Office of the Corrections OMBUDS

Monthly Outcome Report

April 2025

Unexpected Fatality Reviews: 0

Case Investigations: 172

Assistance Provided: 15
Information Provided: 63
DOC Resolved: 23
Insufficient Evidence to Substantiate: 15
No Violation of Policy: 55
Substantiated: 1

Intake Investigations: 94

Administrative Remedies Not Pursued: 0
Declined: 2
Lacked Jurisdiction: 10
Person Declined OCO Assistance: 5
Person Released from DOC Prior to OCO Action: 3
Technical Assistance Provided: 74

Resolved Investigations:

266

Assistance Provided, Information Provided, or Technical Assistance Provided in

57%

of Investigations

Monthly Outcome Report: April 2025

	Complaint Summary	Outcome Summary	Case Closure Reason
		Case Investigations	
Airway Heights Corrections Center			
1.	A loved reports that her incarcerated husband is being denied access to the medication assisted treatment (MAT) program.	The incarcerated individual called the OCO and reported that DOC has resolved this concern and requested that this case be closed.	DOC Resolved
2.	Person reports that DOC is deducting legal financial obligations (LFO) for cause numbers that have been vacated.	The OCO verified that DOC resolved this issue through the resolutions department.	DOC Resolved
3.	Person reports that he was placed on a therapeutic diet that he did not want to stay on. The person requested to return to the mainline diet.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff reviewed this person's record and found that DOC staff had already rescinded the person's special diet.	DOC Resolved
4.	Person reports a multi-man fight happened and someone got stabbed. He was just walking near the group and DOC put him in the hole the next day. DOC then transferred him to a different facility, and he has no information about why.	The OCO reviewed this concern and found that he was moved back to general population and was not infracted.	DOC Resolved
5.	Incarcerated person reports they are approved for transfer to Graduated Reentry (GRE). The person had concerns about what track they were being accepted to.	The OCO provided information that based on a review of their file, this person is approved to transfer to GRE and will begin the GRE program soon.	Information Provided
6.	Incarcerated individual relayed concerns about staff being unprofessional in their conduction of a UA and DOC staff not stopping an individual who was sexually bullying and harassing them.	The OCO reviewed the related resolution request and confirmed that DOC reviewed both of these concerns. For the staff conduct concern, the individual filed the resolution request 9 months after the incident occurred. Per the resolution program manual, one must file a resolution request within 30 days of the incident. Thus, the staff conduct was not further reviewed. However, the individual stated that staff required the door to remain open and for them to face them while conducting the UA, these are both normal for the UA process. For the PREA allegations, DOC reviewed the concern as outlined in the resolution request and was determined to not meet the criteria of a PREA.	Information Provided
7.	Person reports suffering from chronic pain and has been attempting to get a long term pain management plan through DOC medical.	The OCO provided information to the person. OCO staff reviewed the patient's medical records and contacted DOC Health Services staff. OCO staff were informed that the patient was started on the requested treatment plan.	Information Provided

		OCO staff provided information to the patient regarding the cause of the delay in receiving a treatment plan.	
8.	Person reported they received an infraction for eating an orange in the bathroom before count, but no DOC policy states that you cannot do so before the count is called. The infraction was reduced to a general, however the person says they should not have received an infraction at all.	The OCO reviewed this concern and found that the serious infraction was reduced to a general infraction. The OCO confirmed that the officer had "some evidence" to write an infraction, as they had asked the individual to return to their cell with their orange, and the person subsequently went back to the bathroom again. This meets the criteria for refusing an order.	Information Provided
9.	Incarcerated person reported concerns about a DOC staff member.	The OCO reviewed the DOC investigation and found appropriate action was taken. The OCO is only able to share limited information about the investigation results. The OCO shared how to appeal behavior observation entries and recommended the person continue to report concerns regarding staff.	Information Provided
10.	Person reports that he was not informed of the correct timeline for a program that he was required to take. The person believes that the DOC is violating the contract that he signed.	The OCO provided information to the person about the treatment program as detailed in DOC 570.000 and related DOC forms. OCO staff could not substantiate a violation of DOC policy.	Information Provided
11.	Incarcerated individual shared concerns regarding DOC not fulfilling a keep separate request.	The OCO provided information regarding why this request was unfulfilled. After reviewing DOC records and speaking with DOC staff, this office was able to confirm this individual's keep separate request was investigated but DOC staff had insufficient evidence to justify reinstating the keep separate.	Information Provided
12.	Person reported that DOC staff do not allow pill line to happen indoors during the winter, causing geriatric people to wait in below-freezing weather for pill line. The person requested that DOC change the threshold for when pill line is brought indoors.	The OCO provided information to the person. OCO staff reviewed the inclement weather protocol and regional temperature averages. OCO staff contacted DOC leadership at the facility and requested that the temperature at which pill line is moved indoors be raised higher than the average low temperature for the area. Facility leadership declined to change the protocol.	Information Provided
13.	Family member reports that their loved one's cell keeps getting searched and he is being targeted.	The OCO reviewed this concern and found that this individual has been caught multiple times with contraband. This individual has now been moved to a different facility. The OCO cannot find evidence to substantiate that this individual has been targeted.	Insufficient Evidence to Substantiate
14.	Incarcerated person reported concerns regarding DOC staff creating barriers to their release plan.	The OCO was unable to substantiate this concern due to insufficient evidence. The OCO reviewed this person's file and was able to find evidence to confirm that DOC staff are actively assisting this person with release planning. The person currently has a release plan awaiting final approvals.	Insufficient Evidence to Substantiate
15.	Incarcerated individual relayed concerns about an infraction.	The OCO reviewed the infraction materials and did not identify a violation of DOC policy 460.000. DOC had relied upon confidential information, thereby satisfying the "some evidence" standard.	No Violation of Policy
16.	External person reports concerns about their incarcerated loved one's access to an electric wheelchair.	The OCO was unable to substantiate a violation of DOC policy 690.400 as electric wheelchairs are not allowed in DOC prisons per the Durable Medical Equipment (DME)	No Violation of Policy

