with no close custody options due to safety concerns. They are requesting an override to medium custody.	The OCO reviewed the recent custody facility plan and found that the DOC would not approve an override to medium custody based on the individual's previous infraction behavior. They currently score close custody points; however, they do not have any safe close custody options. Due to this, they were referred to the Max Committee per DOC policy 320.250. The committee found that the only suitable housing was in max custody.	No Violation of Policy
151.	Incarcerated individual relayed concerns regarding safety concerns about a potential transfer.	The OCO did not find a violation of DOC policy 300.380 as the OCO reviewed the individual's in-effect custody facility plan and verified that due to infraction behavior, their custody score has changed and their current facility is no longer an appropriate placement.	No Violation of Policy
152.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
153.	Person reported that his cell was searched and staff confiscated	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed this individual's resolutions	No Violation of Policy

	boxes of food. Person said that DOC staff did not follow policy, because they did not itemize all items that were confiscated, and he did not want to provide receipts without receiving an itemized list.	request, which was reviewed by DOC headquarters, who did not substantiate his claim because he did not retain his commissary receipts to prove ownership of the items and cited the facility handbook and cited the facility handbook, page 10 “Edible items must be consumed or discard within 90 days” and page 3, “you must keep the receipt until the food item is gone.” The OCO reached out to DOC staff asking if this individual was given a search report and a property disposition, and they confirmed that he was given a search report, and that because he could not show proof of ownership with receipts during the review and the amount of property did not match the commissary records, the excess amount of food cannot be donated or shipped and can only be destroyed.	
154.	Person reported concern about being past his Earned Release Date (ERD).	The OCO was unable to substantiate a violation of policy by DOC. The OCO found that this individual will be released on his maximum confinement date, and that his original release plan was denied because of victim concerns. DOC policy 350.200 I. B. states, "Individuals requiring an approved release address may be held in confinement up to the Max Ex date until an approved release address is secured."	No Violation of Policy
155.	Person states he was having a medical issue and medical staff took his rescue medication and forgot to bring him a replacement for several hours. The person requests that DOC have nightshift medical emergencies staffed with a medical provider instead of nursing staff. The person also requested that DOC modify policy requiring confiscation of certain essential expired meds without immediate replacement.	The OCO was unable to substantiate a violation of policy by DOC. The person's policy change recommendation was elevated to the OCO policy team to discuss when that DOC policy is up for review. OCO staff verified that no urgent stock medication was ordered based on the nursing assessment. Current DOC policy allows for a medical provider to be on-call and available to order urgent interventions after business hours, these providers are not required to be on-site. Per DOC policy 890.620, the plan to ensure 24-hour emergency medical services availability will be created by facility medical directors, senior facility nurses, and health services managers.	No Violation of Policy
156.	Person reports he suffered immense pain following a surgery because DOC could not bring medications back from the hospital. Days later, when the person went to pill line, he was informed that his medication order had changed from what was originally ordered. The person requested his medications be changed back.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff met with DOC health services staff who has reviewed the patient’s treatment plan. OCO staff were informed the order change was the result of a planned postoperative medication taper.	No Violation of Policy
Washington Corrections Center			
157.	Incarcerated individual relayed concerns regarding a grievance being removed for another review process but not hearing anything	The OCO spoke with DOC staff regarding this concern and confirmed that appropriate action was taken regarding the staff’s conduct that the individual expressed concerns about. This office also spoke with DOC headquarters about	Assistance Provided

	further.	grievances being pulled for administrative review and individuals not being notified of what the outcome of that investigation is. Per page 17 of the Resolution Program Manual, DOC staff should be providing individuals with notification that the concern has been removed from the grievance program for an administrative review. DOC headquarters agreed to meet with the Superintendents and Associate Superintendents to clarify this process.	
158.	Patient reports their surgery has not been scheduled and they only received a consult with the surgeon.	The OCO provided assistance by elevating this concern through DOC health services leadership and adding the case to this office's appointment tracker. The OCO was able to confirm the surgery was approved; the surgery and post-op appointments are now scheduled.	Assistance Provided
159.	Person states he faced a significant delay in receiving the results of imaging done after an injury. The person is requesting to be released on GRE to receive treatment in the community.	The OCO provided assistance. OCO staff reviewed the patient's medical records and substantiated a delay between the time the imaging was done and when the provider met with the patient to discuss the results. OCO staff took the issue to DOC leadership and is engaged in ongoing conversations regarding provider follow ups after injuries. The OCO is unable to impact the patient's requested resolution to be released on GRE.	Assistance Provided
160.	Person reported concern about not receiving treatment related programming.	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 been transferred to a facility and unit to begin programming.	DOC Resolved
161.	Incarcerated individual relayed concerns regarding a delayed transfer that was impacted by a trans housing protocol.	DOC resolved this concern prior to OCO involvement as the individual's transfer was completed.	DOC Resolved
162.	Person reported that he has not been able to get treatment for a toothache and expressed concerns about verbal abuse from staff. Person stated that he wants DOC policy to be more easily available for incarcerated individuals.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records regarding his dental concerns and reached out to DOC staff, who confirmed that this individual has received dental care. The OCO also reviewed his resolutions requests regarding staff conduct and found that resolutions were unable to substantiate verbal abuse from staff. DOC policy can be found on individual's Securus tablets or in the Law Library.	DOC Resolved
163.	A loved one reports that her husband's personal items were ruined including irreplaceable photos during a cell search. The officers destroyed his cell and property by leaving the pictures in a puddle of water on the floor and his legal transcripts were taken and destroyed.	The OCO provided information regarding the torts process and verified that DOC addressed the staff members responsible for the search.	Information Provided
164.	Person reports he is in the IMU for a riot. He was found not guilty of his infraction but was still given a max program. He also reported that he has been waiting months	The OCO reviewed the infraction and found that it was dismissed based on a technical error. However, the DOC still has the evidence to substantiate he was involved in the riot. Per DOC 320.250 Maximum Custody Placement/Transfer/Release, the DOC can recommend a	Information Provided

