Office of the Corrections OMBUDS

Monthly Outcome Report

June 2025

Unexpected Fatality Reviews: 5

Case Investigations: 100

Assistance Provided: 24
Information Provided: 39
DOC Resolved: 13
Insufficient Evidence to Substantiate: 9
No Violation of Policy: 15
Substantiated: 0

Intake Investigations: 61

Administrative Remedies Not Pursued: 1
Declined: 14
Lacked Jurisdiction: 2
Person Declined OCO Assistance: 19
Person Released from DOC Prior to OCO Action: 1
Technical Assistance Provided: 24

Resolved Investigations:

166

Assistance Provided, Information Provided, or Technical Assistance Provided in

52 %

of Investigations

Monthly Outcome Report: June 2025

	Complaint Summary	Outcome Summary	Case Closure Reason
	Unexpected Fatality Reviews		
1.	Person 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-24-017 was delivered to the Governor and state legislators. It is also publicly available on the DOC website.	Unexpected Fatality Review
2.	Person 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-24-018 was delivered to the Governor and state legislators. It is also publicly available on the DOC website.	Unexpected Fatality Review
3.	External person reports concerns about their incarcerated loved one passing 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-24-013 was delivered to the Governor and state legislators. It is also publicly available on the DOC website.	Unexpected Fatality Review
4.	Person 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-24-013 was delivered to the Governor and state legislators. It is also publicly available on the DOC website.	Unexpected Fatality Review
5.	Incarcerated person 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-25-006 was delivered to the	Unexpected Fatality Review

Governor and state legislators. It is also publicly available on the DOC website.

Case Investigations

Airway Heights Corrections Center

6.	An individual reported that the facility held his infraction hearing without him, and DOC claimed he waived his right to the hearing. The form that was submitted to waive his attendance was for another incarcerated person with the same last name.	The OCO provided assistance by contacting DOC and asking them to review this person's infraction hearing and attendance form. DOC has remanded this for a new hearing so the individual has the opportunity to attend.	Assistance Provided
7.	A loved one made a complaint on behalf of an incarcerated individual regarding DOC not providing them with adequate medical care.	The OCO provided information regarding medical follow-up with their medical provider. After review of DOC records and speaking with DOC staff, this office was able to confirm that this individual was scheduled and seen for their requested medical care as it was deemed clinically necessary by DOC medical staff.	DOC Resolved
8.	Incarcerated person reported concerns about their custody level and an infraction they received that they report is false.	DOC resolved this concern prior to OCO action. The OCO verified the person does not have a recent infraction and DOC has promoted him in compliance with this person’s custody facility plan.	DOC Resolved
9.	Incarcerated person reported concern about DOC moving his cellmate from the unit due to false claims.	The OCO provided information to the person that was moved. The OCO asked DOC if the person could be moved back into the previous unit, and DOC verified they were on the list to be transferred back. DOC shared with the OCO the person was moved back into the original unit. The OCO provided information to the person about how to request transfer to the unit if he chooses and how to contact the OCO.	Information Provided
10.	Incarcerated individual shared concerns regarding DOC staff not providing them with post-operation care for their foot.	The OCO was unable to substantiate the concern due to insufficient evidence. After review of this individual's medical records, speaking with DOC staff, and reviewing DOC records, this office was able to confirm that DOC staff provided this individual with post-operation care as requested or when deemed clinically necessary by DOC medical staff. This office also provided this individual with tort claim information.	Insufficient Evidence to Substantiate
11.	Incarcerated individual shared concerns regarding being infracted for attending a mandatory callout.	The OCO was unable to substantiate a violation of policy by DOC. After reviewing DOC records, this office was able to concur that DOC infracted this individual per DOC 460.050 as they attended a callout while serving a cell confinement sanction.	No Violation of Policy
12.	Incarcerated individual reports that DOC was unprofessional and conducted his urine analysis (UA) with no privacy.	The OCO reviewed the individual's resolution request and DOC policy 420.380 for drug and alcohol testing. The policy says the midriff must remain exposed for visual observation of the urine collection process and the individual's hands and genital area. The OCO confirmed that DOC is within policy to ask that incarcerated individuals face staff while taking a urine analysis (UA).	No Violation of Policy

13.	The individual was on cell confinement for a minor infraction and received a major infraction for breaking sanction because he stopped by the kiosk on his way to mainline. The person reports that DOC took 10 days of good time when it could have been none.	The OCO reviewed the individual's infraction history, DOC sanction guidelines, and contacted staff. Because this person had multiple violations in the last year, the DOC was within policy to take 10 days of good time. DOC 460.050 says that for any offense, up to the maximum sanction allowed may be imposed per WAC 137-28-240, WAC 137-28-350, regardless of whether it is a first or subsequent offense.	No Violation of Policy
Clallam Bay Corrections Center			
14.	Person reported that DOC staff remotely opened the door in the dining room, which allowed general population incarcerated individuals to attack Safe Harbor individuals. Person wanted DOC to properly train staff so that this does not happen again.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO spoke with DOC staff, who verified that this incident happened and was caused by staff error and said that the incident has been reviewed by facility leadership. DOC stated that the staff involved, as well as all custody staff, were retrained as to the proper protocols for these doors.	DOC Resolved
15.	An external person reported concerns regarding their incarcerated loved one being placed into solitary confinement without notice or reason. The external person requests a review of the segregation placement.	The OCO provided information regarding the person's situation and shared next steps with them after the DOC investigation is complete. The OCO verified this person is being held in segregation pending an investigation. Once the investigation is complete, this office shared how to appeal any infractions or a new custody facility plan if the investigation results in either of those options.	Information Provided
16.	An external person reported concerns regarding their incarcerated loved one being placed into solitary confinement without notice or reason. The external person requests a review of the segregation placement.	The OCO provided information regarding the person's situation and shared next steps with them after the DOC investigation is complete. The OCO verified this person is being held in segregation pending an investigation. Once the investigation is complete, this office shared how to appeal any infractions or a new custody facility plan if the investigation results in either of those options.	Information Provided
17.	An external person reported concerns regarding their incarcerated loved one being placed into solitary confinement without notice or reason. The external person requests a review of the segregation placement.	The OCO provided information regarding the person's situation and shared next steps with them after the DOC investigation is complete. The OCO verified this person is being held in segregation pending an investigation. Once the investigation is complete, this office shared how to appeal any infractions or a new custody facility plan if the investigation results in either of those options.	Information Provided
18.	Person reported back pain related to a use of force and wanted medical care.	The OCO provided self-advocacy information about communicating with Health Services about any changes in his condition. The OCO reached out to DOC staff and reviewed this individual's health records. This office found that this individual received care and a treatment plan for his back pain and that no further intervention was clinically indicated.	Information Provided
19.	An incarcerated individual is requesting information because their hours of	The OCO provided information regarding why the hours of experience were not awarded. Per RCW 18.106.070 and WAC 293-400A-120&121, the location where the person is incarcerated is not a	Information Provided

	experience (trades) were not awarded by Labor and Industries (LNI).	licensed contractor which is required for awarding hours. The Construction Training Pathways Oversight Committee may refer to the facts of this case in its ongoing monitoring.	
20.	Person reported ongoing concern related to a previous OCO case and said that the kitchen is continuing to send him items that he is allergic to.	The OCO provided information about our ongoing systemic work on special diets. The OCO reached out to DOC staff at the facility about this concern. Current DOC protocol mandates that individuals with multiple allergies are placed on a diet for one of those allergies and then must "self-select" out the items that they cannot eat. The OCO verified that DOC is following this current protocol. The OCO is continuing to systemically review this special diet protocol and discuss it with Health Services leadership. This office also found that this individual has been released from prison.	Information Provided
21.	Person reports that he has been trying for a year to get his daughter on his visiting list.	The OCO contacted DOC, who verified that there are no current visitation applications for this individual's daughter. The OCO wrote the individual and requested more information about the visitors in this case.	Insufficient Evidence to Substantiate
Coyote Ridge Corrections Center			
22.	A loved one reported multiple safety concerns regarding an incarcerated individual's facility placement and wanted them to be moved to a safer facility.	The OCO provided assistance by continually communicating with multiple DOC staff at the facility and headquarters level for several months until they transferred to a safer facility. The OCO reached out to DOC Headquarters and facility staff trying to get Intelligence and Investigations to talk to this individual about their safety concerns. The OCO found that unit staff, but not Intelligence and Investigations, investigated their situation, and stated they could not validate their concerns, and encouraged them to go to general population. This individual was transferred to a different facility and was assaulted upon arrival to the unit and then was placed in solitary confinement. The OCO continued to reach out to HQ staff about their housing protocol and safe placement. After months, this individual's housing protocol was completed, and they were transferred to an appropriate placement.	Assistance Provided
23.	Person reported multiple safety concerns at their current facility and said that they have tried to talk to DOC. Person said they want to be housed at a safer facility.	The OCO provided assistance by continually communicating with multiple DOC staff at the facility and headquarters level for several months until they transferred to a safer facility. The OCO reached out to DOC Headquarters and facility staff trying to get Intelligence and Investigations to talk to this individual about their safety concerns. The OCO found that unit staff, but not Intelligence and Investigations, investigated their situation, and stated they could not validate their concerns, and encouraged them to go to general population. This individual was transferred to a different facility and was assaulted upon arrival to the unit and then was placed in solitary confinement. The OCO continued to reach out to HQ staff about their housing protocol and safe placement. After months, this individual's housing protocol was completed, and they were transferred to an appropriate placement.	Assistance Provided
24.	The person reports that he purchased a keyboard from Securus months ago but has not received the item.	The OCO contacted the Securus liaison at the individual's facility. After OCO's outreach, DOC staff confirmed this person's keyboard was delivered.	Assistance Provided
25.	A loved one reported accessibility concerns for a disabled incarcerated	The OCO provided information about access assistants, ADA accommodations, and the circumstances of his infraction. The OCO reviewed DOC records regarding this individual's ADA	Information Provided