		protocol. The OCO elevated the concerns through DOC health services leadership and discussed accessibility concerns regarding the doors in the SAGE unit. This office confirmed the patient was approved and provided a manual wheelchair. A separate case was opened regarding the patient's other HSRs and ADA concerns.	
17.	An anonymous incarcerated person reported a concern related to a phone number for the Social Security Administration not being accessible from Securus phone systems inside the prisons.	The OCO was unable to substantiate a violation of policy by DOC as certain phone numbers are restricted.	No Violation of Policy
18.	Incarcerated individual relayed concerns about an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
19.	Incarcerated person reported concerns about DOC terminating them from the graduated reentry (GRE) program. The person asked the OCO to review the termination for policy compliance.	The OCO reviewed the GRE termination and spoke with DOC staff about it and was unable to locate a violation of DOC policy. The OCO found there was a delay in the process which delayed the termination. However, the termination was not a violation of policy.	No Violation of Policy
20.	Incarcerated individual relayed concerns about an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as a cell search resulted in finding multiple items associated with the infraction in the common area of the cell, which is a valid cell tag infraction.	No Violation of Policy
21.	Person reported concerns regarding how individuals are chosen for medication assisted treatment for addiction. The person stated that the release date should not affect eligibility to receive treatment.	The OCO was unable to substantiate a violation of policy by DOC. OCO reviewed the current Medication Assisted Therapy (MAT) protocol. OCO staff noted that the person does not meet the current criteria for the MAT program. OCO staff provided information to the person regarding next steps if he wishes to pursue other options for treatment. OCO is monitoring the progress of the MAT program expansion, which is currently paused. DOC does not currently have the capacity to open up this treatment option for all affected incarcerated people. The DOC also has programming and support groups available to the population.	No Violation of Policy
22.	Person reports needing access to mental health and dental care. The person also reports having exhausted the resolutions program, however they still did not receive the care they requested.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed the patient's records, the DOC Health Plan, and the person's resolution requests. OCO staff contacted DOC Health Services staff. OCO staff noted the patient has been seen for dental care multiple times in the last year. OCO staff discussed the patient's medication concerns with their care provider. The OCO was informed that the person's reported concerns are being clinically managed through medications that are approved for use by the DOC formulary. OCO staff reviewed the person's Care Review Committee (CRC) decision and confirmed the patient's medication request was reviewed through the correct process. The OCO cannot compel a medical provider to order a specific medication.	No Violation of Policy