	to transfer to the facility where he will start the program.	max program for individuals who pose a significant risk to safety and security. The max committee found that the evidence of his involvement in the riot met the requirements for a max custody placement. The OCO reached out to transport to verify his transfer, as it has been pending since March.	
165.	Incarcerated individual reports they were initially approved for Graduated Reentry (GRE) however after a meeting DOC denied him from the program and could not provide a reason for the decision. The individual wants to know why they were denied the GRE program.	The OCO provided information regarding Graduated Reentry requirements to be accepted into the program. The OCO spoke with DOC staff regarding the denial and found the individual met the initial screening requirements, however at the meeting that determines eligibility, DOC found that the individual is not eligible for GRE per the policy requirements. The OCO shared that the way DOC interprets community custody revocations results in a denial to the GRE program.	Information Provided
166.	An incarcerated person reports their loved one has been denied visitation.	The OCO provided information regarding additional administrative remedies available to their loved one internal to DOC.	Information Provided
167.	Incarcerated individual reports concerns regarding how he was treated during a use of force and his conditions of confinement in segregation.	The OCO provided information regarding the investigation findings and provided tools to ensure that he is being treated per DOC policy. The OCO reviewed the DOC staff actions and actions taken by facility administration and found that DOC took appropriate action to address the concerns. The OCO shared how to address conditions of confinement with staff and verified that times the staff were notified they acted. The OCO verified the individual in not in segregation any longer.	Information Provided
168.	Incarcerated individual reports concerns regarding his release. The individual has been requesting reentry support and has not received clear answers.	The OCO provided information regarding services DOC will be providing upon his release and how to get more information about them. The OCO verified that DOC is going to provide the individual with reentry services and has access to reentry staff. The OCO shared with the individual how to access reentry staff in his unit, and they can share with him what he will be able to access upon release and answer any further questions.	Information Provided
169.	Incarcerated individual reports concerns regarding his placement and requests to be placed in a protective custody unit.	The OCO provided information regarding DOC's placement decision. The OCO reviewed the individual's most recent custody facility plans (CFPs) and found that DOC placed him in a protective custody unit. The OCO shared this information with the individual. The OCO also confirmed the CFPs were completed per DOC 300.380 Classification and Custody Facility Plan Review.	Information Provided
170.	Incarcerated individual relayed concerns regarding a desire to correct infraction paperwork to allow visitation.	The OCO confirmed that the visitation denial was not appealed and informed the individual that per RCW 43.06C, the denial must be appealed before this office can investigate.	Information Provided
171.	An incarcerated person called into the OCO hotline and requested assistance stating that their time served has not been calculated correctly.	The OCO provided information regarding additional administrative remedies available to them internal to DOC to have their time served reviewed, recalculated, and explained.	Information Provided

172.	Incarcerated individual relayed concerns regarding staff conduct in which they state an officer made inappropriate comments about them and their crime of conviction.	The OCO reviewed the grievance responses that were deemed unsubstantiated because there is no video or audio recording of this incident resulting in DOC being unable to confirm or deny that misconduct did occur. As a result, there was insufficient evidence for OCO to substantiate the individual's concern.	Insufficient Evidence to Substantiate
173.	Person reports he did not receive medical care for an injury following a use of force by DOC. The person also states that DOC staff have stopped responding to his correspondence to prevent him from elevating his resolution request.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff reviewed the patient's medical records and consultations. OCO staff were unable to find evidence of a delay in care for this injury. OCO staff verified that DOC staff followed the recommendations of the consulting specialists. OCO staff were unable to substantiate that the patient's correspondence had not been responded to by DOC staff.	Insufficient Evidence to Substantiate
174.	Incarcerated individual relayed concerns regarding a visitation denial.	The OCO reviewed the visitation denial and were unable to identify a violation of DOC policy. Per DOC policy 450.300 attachment 1, a victim of the incarcerated individual's current offense(s) or any previously adjudicated offense is ineligible for visits. As the individual's current sentence includes convictions for domestic violence in which the individuals who applied to visit are the victims, there is no violation of DOC policy in the denial.	No Violation of Policy
175.	A loved one reports that their family member was in segregation for two months due to refusing a cell assignment and was transferred to a maximum custody prison. This person reports that the incarcerated individual has not had a write-up or been in trouble for years and this is a harsh punishment.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. This person refused housing twice, was infracted, and then transferred to another facility. DOC 300.380 (VI) F says that if a person refuses a housing assignment, they will be infracted and given other transfer opportunities until the custody review score (CRS) no longer allows placement at the intended custody level.	No Violation of Policy
176.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
177.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
178.	Incarcerated individual expressed concerns about the denial of extended family visits (EFVs).	The OCO reviewed the EFV denial and appeal and found no violation of DOC policy 590.100 attachment 2 as it states those with a sex offense will only be eligible for EFVs if screened through SOTAP. As the individual has not participated in SOTAP, the denial is per policy.	No Violation of Policy
179.	Incarcerated individual relayed concerns regarding the denial of extended family visits (EFVs).	The OCO reviewed the EFV denial and appeal that states EFVs were denied due to DOC policy 590.100 attachment 1 "based on the nature of the crime, documented criminal history (including domestic violence (DV) and current/prior behavior)" as there are records that indicate the individual has a DV indicator against a person of a like relationship as well has having struggled to adhere to visit rules with the EFV applicant. Thus, there is no violation of DOC policy	No Violation of Policy