	individual. They reported that he was infracted for not being able to hear an officer's directive when he is hard of hearing. They wanted him to have an access assistant and be allowed different accommodations.	accommodations, including Health Status Reports, Accommodation Status Reports, and Resolution Requests. The OCO also reached out to DOC staff about his accommodations. The OCO verified that this individual received several of the requested accommodations and was offered an access assistant but declined the help of the access assistant. The OCO also reviewed the infraction and could not find sufficient evidence to substantiate that he was infracted because he could not hear the officer's directive.	
26.	External person reported serious health and safety concern in the welding program. The incarcerated individuals in this program are being exposed daily to unsafe levels of welding fumes due to inadequate or malfunctioning ventilation in the workspace.	The OCO did an in-person visit to this facility to review the concern. The facility administration had already received this concern and had an appointment for the space to be inspected to ensure it meets OSHA standards.	Information Provided
27.	The person reports that his family ordered a food package, but he never received it. His family has tried to resolve the issue for five months but has been unsuccessful.	The OCO provided information regarding how to use the resolution program, file a tort claim with the Department of Enterprise of Services (DES), and gave them the customer service phone number for Union Supply 1(866) 404-8989.	Information Provided
28.	Person reports concerns regarding not being provided with a weekly medication for multiple weeks. The patient is requesting that the cause of this issue be identified so it would not reoccur.	OCO staff contacted DOC Health Services staff and were informed that the medication had been given. OCO staff requested a review of the situation by Health Services supervision. OCO staff were informed that the cause of the issue with inventory was identified and corrected.	Information Provided
29.	Person reported concern about being failed for a cell inspection and was infracted. Person said that staff are misusing their authority and that he is being harassed. Person wanted OCO help with his resolution request and wanted the infraction to be dismissed.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed his resolution request, which was reviewed and unsubstantiated at the superintendent and DOC Headquarters level. The OCO could not find an infraction on record for this incident. This office reviewed this individual's Behavioral Observation Entries (BOE) and other resolution requests and could not substantiate harassment.	Insufficient Evidence to Substantiate
30.	Incarcerated individual shared concerns regarding DOC jeopardizing their safety by placing them at a certain facility.	The OCO was unable to substantiate a violation of policy by DOC. After review of DOC records, this office was able to see that DOC staff found no verifiable threat to this individual's safety and thus no facility placement concerns. This individual was classified and transferred in accordance with DOC 350.380. Further review indicates that DOC has transferred this individual to a facility where they feel safe at.	No Violation of Policy
31.	Person reports that DOC staff did not correctly accommodate his needs that were listed in his Health Status Reports resulting in him receiving an infraction.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed the person's infraction documentation and requested that the infraction be overturned. DOC staff declined to overturn the infraction because the impacted person did not notify staff of the health status report (HSR) at the time of the incident. This decision is supported by DOC 420.380.	No Violation of Policy

32.	Incarcerated individual shared concerns regarding DOC holding them past their ERD (Earned Release Date).	The OCO was unable to substantiate a violation of policy by DOC. After review of DOC records, this office was able to confirm that this individual was found guilty of serious infractions close to their original ERD. Due to the severity of these infractions, this individual lost Good Conduct Time (GCT) per DOC 460.050 which extended their ERD further into the future.	No Violation of Policy
Monroe Correctional Complex			
33.	Incarcerated individual reports concerns about a resident needing a higher level of care than can be provided on unit.	The OCO provided assistance by elevating the concerns through DOC leadership. After OCO outreach, the patient was approved and transferred to the In-Patient Unit (IPU) for higher level of care.	Assistance Provided
34.	Incarcerated individual reports concerns about a resident needing a higher level of care than can be provided on unit.	The OCO provided assistance by elevating the concerns through DOC leadership. After OCO outreach, the patient was approved and transferred to the In-Patient Unit (IPU) for higher level of care.	Assistance Provided
35.	Person reports that he received a general infraction in retaliation for requesting witness statements for a serious infraction hearing. He states he was falsely accused of lying to staff, when in fact, it was staff who lied. He submitted a timely appeal but never received a response and this proves staff are actively obstructing his ability to gather evidence/witness statements to defend the infraction.	The OCO reviewed the infractions and spoke with the HQ Prisons Disciplinary Program Manager. The DOC agreed to remove the general infraction for lying to staff.	Assistance Provided
36.	Incarcerated individual reports concerns about a resident needing a higher level of care than can be provided on unit.	The OCO provided assistance by elevating the concerns through DOC leadership. After OCO outreach, the patient was approved and transferred to the In-Patient Unit (IPU) for higher level of care.	Assistance Provided
37.	Person reported concerns regarding a resolution request that was removed from the resolution program for an investigation several months before. The person is requesting that the OCO make sure an investigation takes place.	The OCO provided assistance. OCO staff contacted DOC for the records and continued follow-up contact until the documentation was complete. OCO staff reviewed the staff conduct investigation and noted it had been completed within DOC 850.110, which does not specify timelines for investigations.	Assistance Provided
38.	Person reports issues with the effectiveness of a new dose form of a medication. The person is requesting to return to the original dose form he received.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff contacted Health Services staff and were informed the person had been started on the requested medication.	DOC Resolved
39.	Incarcerated individual shared concerns regarding DOC not providing them with their	The OCO provided information regarding the appeal process. After review of DOC records and speaking with DOC staff, this office was able to confirm that this individual has received some of their mail and did not appeal rejected mail to the headquarters level.	Information Provided

	photographs sent from their family.		
40.	Patient reports concerns about limited programming in the Residential Treatment Unit (RTU).	The OCO provided info about OCO's involvement in the DOC RTU workgroup and pending policy updates that include programming.	Information Provided
41.	Patient reports concerns about access to dental care and pain management.	The OCO elevated the facility specific dental concerns during reoccurring monthly meetings addressing DOC's dental care delays. The individual had not yet attempted resolution through the DOC Resolution Program, and the OCO provided information about the patient's next steps as well as ways OCO is monitoring DOC's dental backlog.	Information Provided
42.	Incarcerated individual shared concerns regarding DOC wrongfully transferring them following an investigation.	The OCO provided information regarding why they were transferred and information regarding DOC policy concerning this situation. After review of DOC records, this office was able to confirm that their transfer decision was reviewed by DOC facility leadership and the HCSC (Headquarters Community Screening Committee).	Information Provided
43.	Incarcerated individual shared concerns regarding DOC not providing them with their photographs sent from their family.	The OCO provided information regarding the appeal process. After review of DOC records and speaking with DOC staff, this office was able to confirm that this individual has received some of their mail and did not appeal rejected mail to the headquarters level.	Information Provided
44.	Person reports that he appealed a Care Review Committee decision and was told that the appeal was never received.	The OCO provided information to the person. OCO staff reviewed the person consultations and Care Review Committee (CRC) requests. OCO staff contacted DOC staff and found there was insufficient evidence to support that an appeal was filed. OCO staff noted that the DOC is moving forward with an additional specialist consultation for evaluation and treatment for the patient's reported symptoms and provided this information to the patient.	Information Provided
45.	Incarcerated individual shared concerns regarding this DOC not providing them with DME (Durable Medical Equipment) despite requiring it.	The OCO provided information regarding how they can obtain their requested DME. After speaking with DOC staff, this office was able to confirm that this individual has refused certain DME options. This office also provided information regarding patient paid healthcare.	Information Provided
46.	Person reports that DOC is not allowing him to promote to a minimum security camp.	The OCO provided information to the person regarding how their crime of conviction affects their eligibility for minimum security camps, per DOC 300.380.	Information Provided
47.	A loved one shared concerns on behalf of an incarcerated individual regarding them not being provided with all the items in a sent food package.	The OCO was unable to substantiate the concern due to insufficient evidence. After review of DOC records and speaking with DOC staff, this office was informed that this individual was provided with all their items and was afforded the opportunity to dispute any missing items upon receiving the package. This office was also able to confirm that this individual spoke with DOC staff regarding this concern.	Insufficient Evidence to Substantiate
48.	Incarcerated individual shared concerns regarding DOC staff acting inappropriately.	The OCO was unable to substantiate the concern due to insufficient evidence. This office reviewed DOC records and the DOC investigation related to this incident and following that review, the OCO was unable to find any evidence related to staff acting inappropriately towards this individual or others. DOC also conducted an investigation of this concern and that investigation was deemed unsubstantiated.	Insufficient Evidence to Substantiate