Cedar Creek Corrections Center

23.	Person reported having a medical condition that required transport to a larger facility for treatment and said he has not received treatment.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and reached out to DOC staff, who confirmed that this individual received a course of treatment for his condition and is currently on medication.	DOC Resolved
24.	Person reported that his resolution requests are not being substantiated and that he is being told to file public records requests instead.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed his resolution requests and found that multiple of his requests have been substantiated at multiple levels. The OCO reviewed his public record requests concerns in a separate case.	Insufficient Evidence to Substantiate
Clallam Bay Corrections Center			
25.	Person reports that he informed staff he has safety concerns about being put back into an active unit. Person says he can refuse housing but will get infracted. He does not feel like DOC is taking his safety concerns seriously and he is being punished for it.	The OCO reviewed this concern and this individual was moved to a general population medium facility.	DOC Resolved
26.	Person reports not being provided with adequate treatment for his pain.	DOC staff resolved this issue prior to OCO action. OCO staff reviewed the person records and contacted DOC Health Services staff. The OCO was informed that the person had been assessed by a specialist and is scheduled to start the medication in the near future.	DOC Resolved
27.	Incarcerated individual relayed concerns about safety concerns and appropriate housing placement.	The OCO reviewed the individual's custody facility plan and spoke to DOC and confirmed that they have no documented security threat group (STG) affiliation limiting the verification of safety concerns by DOC but confirmed that the individual has been transferred to a facility that is a safe harbor.	Information Provided
28.	Individual called to report a staff conduct concern. Individual filed a PREA and is currently housed in restrictive housing. He says he needs help with reading and writing and does not know how to appeal his infractions.	The OCO reviewed this concern and the PREA allegation. The PREA is still open and has not been completed and this individual was moved to a mental health unit at a different facility. This office contacted the ADA coordinator at the new facility to ensure this individual has access to the resolution program and appeals.	Information Provided
29.	Incarcerated person reports they were refused a utensil and fruit while in the Intensive Management Unit (IMU) and DOC did not explain why. The person also reported DOC did not provide him with adequate hygiene items.	The OCO provided information about conditions of confinement (COCs) and shared why DOC did not give them fruit or a utensil. The OCO verified this person was on short term COCs due to an incident that occurred earlier in the day. The person's COCs included a sack lunch only with no utensils. The OCO verified the persons COCs were issued per DOC policy 320.255. DOC substantiated that they did not provide this person with adequate hygiene items and completed training to ensure staff understand the protocol.	Information Provided
30.	Incarcerated person says they have issues reporting concerns about staff during an incident that involved force.	The OCO provided information about the resolution program and its limitations. The OCO reviewed the person's submitted resolution requests related to the concern and found that because the concerns were about actions that are related to another administrative investigation, the resolution program will not accept the concerns per the resolution program manual. The OCO is	Information Provided

		reviewing the person's concerns related to the force used in another case and shared that with this person.	
31.	Incarcerated individual shared concerns regarding DOC staff not providing them with their medication at or after pill-line.	The OCO provided information regarding why DOC medical staff did not provide their medication on the date of their concern. After review of DOC records and speaking with DOC staff, this office was able to confirm that DOC medical staff provided the patient's medication as ordered.	Information Provided
32.	Incarcerated person reported concerns with DOC staff not following the required protocol for addressing emergency resolution requests.	The OCO shared information with the incarcerated person about the resolution program, and its limitations. The OCO substantiated that DOC staff did not follow the protocol for addressing emergency resolutions requests, the OCO verified the DOC staff were reminded how to address emergency resolution requests by the facility. The OCO reviewed all of the emergency resolutions requests the person submitted as well as multiple resolution requests submitted through the regular process. The OCO verified the person received responses to all of the requests submitted in compliance with the resolution program manual.	Information Provided
33.	Incarcerated person reported a concern about their IPIN used to make phone calls has been compromised and he cannot make calls.	The OCO provided information about how to request an IPIN reset or how to get more information about why their IPIN is not working. The OCO verified the persons IPIN was suspended for a short period of time, due to an investigation. The OCO also verified that at the time of our outreach, the person's phone access had been restored and a new IPIN had been set. The OCO verified DOC can suspend IPIN access for a short time to ensure the safety and security of the facility.	Information Provided
34.	Individual reported they were held in restrictive housing for eight months and are waiting to transfer.	The OCO confirmed that this individual has now been moved to a new facility. The DOC has maintained that, due to the individual's LWOP status, a DOC committee had to review the custody facility plan for approval before transfer. This delayed the move. While the OCO confirmed this through the classifications policy, it is still unclear why the transfer took so long. Currently, the DOC has no policy timelines to which it must adhere through this process.	Information Provided
35.	Incarcerated person reports concerns about a staff member's response to a kite, which is a form of communication between incarcerated people and DOC facility staff.	The OCO found there is insufficient evidence to substantiate this concern. The OCO reviewed the available evidence and was unable to substantiate any concerns with the staff member's response. This person is now at a different facility and does not interact with the staff member, which was the person's request for resolution.	Insufficient Evidence to Substantiate
36.	An external person reported their loved one had been living in the transfer pod for months due to the trans housing protocol and were concerned their loved one would not be transferred.	The OCO found that the individual's trans protocol was delayed, and it caused a delay in the transfer. They were then transferred to a different medium facility and stated they had safety concerns and were moved back to restrictive housing. The DOC has no verifiable concerns that are documented to indicate this individual has validated safety concerns. The facility offered to move them to a different unit, but they still refused housing. The OCO could not find a violation of DOC policy 300.380	No Violation of Policy