		590.100.	
180.	Individual is currently on a max program due to no close custody options. He wants the DOC to help him move back to medium custody and needs assistance with mental health.	The OCO reviewed this concern and the individual's placement on Max Custody. He has no housing options in close custody and does not score medium points. The DOC will not give him an override to medium based on his infraction behavior and attempts to introduce contraband into the facility. The current custody facility plan was completed per DOC 300.380 Classification and Custody Facility Plan Review. The OCO shared information with the individual on how to kite mental health.	No Violation of Policy
181.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
182.	Incarcerated individual reported DOC closed the yard without justifiable reason.	The OCO was unable to substantiate a violation of policy by DOC. OCO reviewed all the steps taken by DOC, and DOC has adequately addressed the concern. The WCC Operational Memorandum 420.155 designates the Shift Commander as the individual who can restrict facility movement at WCC. This follows the DOC policy 440.155, IV, Movement in Prisons, Limited Movement, "Written procedures will be developed for the following limited movement situations... restricted movement, formal count, lockdown, etc." All the dates listed in question fall within the criteria for yard closure.	No Violation of Policy
183.	Incarcerated individual relayed concerns regarding getting the same infraction as their cellmate but having a different outcome as their cellmate.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements. The OCO informed the individual the outcome of one person's infraction hearing has no bearings on the outcome of another individual's hearing, so what the outcome of the cellmate's appeal was will have no impact on the individual's.	No Violation of Policy
Washington Corrections Center for Women			
184.	An incarcerated individual reports she is at level 3 and is allowed to have a TV, but DOC staff refuse to give her one. The individual reports that staff say they are getting rid of the TVs in the intensive management unit (IMU).	This office contacted DOC staff about access to TVs in the IMU and confirmed the information reported by the incarcerated individual. The OCO spoke with DOC leadership about this issue and leadership confirmed that TVs in the IMU will not be removed.	Assistance Provided
185.	Patient reports missing her gender affirming care appointment because she was not notified of the scheduled appointment.	The OCO substantiated the appointment was canceled, then confirmed the appointment was rescheduled and occurred. DOC agreed to provide notification of onsite appointment dates and topic of appointment in the future.	Assistance Provided
186.	Person reported being moved to a higher custody level unit without any paperwork being filed after an incident occurred.	The OCO provided assistance. The OCO reviewed DOC records and found that she was moved back to a unit that was appropriate for her custody level and substantiated that she had been moved without proper documentation pending an investigation. This office met with DOC staff about this concern, and they agreed to communicate with classifications staff about filing proper documentation and	Assistance Provided

		communicating with incarcerated individuals about moves to other units.	
187.	Incarcerated individual relayed concerns regarding needing dental care but having an extremely long delay in getting said care.	DOC resolved this concern prior to OCO involvement. The OCO confirmed that the individual had an offsite appointment to address this concern.	DOC Resolved
188.	A loved one reports that an incarcerated individual is not receiving what she is allowed at level three while living in the intensive management unit (IMU). DOC staff do not like her and retaliate by not allowing her to have a TV, slow walking her mail, and not allowing her access to her personal belongings.	The OCO provided information about the next steps this person can take when she is in the IMU and not allowed to have standard level three privileges that are written in policy and available to all incarcerated individuals.	Information Provided
189.	Incarcerated individual reported concerns regarding DOC failing to uphold good faith accounting practices, restricting access of law library, and failing to provide adequate clothing for inclement weather. Incarcerated individual requested we specifically investigate the clothing issue and shared information about the other issues solely for our awareness.	The OCO provided information regarding DOC providing proper clothing per DOC 440.050 State-Issued Items. For state-issued specialized clothing, a prison work assignment where she will work in conditions that require such wear is required. The DOC also provides the option to purchase raincoats through commissary per DOC 440.000 Personal Property in Prisons.	Information Provided
190.	Incarcerated individual reports classification concerns. The individual reports they have the custody points to be placed in a medium unit but DOC continues to place them in close custody.	The OCO provided information about DOC's decision, and options for custody promotion in the near future. The OCO reviewed the individual's Custody Facility Plans (CFPs) and found that DOC has an override in place to keep her housed in close custody for valid security reasons. The OCO shared that the individual should be having another CFP completed soon and to participate in the process to share progress and request an override to minimum custody.	Information Provided
191.	Person reports she has a food allergy that DOC is not accommodating. The person is requesting an alternative meal on the day that food is served.	The OCO provided information to the person regarding provider access and requesting follow-up appointments. OCO staff confirmed the patient received testing to rule out an allergy.	Information Provided
192.	Incarcerated individual relayed concerns regarding being triple sanctioned for an infraction.	The OCO reviewed the infraction materials and found the individual was sanctioned appropriately according to DOC policy 460.050, as a result, there was insufficient evidence to show the individual was triple sanctioned.	Insufficient Evidence to Substantiate
193.	Patient reports concerns about being denied access to prescription medication for foot fungus.	The OCO was unable to substantiate the concern due to insufficient evidence. The related DOC resolution request was investigated and unfounded as there was no medical record indicating the patient had discussed this concern with a provider prior to requesting prescription. The patient was provided with self-advocacy information and pathway	Insufficient Evidence to Substantiate