49.	Incarcerated individual shared concerns regarding not being provided with law library access and their resolution request not being accepted.	The OCO was unable to substantiate the concern due to insufficient evidence. After review of DOC records and speaking with DOC staff, this office was unable to confirm that this individual has sent a request for law library access. This office provided information regarding how this individual can request and potentially obtain law library access and how to request records.	Insufficient Evidence to Substantiate
50.	Incarcerated individual shared concerns regarding not being able to work a job they have worked previously.	The OCO was unable to substantiate a violation of policy by DOC. After review of DOC records and speaking with DOC staff, this office was able to confirm that this individual is no longer eligible for the position they held previously per DOC 700.000. Currently, this individual has work program referrals open and is a part of numerous programs within their facility.	No Violation of Policy
Olympic Corrections Center			
51.	Person reports concerns regarding the scheduling of a necessary medical procedure. The person requests that the OCO verify that the appointment is scheduled before his release. The person shared that there may be billing issues preventing the appointment.	DOC staff resolved this concern prior to OCO action. OCO staff reviewed the person's consultations and noted that the appointment was already scheduled. OCO staff contacted DOC headquarters staff and notified them of potential billing issues that were reported by the patient, though they appear to have been resolved.	DOC Resolved
52.	Person reported concerns regarding a medication they take possibly resulting in a positive drug screen for an extended amount of time.	The OCO provided information to the person regarding the existing process for DOC staff to verify if a person has been ordered a medication that would show up on a drug screen. Per DOC 420.380, Medication Certification Request will be completed by medical staff for positive test results. This is the process where medical staff verify if a person has been on a medication that would cause a positive result.	Information Provided
53.	Person reports that he was told by a specialist that he needed surgery. The person has not been scheduled for this surgery and would like to have it completed.	The OCO provided information to the person. OCO staff reviewed this person's consultations and noted that multiple clinics declined to accept him as a patient, resulting in a delay in the scheduling of the procedure. OCO staff verified the person has been seen by the requested specialist and further evaluation is required before surgery can be scheduled. OCO provided consultation process information to the patient.	Information Provided
54.	An individual reports that a petition regarding room assignments is going around the facility, and people are being peer pressured to sign.	The OCO provided information via hotline and encouraged the individual to work with facility leadership about this concern.	Information Provided
55.	Person reported concern about being denied the full year of Graduated-Reentry (GRE) and said that DOC wanted to send him to programming in the community first before sending him out on GRE, which would limit his time in GRE.	The OCO provided information about his GRE. The OCO reviewed DOC records and found assessments that supported the need for programming in the community. The OCO found that this individual is approved for GRE and will be transferred to community programming and then GRE.	Information Provided

Reentry Center - Reynolds - King			
56.	An external person reports unsanitary conditions at Reynold's Work Release, including bugs and rodents. It was also reported that staff are discourteous, unhelpful, and vindictive, with no investment in the incarcerated individual's successful reentry.	The OCO completed a monitoring visit at this facility and spoke with DOC staff, including facility leadership. This office visited the kitchen, the bathroom downstairs, the computer room, the bathroom and showers on multiple floors, and the living spaces with a TV. OCO staff did not witness any bugs, rodents, mold, or unsanitary conditions, and spent time with staff during the classification process. This office encourages individuals to file a resolution request about specific staff members if they are experiencing any misconduct.	Assistance Provided
Stafford Creek Corrections Center			
57.	Incarcerated person reported concern about access to religious programming. The person asked that the COO come and meet with religious groups at the facility. Later, the person reported concerns about their access to religious services and reported they wanted a job in the chapel but did not receive one.	The OCO provided assistance. The OCO met with religious groups and discussed their concerns in person. The OCO spoke with the facility Religious Coordinator about the concerns. The OCO monitored DOC actions and verified that issues were resolved that could be addressed. The OCO reviewed the DOC decision regarding the person's job post and found that per DOC 700.000, DOC screened the person correctly and DOC found they were not eligible for a job in the chapel. The OCO could not find evidence to support that the person was unable to access religious services.	Assistance Provided
58.	Incarcerated person reported concerns about their housing assignment in solitary confinement.	The OCO provided assistance. The OCO spoke to DOC and requested DOC share with the person that once their custody facility plan (CFP) is finalized DOC will transfer them to the appropriate custody level. The OCO also spoke with DOC and provided input on their next placement, which is not finalized. The OCO also shared how to appeal their custody facility plan if they had concerns about the finalized plan.	Assistance Provided
59.	Person reported that DOC is not allowing him to complete patient-paid dental care. Person said that he has already paid for the care.	The OCO provided assistance by substantiating staff error with the patient paid process, alerting DOC to the error, and providing information to this person about the next steps in the process. The OCO requested and reviewed this individual's DOC dental records and substantiated that records related to his patient paid healthcare were kept at the facility and were not added to his medical file, which delayed OCO action on this case. The OCO reviewed his patient paid dental care records with DOC Headquarters staff, who said that the paperwork was not completed or filed correctly. The OCO found that this individual was seen at this provider in the community and paid prior to incarceration, and that this individual's family will need to contact that provider for a refund. After OCO outreach, DOC staff found that the dental provider in the community no longer has the ability to perform the treatment that this person needs. DOC staff said that they will see if this person wants to continue his care with a different provider. DOC staff also said that this individual will need to start the patient paid process over again, because it was done incorrectly and the original provider is no longer able to provide the treatment he requested. The OCO raised this concern with Health Services leadership at the facility, who said that they would train their staff on how to correctly navigate the Patient Paid Healthcare process.	Assistance Provided
60.	Person reported concerns with his Custody Facility Plan (CFP)	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records, including transfer orders	DOC Resolved

	and expressed safety concerns with a facility transfer. Person requested transfer to a Safe Harbor facility.	and his CFP, and found that this individual is currently in a Safe Harbor unit.	
61.	Incarcerated individual shared concerns regarding DOC staff not providing them with mental health care.	DOC staff resolved this concern prior to the OCO taking action on this complaint. After speaking with DOC staff, this office was informed that this individual has been seen numerous times regarding their request and will continue to be seen in the future.	DOC Resolved
62.	Patient reports concerns about DOC not following specialist orders after a recent appointment with cardiology.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO contacted health services leadership at the facility and confirmed all cardiology recommendations were completed prior to OCO outreach.	DOC Resolved
63.	Incarcerated individual shared concerns regarding being denied early reentry options and not being provided the opportunity to take programming that would make them eligible.	The OCO provided information regarding why this individual was denied for early reentry. After review of DOC records, this office was able to confirm that this individual was denied for early reentry based on a decision from HCSC (Headquarters Community Screening Committee).	Information Provided
64.	Person reports that he was supposed to have cancer care follow-up but the appointment was cancelled. The person is requesting that the appointment be rescheduled.	The OCO provided information to the patient regarding the cancelation of the follow-up appointment. OCO staff reviewed the person's consultations and noted that the original appointment was cancelled by the outside clinic and was immediately rescheduled. OCO staff monitored the appointment to verify the follow-up appointment was attended by the patient.	Information Provided
65.	Person reports concerns regarding DOC not evaluating his medical complaints. The person states that he has received care, but not specifically for the issue he is reporting to the OCO. The person is requesting a meeting with his provider to talk about his specific concerns and to see a specialist.	The OCO provided information to the person regarding self-advocacy steps to report changes in his medical condition. OCO staff contacted DOC Health Services staff to request a review of the patients' concerns and were informed that the patient had been seen and offered treatment but did not present with symptoms consistent with what was reported to the OCO. Currently there is not clinical indication to support the person's request to see a specialist.	Information Provided
66.	Incarcerated individual shared concerns regarding DOC staff not having an adequate procedure for facility movement.	The OCO provided information regarding facility movement. After review of DOC records, this office was able to confirm that this individual and DOC staff had worked out a solution to their specific situation. Currently, DOC facilities are responsible for determining specific procedures that work best for safety and security of their facility. This office also provided information regarding how incarcerated individuals can provide input or request for policy updates.	Information Provided
67.	The individual reports that he was given an infraction for fighting, but says he was defending himself from another incarcerated person who was trying to sexually assault him.	The OCO verified that this person requested protective custody, and that is why he was placed in segregation. DOC is creating a new custody facility plan (CFP), and the OCO provided information about how to appeal an FRMT decision per DOC 300.380, which states that appeals must be submitted to the Superintendent on DOC Form 07-037 within 72 hours of being notified of the decision.	Information Provided