37.	Incarcerated individual relayed concerns about an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 based on the individual's participation in the aiding/conspiring to commit an assault.	No Violation of Policy
38.	Individual reported they have protection concerns and were assaulted previously. They are now in restrictive housing.	The OCO verified that the individual currently has an open custody facility plan. Once it is complete, it will go to the MAX Committee for review. After the MAX review is complete, the individual can appeal if they disagree with the decision, per DOC policy 300.380.	No Violation of Policy
39.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and spoke to DOC about the infraction. The OCO found no violation of DOC policy 460.000 as there was evidence to show the individual's involvement in an assault and participation in an unauthorized gang, substantiating the infraction.	No Violation of Policy
40.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and spoke to DOC about the infraction. The OCO found no violation of DOC policy 460.000 as there was evidence to show the individual's involvement in an assault and participation in an unauthorized gang, substantiating the infraction.	No Violation of Policy
41.	An individual reported they had been living in the transfer pod for months due to a trans housing protocol and were concerned they would not be transferred. The person also reported that they were assaulted on mainline and did not want to return to that population.	The OCO found that the individual's trans protocol was delayed, and it caused a delay in the transfer. They were then transferred and stated they had safety concerns and were moved back to restrictive housing. The DOC has no verifiable concerns that are documented to indicate this individual has validated safety concerns. The facility offered to move them to a different unit, but they still refused housing. The OCO could not find a violation of DOC policy 300.380.	No Violation of Policy
Coyote Ridge Corrections Center			
42.	An incarcerated person asked that DOC issue positive BOEs (behavior observation entries) for helping at a specific event.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO was able to verify that positive BOEs are being given out for this task.	DOC Resolved
43.	Incarcerated individual relayed concerns about not getting positive behavior observation entries (BOEs) for attending flag detail.	The OCO confirmed that the BOEs have now been entered into individual's records.	DOC Resolved
44.	An outside entity shared concerns on behalf of an incarcerated individual regarding DOC not providing them with adequate accommodations.	The OCO provided information regarding steps they can take to request accommodations. After speaking with DOC staff and reviewing DOC records, this office was able to confirm that this individual has no official medical diagnosed disability which permits them to receive official ADA accommodations. This office encouraged this individual to work with their provider to receive an assessment for such diagnoses.	Information Provided
45.	Incarcerated individual shared concerns regarding DOC staff not providing them with accommodations despite repeated requests.	The OCO provided information regarding steps they can take to request accommodations. After speaking with DOC staff and reviewing DOC records, this office was able to confirm that this individual has no official medical diagnosed disability which permits them to receive official ADA accommodations. This office encouraged this	Information Provided

		individual to work with their provider to receive an assessment for such diagnoses.	
46.	Incarcerated individual relayed concerns about a job termination.	The OCO spoke with DOC about this concern and confirmed that the individual was unassigned from the job, not terminated, meaning that they will not get the job back but also will not lose any earned time for failing to program.	Information Provided
47.	Person reports that in a previous OCO case, this office identified an error with his legal financial obligation (LFO) payments and negotiated with DOC to get the money refunded from the county court. Those funds were supposed to be applied to another outstanding debt. However, the money was added to his spendable account instead of being applied to his Prison Litigation Reform Act (PLRA).	The OCO contacted DOC about this concern, and DOC staff confirmed a mistake was made and the money from the county court was not applied to his outstanding PLRA. When the funds were received, they went directly to his spendable account and were spent. The OCO provided information about how to contact the accounting department at DOC headquarters for any other questions related to banking.	Information Provided
48.	Incarcerated individual shared concerns regarding DOC staff not providing them with their preferred treatment.	The OCO provided information regarding their requested treatment. This office was informed that there is no clinical indication for the requested treatment. After speaking with DOC staff, this office was made aware that this individual has not been going to their scheduled appointments.	Information Provided
49.	The incarcerated individual reports that he receives insulin shots four times per day, and when the facility was locked down recently, he was only given one of his shots, seven hours late.	The OCO substantiated that this person only received one of their four insulin shots during a time the facility was locked down, and a medication incident report was documented. The DOC resolutions department also confirmed this medication error with the incarcerated person in writing. The OCO provided the individual with technical assistance regarding how to file a tort claim.	Information Provided
50.	Incarcerated individual relayed concerns regarding DOC not properly addressing their medical concerns.	The OCO contacted DOC about this concern and confirmed that the individual has seen medical several times for various different issues resulting in DOC informing the individual to eat healthy with plenty of fiber.	Information Provided
51.	Incarcerated individual shared concerns regarding DOC not following the proper Administrative Segregation (Ad Seg) policy and not giving them an Ad Seg hearing.	The OCO was unable to substantiate the concern due to insufficient evidence. After review of DOC records, this office was able to confirm that this individual had numerous Ad Seg hearings and was present at all the hearings.	Insufficient Evidence to Substantiate
52.	Person reported concern about his facility placement and an infraction. Person said that the infraction was unfair and that he should be at a lower custody level.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed this individual's custody facility plan and found that this individual was moved to a different facility. The OCO reviewed the infraction and brought it to facility leadership, who reviewed it and declined to dismiss the infraction. The OCO could not find that DOC violated DOC policy 300.380 or DOC policy 460.000.	No Violation of Policy
53.	Incarcerated individual relayed concerns about an infraction, specifically that a	The OCO reviewed the infraction materials and confirmed that a secondary search report was provided as a revision for correcting the placement of where the items were	No Violation of Policy