		for medical care via the DOC grievance response. Individuals must report symptoms, receive a medical assessment, and meet criteria to be considered for prescription medication/treatment.	
Washington State Penitentiary			
194.	Incarcerated individual relayed concerns regarding difficulty getting a Labor and Industries (L&I) claim number related to an incident that occurred while working in a DOC facility.	The OCO provided assistance. The OCO spoke to DOC and requested that a phone call be set up between the individual and L&I so that they can obtain the claim number. DOC confirmed that the phone call has been scheduled.	Assistance Provided
195.	Incarcerated individual relayed concerns regarding receiving an infraction for having a medication on their person that they were not aware required an HSR.	The OCO provided assistance. The OCO asked if DOC would be willing to dismiss the infraction as the individual now has an in effect HSR for this concern. DOC agreed to dismiss the infraction and instead issued a neutral behavior observation entry (BOE) regarding the situation.	Assistance Provided
196.	Patient reports concerns about being discharged from residential treatment unit (RTU) level of care and wants to stay in RTU for mental healthcare access.	The OCO provided assistance by elevating this concern through DOC mental health services leadership. After OCO outreach, the patient was approved and transferred to an RTU.	Assistance Provided
197.	Person reports concerns about being housed in the Close Observation Area (COA) for several months.	The OCO provided assistance by elevating the concerns through DOC health services leadership. DOC agreed to work with the patient to create a pathway out of COA and into more long-term housing options. The OCO stayed in continued conversations and requested updates about the person's housing. After OCO outreach, the patient and health services staff worked together and the patient was able to move out of the COA.	Assistance Provided
198.	Anonymous incarcerated individual reports concerns regarding other incarcerated individuals entering the pod they live in without permission. The individual reported safety concerns about the other individuals entering the pod.	The OCO provided assistance by sharing this information with DOC staff. If incarcerated individuals have concerns about safety in the unit, they are encouraged to speak with the unit supervisor or unit staff so they can address the issue on site.	Assistance Provided
199.	Anonymous incarcerated individual reports concerns regarding other incarcerated individuals entering the pod they live in without permission. The individual reported safety concerns about the other individuals entering the pod.	The OCO provided assistance by sharing this information with DOC staff. If incarcerated individuals have concerns about safety in the unit, they are encouraged to speak with the unit supervisor or unit staff so they can address the issue on site.	Assistance Provided
200.	Incarcerated Individual reports concerns regarding the resolution program at the facility where they are housed. The individual reports that the resolution program does	The OCO provided assistance. The OCO spoke with DOC staff and requested they review the individual's past resolution requests to ensure they were processed per the Resolution Program Manual (RPM). The DOC staff member reviewed the resolution requests and found them to be	Assistance Provided

	not accept his resolution requests and believes that the staff are unwilling to help him.	processed per the RPM. The OCO continued the conversation regarding the resolution program, and recommended the DOC create more options for incarcerated individuals to have support in this area of the facility when filing resolution requests. DOC staff are working to implement a program to assist individuals with filing resolution requests that in this area of the prison. The DOC resolution program is implementing this peer support program statewide.	
201.	Incarcerated individual relayed concerns regarding extended placement in IMU.	The OCO confirmed that DOC resolved this concern prior to OCO involvement as the OCO reviewed the individual's custody facility plan and confirmed that DOC is properly addressing this concern.	DOC Resolved
202.	Person reports safety issues in the general population.	The DOC resolved the issue and validated this individual's protection concerns before the OCO reviewed the case. This office verified this individual is in the process of transferring to a new facility.	DOC Resolved
203.	Incarcerated individual relayed concerns regarding not being allowed to use the law library.	DOC resolved this concern prior to OCO action. The OCO confirmed that the individual has since moved facilities and as a result, the law library access at the previous facility has been resolved.	DOC Resolved
204.	Person states they need a single cell placement to transition from long-term housing in solitary confinement. The person states his mental health counselor recommended a single cell, but the request has not been reviewed by DOC.	DOC staff resolved this concern prior to OCO action. OCO staff contacted Health Services management and were informed the patient's request was accommodated by DOC. OCO staff verified the person is currently in a single cell.	DOC Resolved
205.	External individual reports concerns with the actions of DOC staff. The incarcerated individual and the external individual report concerns about DOC staff not restoring good conduct time (GCT) as they stated they would. The individual reports that now the current facility will not approve that GCT and he requests assistance getting the GCT restored.	The OCO provided information regarding the GCT restorations plan. The OCO spoke with DOC staff at both facilities and found that the GCT that was offered at the previous facility was restored per policy. The OCO provided options for the individual to gather more information about GCT that still can be restored. The OCO could not locate other good conduct time that would be restored.	Information Provided
206.	An external person reported concerns regarding the incarcerated individual being in the Intensive Management Unit (IMU) on maximum custody for several years. The external person also reported that the individual has not had access to programming.	The OCO provided information about how to provide input with his placement decisions. The OCO verified this individual is being reviewed for placement out of state and DOC is reviewing options per policy. 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 further assistance.	Information Provided
207.	Incarcerated individual relayed concerns regarding changes to the	The OCO spoke to DOC and confirmed that the changes to DOC policy 590.100 attachment 1 are retroactive so any	Information Provided