68.	The individual reports that he lost his job for an infraction that was dismissed.	The OCO was unable to substantiate a violation of policy by DOC. This office confirmed that DOC held an FRMT related to this incident, and the person did lose their job, but was given a different position within their living unit.	No Violation of Policy
69.	Incarcerated person reported concerns about recent infractions. The person reported the infractions could have been a result of retaliation.	The OCO was unable to substantiate a violation of policy. The OCO reviewed the infractions and could not substantiate the infractions were a result of retaliation. The OCO reviewed the infractions and found there was substantial evidence for DOC to infract the person.	No Violation of Policy
70.	Incarcerated individual shared concerns regarding being infracted for fighting despite not fighting.	The OCO was unable to substantiate a violation of policy by DOC. After reviewing DOC records and speaking with DOC staff, this office was able to confirm that this individual admitted to fighting and was infracted following the incident. This office also spoke with DOC facility leadership who refused to dismiss this infraction for this individual. This individual was infracted per DOC 460.050.	No Violation of Policy
Washington Corrections Center			
71.	An external person reported concerns regarding their loved one's access to specialist care following a serious diagnosis. The person is requesting to see a specialist for this issue.	The OCO provided assistance. OCO staff reviewed the person's consultations and noted an administrative error in the follow-up appointments that could have led to a missed appointment. OCO staff confirmed the administrative error was fixed before it could cause any delay in care. OCO staff also found that DOC staff had notified the specialist of the recent change in the person's condition and had scheduled with the outside clinic to have the person seen sooner than the previously planned follow up appointment. OCO staff will monitor this appointment as a closed case until it is attended.	Assistance Provided
72.	Person reports he has been trying to access a specific medication for pain management. The person is requesting an ongoing treatment plan for his pain.	OCO staff provided assistance. OCO staff contacted the DOC Health Services staff that the patient had been referred to for approval of the requested medication. It was found that the referral had not yet been reviewed; the responsible provider reviewed the person's referral and contacted the person's medical provider. OCO staff provided information to the patient regarding the current status of the referral. OCO cannot compel a medical provider to order a specific medication, that is a clinical decision that cannot be countermanded by non-clinicians.	Assistance Provided
73.	Person reports concerns regarding his access to a medical appointment with a specialist. The person requests to have the appointment.	OCO staff provided assistance. OCO staff substantiated that the patient was not taken to multiple medical appointments by restrictive housing staff. Due to a lack of documentation, it could not be proven that the patient had been offered the chance to attend or refuse the appointment. OCO staff contacted DOC Health Services and custody staff and requested that they reschedule the patient for the appointment and ensure that staff are aware that the patient needed to go to the appointment. OCO staff monitored the appointment and followed up with DOC staff until the patient attended an appointment.	Assistance Provided
74.	Incarcerated individual shared concerns regarding DOC delaying their review due to an infraction they are not guilty of.	DOC staff resolved this concern prior to the OCO taking action on this complaint. After review of DOC records, this office was able to confirm that this individual has been transferred into GRE (graduated reentry).	DOC Resolved

75.	Incarcerated individual shared concerns regarding not being promoted custody levels despite being eligible for promotion.	The OCO provided information to this individual regarding why they were not promoted. After review of DOC records, this office was able to confirm that this individual had been denied their desired custody level due to a HCSC (Headquarters Community Screening Committee) decision. This individual had also received numerous serious infractions which made them ineligible for promotion.	Information Provided
76.	Incarcerated person reported concerns about their unit's access to laundry services.	The OCO provided information. The OCO made immediate outreach to the facility to report the concern and gather information about the issue. DOC reported the unit had one issue with the laundry order that was resolved the next day. The OCO provided this information to the incarcerated person and recommended filing resolution requests and alerting the unit sergeant when unit issues arise.	Information Provided
77.	Incarcerated person reported concerns about transferring to graduated reentry (GRE) and requested assistance in getting more information about if they will transfer to GRE.	The OCO provided information. The OCO verified the person is accepted into GRE and DOC is currently building them a plan to release to the GRE program. The OCO provided this information to the person. The OCO shared the person should continue working with DOC staff in the process of building the GRE release plan.	Information Provided
78.	Incarcerated person reported concerns about their units access to laundry services.	The OCO provided information. The OCO made immediate outreach to the facility to report the concern and gather information about the issue. DOC reported the unit had one issue with the laundry order that was resolved the next day. The OCO provided this information to the incarcerated person and recommended filing resolution requests and alerting the unit sergeant when unit issues arise.	Information Provided
79.	Person reported that he was infracted years ago and that the infraction is being used to deny his Extended Family Visits (EFV). Person expressed concern that the policy used to justify his EFV denial was not implemented until after the infraction occurred.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the EFV denial and the related infraction and found that DOC was within policy by denying the EFV, because the infraction was Category B, Level 1. Extended Family Visit Eligibility (Attachment 1) states that individuals found guilty of Category B, Level 1 violations are ineligible for EFVs for 3 years after the date they were found guilty of the infraction. DOC policy that is active at the time of review, not the time of infraction, is in effect in determining the eligibility for EFVs.	No Violation of Policy
80.	Individual reports that he received an infraction for property that was in his cell when he moved in.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the person found the items in his new cell and did not turn them into DOC staff.	No Violation of Policy
81.	Person reported that he is being denied Graduated Reentry (GRE) and Reentry Center because of a substance abuse assessment from an old cause number.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed DOC records and found assessments that are up to date and that DOC did not violate DOC 300.500 in denying his GRE. The OCO also found that this individual has a Planned Release Date (PRD) and there would not be enough time for this individual to get onto GRE.	No Violation of Policy
Washington Corrections Center for Women			
82.	Person reports they are being held in restrictive housing and has experienced multiple uses of force.	The OCO did a full investigation and released a public report regarding this concern. The DOC agreed to implement emergency training on use of force at the facility, create a timeline for Superintendent review and create a team to audit use of force at the DOC Headquarters level.	Assistance Provided
83.	An incarcerated individual reported that there is an individual housed in close	The OCO did a full investigation and released a public report regarding this concern. The DOC agreed to implement emergency training on use of force at the facility, create a timeline for	Assistance Provided

	observation that has severe disabilities. She is experiencing multiple uses of force and not allowed out of her cell.	Superintendent review and create a team to audit use of force at the DOC Headquarters level. This individual was also moved to the residential treatment unit and had her medications adjusted.	
84.	Individual reported multiple uses of force, no pathway out of restrictive housing and denied access to her tablet.	The OCO did a full investigation and released a public report regarding this concern. The DOC agreed to implement emergency training on use of force at the facility, create a timeline for Superintendent review and create a team to audit use of force at the DOC Headquarters level. The OCO verified this individual did receive her tablet and has a new pathway out of restrictive housing.	Assistance Provided
85.	Individual reported concerns of a swollen foot and lack of medical care	The OCO contacted medical at DOC Headquarters and asked for a review of her symptoms. She was seen by the physician and an x-ray was ordered.	Assistance Provided
86.	Individual reported excessive use of force.	The OCO did a full investigation and released a public report regarding this concern. The DOC agreed to implement emergency training on use of force at the facility, create a timeline for Superintendent review and create a team to audit use of force at the DOC Headquarters level.	Assistance Provided
87.	Person reports that staff at MCCCW are not refilling medications correctly. This has caused delays that resulted in the person suffering adverse effects from not having her medication. She is requesting that her medications be changed to keep on person and to be reliably refilled.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff reviewed the person's records and contacted DOC Health Services staff regarding the processing timelines for the medication refills. OCO staff confirmed that the change to have medications kept on person was made prior to OCO outreach. OCO staff did not substantiate a significant delay in the processing of the medication refills.	DOC Resolved
88.	External person reported concerns regarding their loved one's access to medical care. They are requesting that the person get to see a specialist.	OCO staff provided information to the person regarding the current status of their consultations. OCO staff reviewed the person's records and consultations. OCO staff noted that the patient was referred for additional evaluation. OCO staff will monitor the appointment until completion.	Information Provided
89.	Incarcerated individual shared concerns regarding DOC staff not providing them with adequate medical care.	The OCO was unable to substantiate the concern due to insufficient evidence. After review of this individual's `medical records, speaking with DOC staff, and reviewing DOC records, this office was unable to confirm this individual's concern. Medical records indicate this individual has been seen regarding their concerns when it was requested and deemed clinically necessary by DOC medical staff. This office encouraged this individual to continue speaking with their provider regarding any concerns that they may experience.	Insufficient Evidence to Substantiate
Washington State Penitentiary			
90.	External person reported concerns regarding their loved one's access to medications for pain control.	OCO staff provided assistance. OCO staff reviewed the person's consultations and Care Review Committee (CRC) requests. OCO staff noted that the CRC had declined the requested medication but did refer the patient to additional specialists for further consideration. OCO staff contacted the medical provider to ensure that the referral had been received. There are technological barriers to improving the referral process to this provider that the DOC is actively working to remedy. Due to OCO outreach, this contact resulted in this referral being responded to by the responsible specialist. The final treatment	Assistance Provided