	second search report was given and they were not allowed to call witnesses.	specifically found, and the individual was able to have witness statements from the officers who wrote the search reports to clarify this. The OCO found no violation of DOC policy 460.000 as regardless of if the search report stated the item was in the individual's locker or in the common area, the individual would be found guilty as one is having it in their own possession and the other is a cell tag, both can result equally in guilt.	
54.	Incarcerated individual relayed concerns about an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as a confidential informant statement and phone call recordings indicated the individual was conspiring to bring in drugs.	No Violation of Policy
55.	Person reported receiving three infractions. They claimed that they are getting infractions in retaliation for filing resolution requests.	The OCO reviewed this concern and found that the three infractions occurred at three different prisons, each involving a separate incident. In all three incidents, there was some evidence to support the finding of guilt. The OCO cannot find a violation of DOC policy 460.000.	No Violation of Policy
56.	Individual reports they were assaulted when they arrived at a facility after they had told DOC staff at intake that they had safety issues.	The OCO reviewed this concern and confirmed this individual was assaulted by multiple incarcerated individuals when he arrived at a facility. After that happened, he was sent to a safe harbor facility. The DOC does not currently have an active policy on safe harbor housing and the process to move someone into safe harbor is based on verifiable information.	Substantiated
Mission Creek Corrections Center for Women			
57.	Person stated that she has a food allergy but does not want to do the allergy test.	The OCO provided information about the special diet protocol. The OCO reviewed this individual's resolutions request and the special diet protocol, which requires an allergy test for the food allergy diet. The OCO encouraged this individual to talk to her provider about other options.	Information Provided
Monroe Correctional Complex			
58.	External person reported that this individual was infracted for a broken screen on their tablet, even though they dropped it on accident.	The OCO reviewed the infraction report and verified the person was found guilty. The OCO contacted DOC Headquarters to challenge that the infraction met the “some evidence” standard. This office verified that the person had turned it into staff immediately and has always maintained it was broken on accident. The infraction was dismissed by the DOC.	Assistance Provided
59.	Person reported concerns regarding the time he has waited to receive surgery. The person requested that OCO verify his surgery is scheduled.	The OCO provided assistance. OCO staff reviewed the person's consultations and confirmed the surgery is scheduled in the near future. OCO cannot share appointment dates with patients.	Assistance Provided
60.	Patient reports concerns about not receiving additional neuro testing recommended by his specialist and approved in 2023.	The OCO provided assistance by elevating this concern through DOC health services leadership. After outreach, the OCO confirmed the additional testing was approved and has been scheduled. This case was added to the OCO's appointment tracker to confirm the appointment occurs.	Assistance Provided
61.	Person reports that he qualifies for a substance use program but has not been	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff contacted the DOC	DOC Resolved

	afforded access. The person is requesting to be able to start the program sooner than he is being told he will.	Health Services staff and were informed the patient was started in the program.	
62.	Person reports his infraction was overturned but he still lost his job, 5 classification points and DOC did not give him the 100 days he was supposed get through the review.	The OCO reviewed this individual's recent custody facility plan (CFP) and he was given back his classification points and the 100 days. He is currently employed at a new job.	DOC Resolved
63.	Person reports having seen the pain management specialist who recommended a specific medication that was denied by the Care Review Committee (CRC). The person requested assistance in getting the medication approved.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff reviewed the person's consultations and contacted DOC health services staff. OCO staff were informed that while the Care Review Committee had denied the medication initially, an additional internal specialist was contacted to review the request. The patient informed this office that they had started the medication.	DOC Resolved
64.	Incarcerated individual relayed concerns about the ADA cells in the IMU at Monroe still not having TVs.	The OCO spoke to DOC about this concern and confirmed that the work orders have yet to be completed due to short staffing.	Information Provided
65.	Incarcerated individual relayed concerns regarding being sexually assaulted and being denied the ability to file a PREA report by staff.	The OCO spoke to DOC about this concern and confirmed an incident report (IMRS) was entered for this situation and it was determined that the allegation did not meet the definition of sexual abuse/harassment and was sent back to the facility to address. The OCO informed the individual they do not have to report PREAs through staff, as individuals can use the PREA hotline or outside agency reporting forms.	Information Provided
66.	Patient reports concerns about cancer related surgery being rescheduled multiple times and not receiving pre-surgery prep ordered by the surgeon.	The OCO elevated this concern through DOC health services leadership and verified the patient was rescheduled and received the surgery prior to OCO outreach. The OCO confirmed the procedure was rescheduled and substantiated delayed appointments due to DOC transport errors. The OCO provided information to the patient about resolution pathways if future concerns arise, since there is no record of the individual reporting his concerns through the DOC resolution program.	Information Provided
67.	Incarcerated individual relayed concerns about not getting access to their legal property while in IMU.	The OCO spoke to DOC about this concern and were in the midst of working with DOC staff to get the individual their legal property when they were transferred. The OCO informed the individual, if they are still having difficulties getting their legal property at their new facility, to contact the OCO.	Information Provided
68.	Incarcerated individual relayed concerns regarding difficulty getting replacement CPAP masks and DOC stating they ordered extras but cannot find them now that the individual needs them.	The OCO spoke to DOC about this concern and confirmed that it is unknown where the previously ordered masks went. However, new masks have been ordered, and staff will keep them in their possession and be accountable for them.	Information Provided
69.	Incarcerated individual relayed concerns about being placed in close custody despite scoring medium.	The OCO spoke to DOC about this concern and confirmed that due to the individual's safe harbor status, the placement options were very limited and the individual was unwilling to go to that particular facility.	Information Provided