	extended family visiting (EFV) policy and concerns about how an infraction may impact an EFV denial.	infraction prior to the date the policy went into effect would impact the EFV eligibility.	
208.	An incarcerated person called into the OCO hotline and requested assistance stating that their time served has not been calculated correctly.	The OCO provided information regarding additional administrative remedies available to them internal to DOC to have their time served reviewed, recalculated, and explained.	Information Provided
209.	Incarcerated individual relayed concerns regarding being stuck at IMU level 2.	The OCO provided the individual with information regarding this concern. The OCO reviewed the individual's in-effect custody facility plan that states they are to maintain IMU level 2 due to being an influential member of a security threat group (STG). As the individual is a confirmed active STG participant, there are no general population housing options at this time.	Information Provided
210.	Person reported his unit is on lockdown after a staff assault. The staff assault happened in a different unit and his unit should not still be on lockdown. This is a violation of the GVRS policy.	Upon receipt of this concern, the OCO contacted the facility. The facility reported that the unit in question had been taken off lockdown. The DOC has policy set in place for emergent situations and is authorized to lockdown a facility, which is separate from GVRS policy.	Information Provided
211.	Person reports he did not receive medical care following a use of force incident. The person requested to get treatment for his injury.	The OCO provided self-advocacy information to the person regarding how to access care at his current facility. OCO staff were unable to substantiate that the person was not given medical care following the injury. OCO contacted DOC Health Services staff and were informed that no further treatment is indicated for that injury.	Information Provided
212.	An incarcerated person reported that they were not being provided resources needed to access the legal system.	The OCO provided information regarding additional administrative remedies available to them internal to DOC to gain access to materials needed to access the legal system and provided information on legal resources that are publicly available.	Information Provided
213.	Incarcerated person reports the quality of the headphones people in the IMU are able to purchase break after a very short period of time and people aren't allowed to order any other pairs	The OCO has received numerous concerns regarding the quality of the headphones and has escalated this information to the DOC. The OCO shared information with the incarcerated person on how to file a tort claim.	Information Provided
214.	Person reported that DOC staff are using the old mail policy and rejecting pictures that are sent to him, and said the rejections contradict what staff have told him about the new mail policy.	The OCO provided information. The OCO reached out to DOC staff, who said that this individual never appealed the rejections to DOC Headquarters. The OCO asked staff how incarcerated individuals are informed about the option to appeal rejections to DOC Headquarters, and they said that this appeal option is listed in DOC Mail for Individuals in Prisons 450.100 Attachment 2. The OCO provided information about how to appeal to DOC Headquarters.	Information Provided
215.	Incarcerated individual relayed frustrations with infraction sanctions.	The OCO reviewed the individual's grievances regarding a desire to amend policy so that package loss is not a sanction. DOC is unable to change RCW or policy at the	Information Provided

		facility level but forwarded the information to headquarters policy staff. The OCO informed the individual that as their policy feedback has already been forwarded to headquarters policy staff, there are no further steps they need to take at this time, but if they have future policy suggestions, they can send a kite directly to HQ policy staff with those suggestions.	
216.	Incarcerated individual is receiving unclear information regarding property policy and what happened to his property after a medical procedure.	The OCO provided information regarding current policies related to property. DOC staff shared that he was refunded the money spent on the items in question, and that he may be able to purchase the items again if it is allowed by current policy.	Information Provided
217.	Incarcerated individual reports concerns regarding access to legal call.	The OCO provided information to the individual that they can now make legal calls where they live. The OCO was able to verify that the individual did not have access to calls at the area of the facility he was being housed. Since this report he was able to make a few calls while housed in that area of the facility and now is housed in an area of the facility where he has access to the phones.	Information Provided
218.	Person reported a dental concern and said that he was recently transferred to a different facility and wanted to get dental work completed before release.	The OCO provided information. The OCO reached out to DOC staff at his current facility, who confirmed that this individual has not kited health services about dental concerns. For the OCO to investigate this issue, this individual needs to kite health services to let them know about his dental concerns.	Information Provided
219.	Incarcerated individual relayed concerns regarding being stuck at IMU level 2.	The OCO provided the individual with information regarding this situation. The OCO reviewed the individual's in effect custody facility plan that states they are to maintain IMU level 2 due to being an influential member of a security threat group (STG).	Information Provided
220.	An Incarcerated person reported that they were not being provided resources needed to access the legal system.	The OCO provided information regarding additional administrative remedies available to them internal to DOC to gain access to materials needed to access the legal system and provided information on legal resources that are publicly available.	Information Provided
221.	An incarcerated individual has a health status report (HSR) for special shoes, and the podiatrist recommended special shoes, but DOC has not provided them despite many requests.	The OCO contacted DOC health services who verified that the provider gave the individual a new pair of special shoes to try out with additional supportive gear. This office notified the individual that if the new shoes do not fit, he should let the provider know so they can schedule another appointment with Orthotics.	Information Provided
222.	An incarcerated person reported that they were not being provided resources needed to access the legal system.	The OCO provided information regarding additional administrative remedies available to them internal to DOC to gain access to materials needed to access the legal system and provided information on legal resources that are publicly available.	Information Provided
223.	Person reports that their unit does not have access to sweat lodges or group smudges even in small groups. Also, they stated that they	Currently, the unit mentioned in this concern is temporary housing for the individuals placed there. The DOC is treating the population in this unit as a protected custody unit, which means they cannot mix with the general population.	Information Provided