		decision is a clinical decision that cannot be countermanded by non-clinicians.	
91.	External person reported a concern about an incarcerated person being assaulted by other incarcerated people.	The OCO provided assistance. The OCO made immediate outreach to DOC to verify the incarcerated person received medical care and was able to contact his family. The OCO reviewed the person's file and spoke with DOC about the safety concerns. DOC shared based on the information they had the person's placement before the assault was not a threat. DOC created a new plan for this person. The OCO monitored the person's custody facility plan (CFP) and verified the person attended the CFP meeting and their statements were included in the final plan. This person has been transferred to another facility and is no longer in segregation.	Assistance Provided
92.	An incarcerated individual reported concern with the safety of another incarcerated individual and said this individual was assaulted.	The OCO provided assistance by continually communicating with multiple DOC staff at the facility and headquarters level for several months until they transferred to a safer facility. The OCO had been in communication with DOC staff and had been following this situation in a previous case and reviewed the incident of this individual being assaulted. The OCO continued to reach out to HQ staff about their housing protocol and safe placement. After months, this individual's housing protocol was completed and they were transferred to an appropriate placement.	Assistance Provided
93.	Person said he is Native American and reported that the facility is denying him his religious rights because they closed down the sweat lodge. Person wanted the sweat lodge to be reopened.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and reached out to facility staff, who stated that the sweat lodge was closed for specific units for about 8 weeks due to safety and security concerns from a threat that was made. DOC staff described the other religious activities for the Native American religious group, and the OCO found that they were allowed reasonable access to their religious activities while the sweat lodge was closed. The OCO confirmed that the sweat lodge is now open again.	DOC Resolved
94.	A loved one shared concerns on behalf of an incarcerated individual regarding DOC holding them in involuntary protective custody and providing them with no privileges.	DOC staff resolved this concern prior to the OCO taking action on this complaint. After review of DOC records, this office was able to confirm that this individual has been transferred to a facility they are currently safe at.	DOC Resolved
95.	Incarcerated individual shared concerns regarding not receiving their glasses.	DOC staff resolved this concern prior to the OCO taking action on this complaint. After speaking with DOC staff, this office was able to confirm that this individual has received their glasses.	DOC Resolved
96.	A loved one shared concerns on behalf of an incarcerated individual regarding not being provided with mental healthcare and DOC staff jeopardizing their safety following an incident.	The OCO provided information regarding their facility placement. This office reviewed the investigation following the incident in question, spoke with DOC staff, and also reviewed DOC records. After review, this office was unable to determine staff misconduct due to insufficient evidence. This individual has since been moved to a different facility.	Information Provided
97.	A loved one shared concerns on behalf of an incarcerated individual regarding being held in IMU (Intensive Management Unit) despite being found not	The OCO provided information regarding why they are classified as MAX custody. After review of DOC records, this office was able to see that although this individual was found not guilty of the infractions, they were still determined to be an influential member of an STG (security threat group). Due to their involvement in the STG, this individual was classified as MAX custody.	Information Provided

	guilty of the infractions that placed them there.		
98.	Incarcerated individual shared concerns regarding not having access to their legal documents while in IMU (Intensive Management Unit).	The OCO provided information regarding why they were unable to access their legal documents while in the IMU. After reviewing DOC records and speaking with DOC staff, this office was able to confirm that this individual has been released from IMU and has full access to their property. This individual's legal property had been mixed with their normal property and per DOC 590.500 was treated as regular property as they were in IMU.	Information Provided
99.	Individual reports that DOC failed to provide all the records they requested for their substance abuse treatment.	The OCO provided information to the individual via the OCO hotline regarding how to appeal a response they received about their DOC public records request.	Information Provided
100.	Incarcerated individual shared concerns regarding DOC not providing the population with access to a sociologist.	The OCO provided information regarding the services DOC provides individuals with under the WA DOC Health Plan.	Information Provided
101.	Patient reports concerns about access to mental health treatment and requested placement in a Residential Treatment Unit (RTU).	The OCO elevated this concern through facility health services leadership. At this time, the patient was not recommended or approved for RTU placement. The OCO shared information about OCO's involvement in the DOC RTU workgroup and pending policy updates.	Information Provided
102.	Person reports that DOC is not honoring DOC 440.050 by not providing their preferred undergarments.	The OCO provided information. OCO staff reviewed the person's records and contacted DOC staff. OCO staff were informed that the requested item has been denied by the security council statewide. OCO staff confirmed the person was issued approved garments to meet the policy requirements. OCO staff did note that the decision from the security council does not align with policy language and requested that the policy language be changed to align with the council's decision. DOC staff confirmed that they have requested the policy be reviewed for updates by the policy author.	Insufficient Evidence to Substantiate
103.	Incarcerated individual shared concerns regarding not receiving their mail rejection from their facility and being unable to appeal the facility decision to HQ.	The OCO was unable to substantiate the concern due to insufficient evidence. After speaking with DOC staff and reviewing DOC records, this office was able to confirm that this individual received their rejection.	Insufficient Evidence to Substantiate
104.	Individual reports he was told he would be reclassified and sent to general population. However, after his custody facility plan (CFP) was reviewed by headquarters, his max custody placement was extended. The individual is being released soon and is very concerned that he will be released from the IMU.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the person's Custody Facility Plan and DOC's reasons for continuing to house them in segregation. These DOC decisions comply with DOC 300.380 Classification and Custody Facility Plan Review.	No Violation of Policy
105.	An external person reports concerns regarding their loved one getting an infraction, sanctions, restrictive housing,	This office was unable to substantiate a violation of policy because the individual did participate in behavior that would demote his custody level and result in level one only. DOC 320.250 (C) MAX committee will consider the individual's eligibility to progress	No Violation of Policy

	and the conduct of their classification counselor.	through the levels based on the reason(s) the individual was demoted to MAX custody. The OCO encouraged the individual to continue programming and work with his classification counselor at his next review.	

Intake Investigations			
Airway Heights Corrections Center			
106.	An incarcerated person reported a concern related to the behavior of a DOC staff member and a behavior observation entry (BOE).	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond the intake phase.	Declined
107.	An incarcerated person reported a concern about DOC not accepting/documenting a PREA report.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time. The OCO verified that the PREA was documented and the PREA is being reviewed under a different case.	Declined
108.	An incarcerated person reiterated a concern related to their housing which they previously reported.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time.	Declined
109.	An incarcerated person reported a concern related to DOC not marking the correct gender in their records.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time.	Declined
110.	An incarcerated person reported a concern related to their housing and a desire to be transferred to a specific other prison.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time.	Declined
111.	An incarcerated person reported a concern related to specific clothing being issued per an HSR in the future if they change facilities.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time. Additionally, the concern acknowledged that currently the facility is issuing the clothing.	Declined
112.	External person reported concerns about a volunteer suspension. The external person reported the suspension affected specific groups from meeting and named an incarcerated contact.	The OCO did not receive a response from the incarcerated person with further information to investigate.	Person Declined OCO Assistance
113.	A friend or family member reports concerns on their loved one's behalf that his property was mishandled and broken by DOC staff.	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