70.	Incarcerated individual shared concerns regarding DOC not providing them with a new medical hat and taking a hat their family sent in.	The OCO provided information regarding how this individual can receive a new hat. After reviewing DOC records and speaking with DOC staff, this office was able to confirm that this individual attempted to receive a hat from a non-DOC issued source which is not allowable except for certain circumstances. DOC staff also offered this individual alternative options for hats and care for their concern.	Information Provided
71.	Incarcerated individual relayed concerns regarding a PREA concern that they were not allowed to report.	The OCO contacted DOC regarding this concern and confirmed that the allegation was reported and determined to not be opened for investigation, but an incident report (IMRS) was created for this.	Information Provided
72.	Incarcerated individual relayed concerns regarding their time not being calculated correctly.	The OCO reviewed the related resolution request and confirmed that DOC records verified the individual's earned release date (ERD) and it is correct.	Information Provided
73.	Incarcerated person requested the OCO assist in having a criminal investigation re-opened. The person reported DOC is retaliating against him for trying to have the investigation re-opened.	The OCO provided information about who has authority to re-open criminal investigations. The OCO reviewed the person's file and was unable to substantiate any retaliation for requesting this investigation be re-opened. Re-opening a criminal investigation is not a decision the DOC or OCO can make. The OCO provided ways to request the entity re-open the investigation.	Information Provided
74.	Incarcerated individual shared concerns regarding DOC wrongfully infracting him upon return from an off-site hospital visit.	The OCO was unable to substantiate the concern due to insufficient evidence. After review of DOC records, this office was able to confirm that this individual was discharged from the hospital and there was no clinical indication stating they needed to stay. Following this, DOC staff infracted this individual due to their failure to follow directives at the off-site visit.	Insufficient Evidence to Substantiate
75.	Individual reports they have no access to the grievance program, and he was told he did not need access because he could send a kite to his medical provider. Person says he would send a kite to his provider and their supervisor, but still receive no response.	Th OCO verified that this individual has been banned from the grievance program due to abuse of the program. This office contacted medical staff regarding kite responses and the DOC shared that they do respond to this individual, however this individual will send multiple kites to multiple staff members at one time. The OCO was able to review multiple kites and verify that they had been responded to by different staff members.	Insufficient Evidence to Substantiate
76.	Incarcerated individual shared concerns regarding DOC failing to provide adequate medical care for their back and blocking their ability to review their medical records.	The OCO was unable to substantiate the concern due to insufficient evidence. After reviewing DOC records and speaking with DOC staff, this office was able to confirm that this individual has been actively working with medical staff to take care of their concern. This office was informed that there is no clinical indication for the requested treatment, but numerous alternatives have been provided to them. DOC records also indicate that this individual has been provided with their medical records.	Insufficient Evidence to Substantiate
77.	Incarcerated individual shared concerns regarding DOC staff opening their legal mail without them present on purpose.	The OCO was unable to substantiate the concern due to insufficient evidence. After review of DOC records, this office was able to confirm that DOC staff incorrectly opened their legal mail but DOC staff adequately followed the protocol outlined within DOC policy 450.100 for these	Insufficient Evidence to Substantiate