	have religious beads that the DOC is not allowing them to have under the wrong policy.	Due to this, there is no safe and secure way to allow this group to attend the sweat lodge. During this temporary time, the DOC has authorized the small yard in the unit to be used for smudging. The DOC is not willing to give the individual the beads named in the concern until after 30 days, per policy, when they can receive a Curio card.	
224.	Incarcerated individual reported DOC demoting them to a stricter custody level after receiving information regarding a threat to the individual's safety. Following this, individual requested camp placement but instead was promoted to medium custody.	The OCO provided information regarding custody level promotions. Per DOC policy 300.380 Classification and Custody Facility Plan Review, custody level promotions or demotions only move one level at a time (e.g., Close to Medium, Close to MAX), unless there are outstanding circumstances to promote or demote an individual more than one level. Based on his current CFP, remaining serious infraction free, and having protection concerns, he has been granted an override to medium custody following a transfer for his safety.	Information Provided
225.	Person reports several issues with how the treatment for a broken bone was provided. The patient states that DOC was not responding to several resolution requests submitted about this injury. The patient states that the surgeon further injured him and was requesting further imaging.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff reviewed the patient's medical records and resolution requests. OCO staff noted the patient's correspondence had been responded to by DOC and treatment for the injury had been provided. The OCO provided information to the patient regarding how to report concerns about care provided by community hospitals.	Insufficient Evidence to Substantiate
226.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
227.	External person reports their loved one's safety is in danger in general population and they have been infracted for refusing housing.	The OCO reviewed this concern and verified this individual refused housing and refused to provide a statement describing why his safety was in jeopardy. He was then infracted, which is within DOC 460.000 Disciplinary Process for Prisons. He is now living in the general population.	No Violation of Policy
228.	Person reports concerns regarding long-term placement in the IMU, even though he should be screened for the transition pod.	The OCO reviewed the last Custody Facility Plan, per DOC 300.380 Classification and Custody Facility Plan Review. It was determined that the individual had not met the expectations of the max program, and staff recommended that he stay on the program pending completion of expectations. The Max Committee agreed with those recommendations.	No Violation of Policy
229.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
230.	Incarcerated individual relayed concerns regarding frustrations with mail denials and rejections.	The OCO reviewed the individual's grievance regarding the process for materials coming in. DOC states that the mailroom will continue to follow policy for the safety and security of the facility and to prevent contraband from entering. Thus, there is no violation of DOC policy 450.100.	No Violation of Policy
231.	Incarcerated individual relayed concerns regarding previously	The OCO reviewed the EFV denial and confirmed that the denial is in accordance with DOC policy 590.100 due to their	No Violation of Policy

	being approved for extended family visits (EFVs) and now being denied.	being a domestic violence (DV) indicator of a like victim.	
232.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
233.	Incarcerated individual relayed concerns regarding frustrations with DOC not verifying their safety concerns.	The OCO reviewed the individual's record and confirmed that DOC found them to not be safe harbor eligible. As there are not currently verifiable safety concerns, their housing is appropriate per DOC policy 300.380. The OCO informed the individual that they will be reevaluated in six months at which point they can continue to provide details to have DOC verify the safety concerns.	No Violation of Policy
234.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
235.	Person reports concerns regarding his long-term pain management plan following surgery.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed the patient's medical records and confirmed the patient's medication changes were part of a planned medication taper. OCO staff verified the patient has access to pain management treatment. Per DOC 600.000, Clinical decisions are the sole province of the responsible health care practitioner and are not countermanded by non-clinicians.	No Violation of Policy
236.	Person reported he was placed in solitary confinement after an infraction. Person reported that officers used force on him and almost broke his hand.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed this use of force incident and found that it was within DOC's confidential Use of Force policy. The OCO also found that this individual did not appeal his infractions. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. The OCO reached out to DOC staff and confirmed that this person received health care services for his hand and follow up care. If this individual needs additional health care for his hand, he can kite health services and request to be put on sick call.	No Violation of Policy

Intake Investigations

Airway Heights Corrections Center

237.	Incarcerated individual relayed concerns regarding the law library not providing a malpractice tort form.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
238.	External person reported a concern on an incarcerated individuals' behalf regarding a	The OCO sent the individual an Ombuds Review Request form to ensure this was a concern they wanted investigated but never received confirmation from the individual. As a	Person Declined OCO Assistance

	mailing issue.	result, this case was closed without further investigation.	
239.	Loved one made complaint on behalf of incarcerated individuals regarding a kiosk being unusable.	The OCO sent the individual an Ombuds Review Request form to ensure this was a concern they wanted investigated but never received confirmation from the individual. As a result, this case was closed without further investigation.	Person Declined OCO Assistance
240.	A loved one reports that her incarcerated son was prescribed medication while in county jail but has been at a new facility for over a month and still has not received his medication.	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
	Coyote Ridge Corrections Center		
241.	Person reports that he came into DOC custody after an injury and is not receiving the treatment and medical equipment he needs. The person is requesting to be issued multiple mobility related items and to be scheduled for physical therapy.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
	Monroe Correctional Complex		
242.	External person reports concerns about an incarcerated individual's dental care. The patient followed up and requested incarcerated individuals be able to access chewing tobacco.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
243.	Incarcerated individual relayed concerns regarding an infraction.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
244.	This person reports that a staff member is harassing him by requesting the individual take his braids out. This person reports that DOC staff have the authority to do this, but no one ever has.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
245.	The incarcerated individual is requesting self-advocacy information about how to address PREA definition concerns and who to contact within PREA management at the national level.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
	Stafford Creek Corrections Center		
246.	Incarcerated individual relayed concerns regarding not receiving dental services.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal	Administrative Remedies Not Pursued