114.	A friend or family member reported on their loved one's behalf that he was removed from the Medication Assisted Treatment (MAT) program when he was transferred to a different facility because his release date had changed.	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
115.	A friend or family member reported concerns that staff at Airway Heights Corrections Center lost their loved one's wedding band when they inventoried his property and will not allow a replacement of the same band to be sent in because the original one was not ordered from Union Supply.	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
116.	Person reported multiple concerns regarding how DOC has not carried out the DRW settlement agreement.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint.	Person Declined OCO Assistance
117.	A friend or family member reported concerns that their loved one was infracted for a tablet related issue, but the sanctions did not include his tablet being taken away. His tablet was taken away however and has not been returned.	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
118.	An incarcerated person reported a concern related to a PREA investigation.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint.	Person Declined OCO Assistance
119.	An external person reported on their loved one's behalf that they have been denied necessary medical care.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program to address their concern prior to contacting the OCO. The OCO also provided information about the Care Review Committee (CRC) and appeal process.	Technical Assistance Provided
120.	An incarcerated person reported a concern related to an infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal infractions.	Technical Assistance Provided
121.	Person reported that he had a negative experience with the SOTAP program which impacted his Indeterminate Sentence Review Board (ISRB) hearing and the program's therapist behavior.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program to address staff conduct prior to contacting the OCO.	Technical Assistance Provided

122.	An incarcerated person reported a concern related to their custody facility plan and an infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal their custody facility plan and infraction.	Technical Assistance Provided
Clallam Bay Corrections Center			
123.	Person reports that staff prevented him from seeing medical after they had pulled on an injured limb. The person also reports that their medications are not being administered appropriately.	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
124.	This person's wife reported concerns about being denied visitation and communication with her husband.	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
125.	A friend or family member reported concerns that a memorandum distributed to all incarcerated individuals stated that beads are now classified as hobby craft items instead of religious items and must be purchased through hobby craft channels, violating both DOC policy and federal laws.	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
126.	An incarcerated person reported a concern related to their custody facility plan and access to programming.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal custody facility plans.	Technical Assistance Provided
Coyote Ridge Corrections Center			
127.	A friend or family member reported concerns that their loved one was infracted for contraband that DOC claims contained drugs.	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
128.	An external person reports that her son is in danger, has been placed in administrative segregation for no reason, and is being harmed by his cellmate.	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. However, due to the safety concerns involved in the complaint, the OCO confirmed with DOC that the individual is safe and is not being harmed by his cellmate.	Person Declined OCO Assistance
Monroe Correctional Complex			
129.	An incarcerated person reported a concern related to property.	Due to limited resources, the OCO is only able to review one case per individual at a time.	Declined
130.	An incarcerated person reported a concern related to access to durable medical	Due to limited resources, the OCO is only able to review one case per individual at a time.	Declined

	equipment (DME) in the closed observation area (COA).		
131.	An incarcerated person reports concerns related to not having access to religious texts.	Due to limited resources, the OCO is only able to review one case per individual at a time.	Declined
132.	An incarcerated person reported a concern about a staff conduct issue that happened in the infirmary.	Due to limited resources, the OCO is only able to review one case per individual at a time.	Declined
133.	External person reports a concern about issues with vending machines in the visitation room.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
134.	A friend or family member reported concerns that their loved one was infracted for not being able to provide a sample for a urine analysis (UA) test.	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
135.	A friend or family member reported that they were not approved for Extended Family Visits (EFV). They appealed the denial but the decision was upheld.	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
136.	An incarcerated person reported a concern related to wanting to ask DOC to change Washington Administrative Codes related to discipline in prisons.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to provide input on DOC policies.	Technical Assistance Provided
137.	An incarcerated person reported a banking concern.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about pursuing the concern internal to DOC via the resolution program.	Technical Assistance Provided
138.	Individual called and requested assistance regarding the infraction process.	The OCO provided technical assistance regarding the DOC infraction process and submitting an infraction appeal before the OCO can review.	Technical Assistance Provided
139.	Patient reports concerns about access to dental care.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about next steps for addressing dental access.	Technical Assistance Provided
	Olympic Corrections Center		
140.	A loved one of an incarcerated person reported a concern related to the behavior of a DOC staff member.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to report DOC staff behavior to DOC.	Technical Assistance Provided
	Stafford Creek Corrections Center		
141.	An incarcerated person reported a concern related to the behavior of DOC staff.	Due to limited resources, the OCO is only able to review one case per individual at a time.	Declined

142.	An incarcerated person reported a concern related to a negative behavioral observation they received.	Due to limited resources, the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
143.	An incarcerated person reported a concern related to a negative behavioral observation they received.	Due to limited resources, the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
144.	Incarcerated individual shared concerns regarding their tort claim being denied following a medical injury.	The OCO lacks jurisdiction to investigate this complaint because the complaint relates to an action taken by an agency other than the Washington State Department of Corrections.	Lacked Jurisdiction
145.	Person reported that DOC staff took away all of the incarcerated individual's art supplies and religious items.	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
146.	A friend or family member reported concerns about how and why the facility their loved one is housed at conducts urine analysis (UA) testing.	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
147.	An external person reports concerns about her loved one living in solitary confinement for extended periods of time and how this is impacting his mental health.	The incarcerated individual advised the OCO that he did not want this office to investigate the complaint.	Person Declined OCO Assistance
148.	An incarcerated person reported a concern related to an infraction.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint.	Person Declined OCO Assistance
149.	An incarcerated person reported a concern related to an infraction.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint.	Person Declined OCO Assistance
150.	An incarcerated person reported a concern related to the behavior of a DOC staff member, a PREA report, and the loss of a job.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to file a PREA as no PREA has been filed, how to report staff behavior to DOC, and filing a resolution request about loosing their job.	Technical Assistance Provided
151.	An incarcerated person reports a concern related to an infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal infractions.	Technical Assistance Provided
152.	An incarcerated person reported a concern related to property broken by DOC staff when he was moved from one DOC facility to another.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to pursue the concern internally with DOC and then how to pursue a tort claim with DES if they choose to take that step.	Technical Assistance Provided
Washington Corrections Center			
153.	Individual reports that he wants an unbiased hearings	The incarcerated individual advised the OCO that he did not want this office to investigate the complaint because most of his infractions were dismissed upon appeal.	Person Declined OCO Assistance

	officer for his recent infractions.		
154.	An incarcerated person reported a concern related to the behavior of a DOC staff member.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
155.	An incarcerated person reported a concern related to the behavior of a DOC staff member.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to report the concern to DOC before reaching out to the OCO.	Technical Assistance Provided
156.	Loved one reports that an individual was given a drug related infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal visitation rejections, denials or terminations.	Technical Assistance Provided
157.	An incarcerated person reported a concern related to a delay in completion of their custody facility plan.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal their custody facility plan. The OCO also verified that a new custody facility plan was finalized and the person has been transferred to a different facility.	Technical Assistance Provided
158.	Person reported concerns about his sentence being calculated incorrectly and not being able to access his property.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program to address these concerns with the DOC prior to contacting the OCO. The OCO also provided the contact information for the DOC calculations unit regarding the time calculation issue.	Technical Assistance Provided
159.	An incarcerated person reported a concern related to their time calculation.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to address the concern with DOC.	Technical Assistance Provided
160.	Person reported that the time on a negotiated community custody violation was calculated incorrectly. DOC added more time than was negotiated and his Early Release Date was changed.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program and contacting the DOC calculations unit at Headquarters to resolve this concern.	Technical Assistance Provided
	Washington Corrections Center for Women		
161.	Person reported concerns about a staff member's behavior and is concerned the staff member has not been removed from their position.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program to address staff conduct concerns prior to contacting the OCO.	Technical Assistance Provided
162.	Person reported concerns about receiving an infraction and wants to file an appeal.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about appealing the infraction and contacting the OCO if the infraction was not overturned on appeal.	Technical Assistance Provided
	Washington State Penitentiary		
163.	An incarcerated person reported a staff conduct issue	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time.	Declined

	that occurred in the infirmary. This person states that the DOC staff member who reviewed video footage says there is no evidence of an assault. However, the individual believes that DOC staff are lying.		
164.	Person reported concerns about not receiving care for an injured hand. They were scheduled to see an Orthopedic Specialist before being transferred to a different facility and the new facility has not addressed the need to see the specialist.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about contacting Health Services to schedule an appointment with the Orthopedic Specialist and filing a Resolution Request if this concern has not been resolved.	Technical Assistance Provided
165.	This person reported concerns about being taken off of the Medication Assisted Treatment (MAT) program for missing appointments, however, there were factors out of his control that contributed to him missing the appointments.	The OCO provided technical assistance about the Medication Assisted Treatment (MAT) program and filing a Resolution Request prior to contacting the OCO if their MAT needs are not met.	Technical Assistance Provided
166.	An incarcerated person reported a concern related to property not being transferred correctly at a recent facility move.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to use the resolution program.	Technical Assistance Provided