		situations. There is insufficient evidence to substantiate purposeful staff misconduct.	
78.	Person reports that he was supposed to receive medication as part of his mental health treatment plan. The person stated that the needed assessment has been delayed by DOC staff, preventing him from receiving the entire treatment plan.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff reviewed the person's medical records and verified that DOC staff were performing a psychiatric assessment, however they were unable to complete the assessment in a single session and follow ups were scheduled to complete the assessment. DOC staff must provide sufficient time for the patient to answer the questions which may result in more than one appointment being needed to complete the assessment. The OCO did not substantiate that the delay was caused by DOC staff actions.	Insufficient Evidence to Substantiate
79.	An incarcerated person reported a concern related to the behavior of a DOC staff member. They reported that they were told to stop contacting their victim.	The OCO reviewed this concern and there was no violation of policy or staff misconduct found. Per DOC 450.050 an individual's contact with specific persons will be restricted or prohibited when the individuals Judgment and Sentence prohibits contact with the person.	Insufficient Evidence to Substantiate
80.	External person reports that their loved one was denied access to programming that is necessary for his release. The person stated that their loved one has requested reassessment but he is being told he is not eligible for the program.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed the person's records and noted that they were not found to be amenable to treatment, which is a requirement for entry into the program. OCO staff confirmed the person has been reassessed multiple times for eligibility.	No Violation of Policy
81.	Incarcerated individual relayed concerns regarding being held past their release date.	The OCO reviewed the individual's record and confirmed that their housing has been approved and DOC is working on their "offender release plan" (ORP).	No Violation of Policy
82.	Incarcerated individual relayed concerns about an infraction and that DOC did not allow them to submit the item for supplemental testing.	The OCO reviewed the infraction materials and confirmed that DOC did send the pen to the lab for confirmation testing. The OCO found no violation of DOC policy 460.000 as a pen with residue was found in the common area of the cell and tested positive for drugs through a presumptive positive test and confirmation testing from the lab.	No Violation of Policy
83.	Person reports being removed from programming before finishing his last assignment. The person does not believe his removal from the program was correct and is requesting to be reinstated and allowed to finish.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed the person's termination and DOC policy 570.000. OCO staff noted that the termination was carried out within policy and the person was allowed to appeal the termination.	No Violation of Policy
84.	Incarcerated person reported a concern about an infraction.	The OCO reviewed the infraction and requested that DOC dismiss the infraction, DOC was unwilling to dismiss the infraction and said the infraction meets the current criteria to be upheld.	No Violation of Policy
85.	Person reports that he was found guilty of several infractions and now he is being kicked out of medium. He has several safety concerns, has been in protective custody and needs safe harbor. He cannot go to mainline or close custody and is also disabled.	The OCO reviewed this concern and found that he was transferred to a safe harbor with medical access. There is no violation of DOC policy 300.380	No Violation of Policy

86.	Incarcerated individual relayed concerns regarding having their infraction overturned but still being demoted to MAX.	The OCO reviewed the individual's record and found no violation of the individual's placement per DOC policy 300.380 as even though the individual was found not guilty of the infractions, investigative information confirmed the individual sought out safe harbor and then became involved in security threat group (STG) activities.	No Violation of Policy
87.	Incarcerated person reported concerns about an infraction. The person requested the OCO review the infraction and recommend the DOC dismiss it on the basis of the concerns reported.	The OCO was unable to locate a violation of DOC policy after reviewing available evidence. The OCO verified the DOC has evidence to uphold this infraction. The OCO reviewed the concerns and verified DOC issued and upheld the infraction based on the "some evidence" standard in this situation.	No Violation of Policy
88.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
89.	Person reports that he is in a wheelchair due to amputation. He does not feel safe in the restrictive housing unit because he has open wounds and wants an override to medium.	The OCO reviewed this concern and he is now living in close custody with access to medical services. This office could not find a violation of DOC policy 300.380	No Violation of Policy
Olympic Corrections Center			
90.	Incarcerated individual shared concerns regarding DOC staff attempting to block them from accessing the GRE (graduated reentry) pathway.	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 there was a misunderstanding between staff and the individual. DOC staff are actively working to provide this individual with a pathway to GRE.	DOC Resolved
91.	Person reported that he has not gotten a refill of his medication, which was recently approved. Person also stated that he was supposed to get a referral for a specialist, but he has not seen the specialist yet.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and reached out to DOC staff, who confirmed that this individual met with a specialist and has received his medication.	DOC Resolved
Other			
92.	Incarcerated individual shared concerns regarding DOC staff not keeping them up to date on their potential return from out-of-state transfer.	The OCO provided assistance. After the OCO's inquiry, DOC staff shared that they will get in contact with this individual regarding their concern.	Assistance Provided
Reentry Center - Peninsula - Kitsap			
93.	Person reported that he was told he will not be able to move back to his county of origin. He stated that he has no violent crimes and needs to go back to take care of his father.	The OCO provided information regarding how to appeal a release plan denial. Appeals may be submitted within 10 business days of receiving notice of the denied release plan or county of origin determination, including the reason and any additional information to the Assistant Secretary for Reentry at PO Box 41126, Olympia, WA 98504-1126.	Information Provided
Reentry Center - Reynolds - King			
94.	External person reported concerns about an incarcerated person being told they	The OCO provided information regarding the community work crew and the DOC expectations for people at a Reentry Center. The OCO reviewed the concern and	Information Provided