		grievance process, administrative, or appellate process.	
247.	A loved one reports concerns about an individual who a former gang member being sent to close custody.	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
Washington Corrections Center			
248.	Incarcerated individual relayed concerns regarding receiving an infraction.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
Washington State Penitentiary			
249.	Incarcerated individual relayed concerns regarding having difficulty contacting their family.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
250.	Incarcerated individual relayed concerns regarding receiving the incorrect property.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
251.	Loved one made complaint on behalf of incarcerated individuals regarding a power outage at a facility.	The OCO sent the individual an Ombuds Review Request form to ensure this was a concern they wanted investigated but never received confirmation from the individual. As a result, this case was closed without further investigation.	Person Declined OCO Assistance
252.	Person reported concern about a medical condition and wanted to be seen by medical.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
253.	Person reported concerns about needing a Health Status Report (HSR) to accommodate a disability.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-002

Report to the Legislature

As required by RCW 72.09.770

May 16, 2024

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

Table of Contents

Unexpected Fatality Review Committee Report

UFR-24-002 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

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

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on April 18, 2024:

DOC Health Services

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

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Charles Anderson, Deputy Assistant Secretary
- Lorne Spooner, Director - Correctional Services
- Page Perkinson, Program Manager - Correctional Operations
- Rochelle Stephens, Project Manager - Men's Prisons

DOC Risk Mitigation

- Mick Pettersen, Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Deputy Director

Department of Health (DOH)

- Ellie Navidson, MSN, 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: 1978 (45-years-old)

Date of Incarceration: July 2023

Date of Death: January 2024

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

His cause of death was respiratory failure secondary to complications of an Influenza B infection and cardiopulmonary arrest. His manner of his death was natural.

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

Days Prior to Death	Event
7 days prior	• The incarcerated individual declared a medical emergency reporting he had flu-like symptoms for the previous six (6) days. • He was evaluated by a physician and diagnostic testing was performed. • He was transported by ambulance to the hospital when his condition worsened. • He was evaluated in the emergency room and diagnosed with sepsis secondary to community-acquired pneumonia and Influenza B. • He was started on appropriate treatment and admitted to the hospital.
6 days prior	• His condition continued to deteriorate. • He developed septic shock and acute respiratory distress syndrome (ARDS). • He was transferred to the intensive care unit (ICU) and required mechanical ventilation to maintain his oxygen levels. • A seriously ill notification was initiated, and family visitation arranged.
5 days prior - 4 days prior	• He continued to require ventilator support and his oxygen levels temporarily improved. • His oxygen levels worsened again.
3 days prior	• Diagnostic procedure showed extensive airway inflammation, ulcerations, and lung tissue death. • Hospital staff had a care discussion with his family. • Family requested resuscitation (full code status) be provided in the event his heart stopped.
1 day prior	• His condition deteriorated further. • ICU staff were unable to maintain his oxygen levels and blood pressure.

Day 0	• Hospital staff had additional discussions with his family. • The family chose to keep his full code status. • That evening his heart stopped. • Hospital staff successfully regained a heartbeat and determined further resuscitation efforts were futile due to his worsening status. • His blood pressure rapidly dropped, and his heart stopped again. • He was declared deceased by hospital staff.

UFR Committee Discussion

The UFR committee met to discuss the findings and recommendations from the DOC Mortality Review Committee. The UFR committee considered the information from the review 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.
    1. The MRC committee found:
        a. A seasonal influenza vaccination may have prevented the incarcerated individual from developing more severe disease and complications.
        b. Routine immunizations are not emphasized during DOC primary care visits.
        c. Incarcerated individuals may not be aware of the importance of routine immunizations nor how they can request vaccinations.
    2. The MRC committee recommended:
        a. Promoting routine vaccinations to educate staff and incarcerated individuals, and
        b. Including immunizations as part of the Patient Centered Medical Home focus in 2024.

B. The UFR committee reviewed the unexpected fatality and discussed the following topics.
    1. Care synopsis:

        This incarcerated individual had not received an influenza vaccine this season. He was relatively young, otherwise healthy, and was not identified as high risk for complications of influenza. He did not immediately request medical care when he became ill and there is not documentation that shows why he chose not to receive a vaccination. He had not documented his end-of-life care wishes. His family members participated in care planning with hospital team.

        Clinicians on the committee discussed that he received appropriate medical treatment from the time of his care request through his death. They agreed that no clinician would expect this outcome. Influenza B infection has a five times higher death rate than Influenza A in those that are unvaccinated. The only variable that may have changed this outcome was receiving a flu vaccination. Members acknowledged that even so, flu vaccines are not 100% effective but have been shown to lessen the severity of the disease.