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

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

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

Abbreviations & Glossary

ADA: Americans with Disabilities Act

AHCC: Airway Heights Corrections Center

ASR: Accommodation Status Report

BOE: Behavioral Observation Entry

CBCC: Clallam Bay Corrections Center

CCCC: Cedar Creek Corrections Center

CI: Correctional Industries

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

CO: Correctional Officer

CRC: Care Review Committee

CRCC: Coyote Ridge Corrections Center

CUS: Correctional Unit Supervisor

DES: Department of Enterprise Services

DOSA: Drug Offender Sentencing Alternative

EFV: Extended Family Visit

ERD: Earned Release Date

GRE: Graduated Reentry

HCSC: Headquarters Community Screening Committee

HSR: Health Status Report

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

J&S: Judgment and Sentence

MCC: Monroe Correctional Complex

MCCCW: Mission Creek Corrections Center for Women

OCC: Olympic Corrections Center

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

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

SCCC: Stafford Creek Corrections Center

SOTAP: Sex Offender Treatment and Assessment Program

SVP: Sexually Violent Predator

TC: Therapeutic Community

WaONE: Washington ONE ("Offender Needs Evaluation")

WCC: Washington Corrections Center

WCCW: Washington Corrections Center for Women

WSP: Washington State Penitentiary

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-017

Report to the Legislature

As required by RCW 72.09.770

May 7, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

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Unexpected Fatality Review Committee Report

UFR-24-017 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 3, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Rae Simpson, Director - Quality Systems
- Patricia Paterson, Chief of Nursing
- Mark Eliason, Deputy Assistant Secretary
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

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

DOC Risk Mitigation

- Michael Pettersen, Director

DOC Community Corrections Division

- Kristine Skipworth, Administrator – East Region
- Kelly Miller, Administrator – Graduated Reentry

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

Health Care Authority (HCA)

- Dr. Christopher Chen, Associate Medical Director

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

Fatality Summary

Year of Birth: 1990 (33-years-old)

Date of Incarceration: October 2022

Date of Death: October 2024

At the time of death, the incarcerated individual was in a community hospital after being transferred for medical care from a contracted community jail.

His cause of death was due to a low grade glioneuronal tumor consistent with ganglioglioma. His manner of death was natural.

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

Weeks Prior to Death	Event
19 weeks	• The incarcerated individual began his community supervision.
7 weeks	• He failed to report for supervision and a DOC Secretary's warrant was issued for his arrest. • He was arrested and incarcerated in Oregon on new charges.
6 weeks	• WA DOC was notified of the incarcerated individual's arrest and requested extradition from Oregon.
1 week	• The incarcerated individual waived extradition and was transported to a community jail in Washington on behalf of the department.
Days Prior to Death	**Event**
6 days	• The incarcerated individual waived extradition and was transported to a community jail in Washington on behalf of the department.
2 days	• The incarcerated individual experienced a medical emergency and was transported to a community hospital for treatment.
1 day	• DOC authorized a conditional release from confinement.
0 day	• The incarcerated individual was pronounced deceased by hospital staff.

UFR Committee Discussion

The UFR committee met to discuss the findings and recommendations from the DOC Mortality Review

Committee and the DOC Critical Incident Review. The UFR committee considered the information from both reviews and offered no recommendations for corrective action.

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

    1. The committee found:

        a. The incarcerated individual was exhibiting signs of a serious illness, and his care needs were unmet during his final incarceration in the community.

        b. The medical information relayed from the community jail to the DOC Utilization and Management Nurse Desk staff was incomplete and did not accurately reflect the seriousness of the individual's condition.

    2. The committee recommended:

        a. The WA DOC Chief Medical Officer (CMO) report the missed care opportunities to the CMO of the Oregon jail and the CMO of the DOC contracted community jail where the individual was incarcerated in the weeks prior to his death.

        b. Health Services explore how unmet care needs can be highlighted when a person is transferring from another correctional health care system into DOC care.

B. Independent of the mortality review, the DOC conducted a critical incident review (CIR) to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operational procedures. A root cause analysis was conducted and did not identify any operational issues that caused or contributed to the incarcerated individual's death.

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

    1. Health information sharing between DOC and other care systems.

        a. Committee members noted DOC's lack of an electronic health record creates barriers to information sharing and care transitions.

        b. The Health Care Authority provided information regarding the upcoming pilot launch of a statewide electronic health information exchange.

Committee Findings

The incarcerated individual died as a result complications from a brain tumor. His manner of death was natural.

Committee Recommendations

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

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

DOC should continue work with the Washington Association of Sheriffs and Police Chiefs (WASPC) to develop agreements with all county jurisdictions to develop and implement a more thorough interfacility transfer document that highlights areas of clinical concern and considers use of a standardized reporting format to ensure that all pertinent medical information is conveyed in the referral.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-018

Report to the Legislature

As required by RCW 72.09.770

May 23, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

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Unexpected Fatality Review Committee Report

UFR-24-018 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.

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 May 5, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Penny Bhagia, Deputy Chief Medical Officer
- Dr. Rae Simpson, Director – Quality Systems
- Mark Eliason, Deputy Assistant Secretary
- Patricia Paterson, Chief of Nursing
- Darren Chlipala, Administrator
- Mary Beth Flygare, Health Services Project Manager

DOC Men's Prison Division

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

DOC Community Reentry Division

- Sara Sytsma, Deputy Assistant Secretary
- Carrie Stanley, Reentry Center Administrator
- Michelle Eller-Doughty, Reentry Center Operations Administrator

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, Deputy Director
- Madison Vinson, Assistant Corrections Ombuds - Policy

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Heather Schultz, Associate Medical Director

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

Fatality Summary

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

Date of Incarceration: August 2023

Date of Death: October 2024

At the time of death, this incarcerated individual was housed in a DOC contracted community reentry center (RC) and was receiving medication-assisted treatment (MAT) from a community treatment provider.

His cause of death was due to infection with SARSCoV-2 (COVID-19). The manner of his death was natural.

Prior to his death, the incarcerated individual did not show the usual signs or symptoms of COVID-19 infection. The Committee discussed the possible side-effects he may have been experiencing from MAT and identified opportunities to support individuals with opioid use disorder (OUD) reentering the community.

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

Days Prior to Death	Event
4 days	• The incarcerated individual was seen for an intake exam by a community opioid treatment program and began medication-assisted treatment (MAT) to help support his sobriety.
3 days	• He received a dose of medication at the treatment center.
2 days	• Missed dose of medication.
1 day	• He was seen at the treatment center where the dose of his medication was increased. • He was provided with two individual doses for the weekend. • He turned in the weekend doses to RC staff which were secured.
Day of Death	**Event**
02:50 hours 05:30 hours 10:30 hours 13:20 – 14:15 hours	• He requested and took his daily dose of medication. • He was observed doing laundry at the facility and missed breakfast. • RC staff checked on him in his room where he was sleeping but able to awaken. • Another resident informed RC staff, the incarcerated individual was not looking well. • 911 was called and first aid including CPR and Narcan were administered.

	• The incarcerated individual was declared deceased by emergency medical personnel.

UFR Committee Discussion

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

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

   1. The committee found:

      a. The incarcerated individual had a past medical history of opioid use disorder and was receiving medication-assisted treatment (MAT) from a community treatment center. Records from the community provider were not available for review.

      b. Available records indicate the incarcerated individual had not used illicit narcotics or been prescribed MAT for approximately one year prior to his death lessening his tolerance to opiates.

      c. The strength of medication provided by the community treatment provider is recommended for individuals currently consuming opiates and the incarcerated individual may have experienced unwanted side-effects including slow and ineffective breathing.

   2. The committee recommended:

      a. Referral to the UFR Committee for review.

      b. The DOC Director of Addiction Medicine provide education on MAT to reentry center staff.

      c. Inform the State Opioid Treatment Authority of the mortality review committee findings and request a review of the treatment provided to the incarcerated individual by the community clinic.

      d. Remove this treatment provider from the community treatment resource list provided to the incarcerated individual pending the outcome of the State Opioid Treatment Authority review.

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

   1. The CIR found:

a. While residing at the RC, the incarcerated individual was working, completed chemical dependency treatment and had negative urine drug screens.

b. RC staff noted the incarcerated individual appeared off his baseline after starting MAT and assumed his behavior was medication related.

2. The CIR recommended:

a. Provide education on MAT and common side effects for all RC staff.

b. Provide written education to all RC residents upon intake related to MAT and common side effects.