2. Vaccinations in prison facilities:

   Overall vaccine rates in prison are similar to the general population. Influenza vaccines are offered to all incarcerated individuals through vaccine clinics and for individuals identified as high risk, in-person appointments are offered with facility infection prevention nurse. Flu vaccine clinics are promoted through communication sent to incarcerated individuals and flyers are posted throughout the facility including their living units. The committee agrees prioritizing a routine vaccination program for incarcerated individuals will increase acceptance rates and reduce the spread of infectious disease within prison facilities.

   Members discussed the historical distrust of medical care offered in prisons and that incarcerated individuals are less likely to report a contagious illness when isolation is required. DOC Health Services wants to have more discussion around decreasing vaccine hesitancy including how to promote preventative vaccinations as routine part of any care visit. Part of the strategy is building relationships and credibility with the incarcerated individuals.

   The way vaccines are presented is impactful especially with younger otherwise healthy individuals. Members advocated using a multi-pronged, creative approach to positively impact vaccination rates. This may include a peer-to-peer education model, tailoring education materials from DOH and HCA for the incarcerated population and utilizing electronic media opportunities to share the message. The OCO representative offered to assist with messaging and acknowledges that years of Covid mitigation strategies may have hindered vaccination discussions in the prison facilities.

3. DOC end-of-life processes:

   The committee reviewed the DOC process that occurs when an incarcerated individual becomes seriously ill. A DOC Health Services clinical staff member reviews the individual's advanced care planning wishes and notifies custody of the individual's health status. This notification triggers a series of actions including:

   - Notifying next of kin or emergency contacts identified by the incarcerated individual,
   - Notifying the facility chaplain, classification counselor, etc.,
   - Providing permission for the community hospital to communicate with next of kin/emergency contact, and
   - Arranging special communication or visitation.

   Members requested the seriously ill notification happen earlier in the disease process when the incarcerated individual chooses to involve their next of kin in care planning. Ideally, interdisciplinary discussions happen when an incarcerated individual is diagnosed including coordinating the most appropriate support (which may be the next of kin) and working closely with custody staff to support communication and visitation.

Committee Findings

The incarcerated individual died as a result of respiratory failure secondary to complication of an Influenza B infection and cardiopulmonary arrest. The manner of his death was natural.

Committee Recommendations

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

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

1. DOC should explore using a multi-pronged, creative approach to positively impact vaccination rates.
2. DOC should start advanced care planning conversations during intake for incarcerated individuals at intake and revisit annually regardless of age.

The Office of the Corrections Ombuds (OCO) investigates complaints regarding any Department of Corrections' (DOC) actions or inactions that adversely affect the health, safety, welfare, and rights of incarcerated individuals. RCW 43.06C.040. RCW 43.06C.040(2)(k) directs the ombuds to render a public decision on the merits of each complaint at the conclusion an investigation. All cases opened by the OCO are considered investigations for the purposes of the statute. As of March 15, 2022, the OCO opens an investigation for every complaint received by this office. The following pages serve as the public decisions required by RCW 43.06C.040(2)(k).

Case Closure Reason	Meaning
Unexpected Fatality Review	The incarcerated person died unexpectedly, and the death was reviewed by the unexpected fatality review team, as required by RCW 72.09.770.
Assistance Provided	The OCO achieved full or partial resolution of the person's complaint.
Information Provided	The OCO provided self-advocacy information.
DOC Resolved	DOC staff resolved the concern prior to OCO action.
Insufficient Evidence to Substantiate	Insufficient evidence existed to substantiate the concern.
No Violation of Policy	The OCO determined that DOC policy was not violated.
Substantiated	The OCO verified the concern but was unable to achieve a resolution to the concern.
Administrative Remedies Not Pursued	The incarcerated person did not yet pursue internal resolution per RCW 43.06C.040(2)(b).
Declined	The OCO declined to investigate the complaint per WAC 138-10-040(3).
Lacked Jurisdiction	The complaint did not meet OCO's jurisdictional requirements (typically when complaint is not about an incarcerated person or not about a DOC action).
Person Declined OCO Involvement	The person did not want the OCO to pursue the concern or the OCO received no response to requests for more information.
Person Left DOC Custody	The incarcerated person left DOC custody prior to OCO action.

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

Abbreviations & Glossary

ADA: Americans with Disabilities Act

AHCC: Airway Heights Corrections Center

ASR: Accommodation Status Report

BOE: Behavioral Observation Entry

CBCC: Clallam Bay Corrections Center

CCCC: Cedar Creek Corrections Center

CI: Correctional Industries

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

CO: Correctional Officer

CRC: Care Review Committee

CRCC: Coyote Ridge Corrections Center

CUS: Correctional Unit Supervisor

DES: Department of Enterprise Services

DOSA: Drug Offender Sentencing Alternative

EFV: Extended Family Visit

ERD: Earned Release Date

GRE: Graduated Reentry

HCSC: Headquarters Community Screening Committee

HSR: Health Status Report

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

J&S: Judgment and Sentence

MCC: Monroe Correctional Complex

MCCCW: Mission Creek Corrections Center for Women

OCC: Olympic Corrections Center

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

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

SCCC: Stafford Creek Corrections Center

SOTAP: Sex Offender Treatment and Assessment Program

SVP: Sexually Violent Predator

TC: Therapeutic Community

WaONE: Washington ONE ("Offender Needs Evaluation")

WCC: Washington Corrections Center

WCCW: Washington Corrections Center for Women

WSP: Washington State Penitentiary