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

1. Infection prevention including COVID vaccination in reentry centers –

a. RC residents are provided with cleaning and disinfection supplies.

b. Residents are encouraged to lay-in and not attend work or socialize when feeling unwell.

c. Reentry centers do not have a process to promote vaccinations for residents.

2. Overdose/Harm Reduction strategies –

a. DOC Addiction Medicine Team completed reentry center staff member training regarding medication-assisted treatment.

b. Residents are provided with personal Narcan kits and education during intake with additional kits available throughout the facility.

c. Staff are trained in emergency response and use of Narcan.

d. Residents with a history of substance use are referred for assessment and chemical dependency treatment. DOC provides contact information for providers to the incarcerated individual.

Committee Findings

The incarcerated individual died as a result of infection with SARSCoV-2 (COVID-19). The manner of his death was natural.

Committee Recommendations

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

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-013

Report to the Legislature

As required by RCW 72.09.770

May 30, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

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Unexpected Fatality Review Committee Report

UFR-24-013 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 17, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Eric Rainey-Gibson, Director - Behavioral Health
- Dr. Ashley Espitia, Psychologist 4 - Suicide Prevention
- Shane Evans, Administrator
- Dr. Rae Simpson, Director - Quality Systems
- Mark Eliason, Deputy Assistant Secretary
- Patricia Paterson, Chief of Nursing
- Mary Beth Flygare, Health Services Project Manager

DOC Men's Prison Division

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

DOC Risk Mitigation

- Michael Pettersen, Director

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, Director
- Ollie Webb, Assistant Corrections Ombuds - Investigations
- Madison Vinson, Assistant Corrections Ombuds - Policy

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Judy Zerzan, Medical Director

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

Fatality Summary

Year of Birth: 1992 (32-years-old)

Date of Incarceration: April 2014

Date of Death: July 2024

At the time of death, the incarcerated individual was being cared for in a community hospital after being transferred from a DOC prison facility.

The cause of death was asphyxia due to hanging. The manner of death was suicide.

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

Days Prior to Death	Event
3 days	• A routine tier check was completed. • Approximately 10 minutes later, another resident notified custody staff the incarcerated individual needed aid. • Custody and medical staff responded, called 911 and rendered medical aid. • Community Emergency Medical Services transported the incarcerated individual to the hospital via ambulance.
0 days	• The incarcerated individual 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 and the DOC Critical Incident Review. The UFR committee considered the information from both reviews in formulating recommendations for corrective action.

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

   1. The committee found:

      a. The incarcerated individual had a past medical history of gender dysphoria, PTSD, depression, substance use disorder, asthma, seizure disorder and previous suicide attempts while a teen.

b. She was being seen by her primary care, mental health and gender affirming (GA) care teams for management of her needs.

c. She did not express to staff any desire to die by suicide in the weeks or months before her death but did express frustration with the DOC GA care process.

2. The committee supports:

a. Referral to the UFR Committee for review.

b. Continuing the work of the DOC Suicide Risk Reduction workgroup.

c. GA care team in ensuring timely care without delays.

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

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

1. The CIR found:

a. That custody staff did not consistently follow safety inspection procedures when conducting tier checks on the day of the incident, including failing to look into the cell. This was identified as a concern and not a causal factor for the death. This concern is being administratively remediated at the facility level.

The CIR team did not identify any recommendations to prevent a similar fatality in the future.

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

1. Consistency of Tier Checks:

a. Members noted tier checks not being completed and documented consistently as a repeat concern.

b. Members support DOC explore options to improve the consistency and quality of tier checks.

2. Housing, support and care for transgender individuals:

a. A transgender incarcerated individual may be housed in a facility that does not align with their identified gender. They may also experience an increased sense of isolation and vulnerability during incarceration.

1. DOC staff follow policy 490.700 Transgender, Intersex, and/or Non-Binary Individuals to ensure equitable treatment when determining housing, classification, and programming needs for transgender individuals.

2. Committee members support reestablishing facility LGBTQI peer support groups that were suspended during the pandemic.

b. A representative from OCO stated transgender incarcerated individuals have contacted their office with concerns that legislative changes may result in changes to gender affirming care coverage in DOC.

    1. The DOC health plan coverage aligns with the Washington Apple Health Transhealth Program.

    2. Committee members support a communication be sent to incarcerated individuals providing reassurance that no reduction for covered gender affirming care is planned.

Committee Findings

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

Committee Recommendations

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

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

a. DOC should explore options to improve the consistency and quality of tier checks.

b. DOC leadership should send a communication to incarcerated individuals providing reassurance that no reduction for covered gender affirming care is planned.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-006

Report to the Legislature

As required by RCW 72.09.770

June 20, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

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Unexpected Fatality Review Committee Report

UFR-25-006 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.

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 May 29, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Penny Bhagia, Deputy Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary
- Patricia Paterson, Chief of Nursing
- Shane Evans, Administrator
- Dr. Rae Simpson, Director - Quality Systems
- Mary Beth Flygare, Health Services Project Manager

DOC Men's Prisons Division

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

DOC Risk Mitigation

- Michael Pettersen, Director

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, Director
- Ollie Webb, Assistant Corrections Ombuds - Investigations

Department of Health (DOH)

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

Health Care Authority (HCA)

- Dr. Christopher Chen, Associate Medical Director

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

Fatality Summary

Year of Birth: 1931 (93-years-old)

Date of Incarceration: February 2000

Date of Death: February 2025

At the time of death, this incarcerated individual was being cared for in a community hospital after being transferred for medical care from a DOC prison infirmary.

His cause of death was due to multi-organ system failure and advanced kidney disease. The manner of his death was natural.

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

Days Prior to Death	Event
Day 12	• The incarcerated individual was transported to the local community hospital for care.
Day 3	• His condition worsened, and per family wishes he was transitioned to comfort care.
Day 0	• He was pronounced deceased by hospital staff.

UFR Committee Discussion

Upon the request of the Office of the Corrections Ombuds, the UFR committee met to discuss the findings from the DOC Mortality Review Committee and the DOC Critical Incident Review. The UFR committee members considered the information from both reviews and offered no recommendations for corrective action.

A. The DOC Mortality Review Committee (MRC) reviewed the medical record, the antecedent care provided by DOC and previous hospitalizations. They did not identify any additional recommendations to prevent a similar fatality in the future.

    1. The committee found:

        a. The incarcerated individual was an elderly gentleman being treated for several serious medical conditions.

        b. After returning from the hospital, the incarcerated individual was erroneously

administered medications. A clinical review determined the error was not a causal factor for his death, but did identify staff reliance on care coordination via telephone may increase miscommunications and errors.

c. Prior to his final hospital admission, he was receiving supportive care in the facility infirmary due to his chronic health concerns.

d. His portable orders for life sustaining treatment form had not been updated since 2013.

e. At the wishes of his family, he was transitioned to comfort care at the hospital and passed away.

2. The committee supports:

a. Advancing the efforts of the DOC Hospice and Palliative Care Workgroup to facilitate the normalization of discussions surrounding end-of-life care between DOC staff and incarcerated individuals.

b. Reviewing and revising clinical protocols and processes to provide clear guidance and facilitate accurate care planning documentation.

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

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

The CIR did not identify any operational issues that caused or contributed to the incarcerated individual's death.

C. The UFR committee reviewed the unexpected fatality and discussed the following.

1. Fatality reviews.

a. DOC reviews the death of every incarcerated individual through the Mortality and Critical Incident Review processes. Deaths that meet the RCW definition of an unexpected fatality are then referred for review by the interagency UFR Committee.

2. Housing options for elderly incarcerated individuals in DOC prison facilities.

a. Many incarcerated individuals prefer to remain in their unit with their community as long as possible. DOC works to support this wish and is implementing changes to infirmary operations to allow more peer interaction and support once they require infirmary support.

3. Care transitions.

    a. Committee members discussed the care transition and communication challenges faced by DOC staff after an individual receives care in the community, acknowledging a non-contributory medication error that occurred weeks prior to this patient's death as an important safety gap.

    b. Members discussed DOC's lack of an electronic health record (EHR), the use of contracted nurses to maintain staffing levels and the need to ensure essential onboarding for each of these temporary staff, and transitions of care from community hospitals back to DOC being key gaps for intervention.

    c. Members support DOC Health Services' plan to continue expansion of the Patient Centered Medical Home, augment and standardize the current on-boarding process for contract nursing staff, revise protocols and templates to facilitate accurate care planning documentation and continue the pursuit of an Electronic Health Record.

Committee Findings

The incarcerated individual died as a result of multi-organ system failure and advanced kidney disease. The manner of death was natural.

Committee Recommendations

The UFR committee did not offer any recommendations for corrective action.