	have to work on a community work crew for no pay.	visited the facility, where we found that the work crew is assigned when a person is not actively programming. The OCO monitored the person's situation and found that he was able to get other programming after one work crew session. He is not on the crew anymore because he is programming. Outside programming can include classes, appointments, interviews, job searches or employment.	
Stafford Creek Corrections Center			
95.	Patient reports concerns about delayed appointments and access to hormone replacement therapy (HRT) and gender affirming care services.	The OCO provided assistance by elevating these concerns through DOC Health Services leadership. After OCO outreach, DOC agreed to schedule the patient to discuss HRT options with a provider and appointments with the Gender Affirming Care specialists. This office added the appointments to the tracker and confirmed the appointments were scheduled and occurred. The OCO also provided information about the DOC Transgender Toolkit.	Assistance Provided
96.	Person reports that he has been without his medical property for a long time due to limited availability of a specialist in the area. The person is requesting assistance in getting his property replaced.	The OCO provided assistance. OCO staff met with DOC staff in multiple parts of DOC Health Services to get a billing issue resolved and the item ordered. OCO staff followed up with DOC staff consistently until the items were delivered to the patient.	Assistance Provided
97.	Patient reports concerns about access to mental health providers and chaplain related to a mental health emergency. The individual also mentioned a new concern about his paycheck. The person requested that the OCO contact DOC immediately and ask for him to be seen by his mental health provider and the chaplain.	The OCO elevated the concerns through DOC health services leadership and also contacted the facility chaplain. The patient's mental health provider was not on site that day, so DOC sent mental health staff to conduct multiple wellness checks with the patient throughout the day. After OCO outreach, the chaplain agreed to meet with the individual the same day, and DOC confirmed the patient was also scheduled to see his mental health provider the next day in office. The OCO also provided information about next steps for addressing paycheck issues with DOC prior to OCO assistance.	Assistance Provided
98.	Patient reports concerns about access to medical records and requested copies of healthcare policies from the OCO to avoid copy costs.	The OCO provided assistance by elevating the concerns through DOC health services leadership. After OCO outreach, DOC agreed to upload the DOC Health Plan and other relevant health services policies and guides to the SecurUs tablets. DOC also agreed to send the patient a care review committee (CRC) appeal form and the OCO provided more information about the CRC appeal process and DOC records requests.	Assistance Provided
99.	Person reported that he is diabetic but was taken off of the diabetic diet because he is not insulin dependent.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records, including resolution requests and this individual's dietary records, and found that he was put back on the diabetic diet. The OCO is continuing to review systemic concerns about special diets.	DOC Resolved
100.	Incarcerated individual relayed concerns regarding the kitchen not being able to accommodate their health status report (HSR) but they state they got the HSR at the kitchen manager's recommendation.	The OCO reviewed the individual's HSR and spoke to DOC about this concern, the OCO confirmed that the kitchen is unable to accommodate the individual's HSR due to the requirements and they must find an alternative job.	Information Provided

101.	Incarcerated individual shared concerns regarding DOC not honoring their lower tier and lower bunk (lower/lower) HSR (Health Status Report).	The OCO provided information to the individual as to why it took DOC an extended period of time to provide them with adequate accommodation. The OCO was able to confirm that this individual has been properly accommodated per their HSR. Currently within DOC, there is an excess of individuals that require a lower/lower HSR but there is a lack of adequate space to house these individuals.	Information Provided
102.	Incarcerated individual shared concerns regarding their hobby permit being permanently revoked.	The OCO provided information regarding why their permit was permanently revoked. After speaking with DOC staff and reviewing DOC records, this office was able to confirm that this individual violated their J&S (judgement and sentence) conditions with the hobby craft. This office verified that DOC staff revoked their permit. This office also provided information regarding how they can potentially obtain their permit via an appeal.	Information Provided
103.	Person reports he was given medication and other items by an outside specialist that were confiscated from him when he returned to the facility. He was told that he needed a Health Status Report and medical order for those items, but he has not been updated on the status of those orders.	The OCO provided information to the person regarding the necessary approvals required by the DOC Health Plan. Per the DOC Health Plan, it is the responsibility of the patient's primary care practitioner to evaluate the appropriateness and necessity of the recommendations in light of the patient's overall health care while considering the WA DOC Health Plan, DOC policy, and any other pertinent factor.	Information Provided
104.	Person reported that changes were made to a cultural event that excluded multiple members of that group, without their input. The person states they feel they were put in danger by the way DOC made these changes and is requesting a single cell due to the anxiety it caused.	OCO provided information to the person regarding the changes made to the cultural event changes. OCO staff reviewed DOC memos, related policy, and the person's resolution requests. OCO staff noted that DOC followed the process set in a DOC memo regarding changes to community events. OCO staff noted that the person has not had a single cell review in several years. OCO staff also provided information to the person regarding the steps to request a single cell review through classification and how to request a single cell recommendation from Health Services.	Information Provided
105.	An external person reported concerns about their loved one being denied for the Graduated Reentry Program (GRE).	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the incarcerated person's file and found DOC determined no lower levels of custody can be approved, due to community concerns. DOC can override a person's custody level per DOC policy 300.380.	No Violation of Policy
106.	Person reports they received an infraction for failure to produce during a urinary analysis (UA). They shared that they have a medical reason for failing to provide, and they were issued a health status report (HSR) after the fact.	The OCO could not find a violation of DOC policy 460.000. The individual did not have an HSR at the time of the infraction, and they were unable to provide a urine sample for the UA within the one-hour timeframe.	No Violation of Policy
107.	Incarcerated individual shared concerns regarding DOC denying their magazine order despite providing it to other individuals.	The OCO was unable to substantiate a violation of policy by DOC. DOC 450.100 provides the outline for mail that is both authorized and unauthorized. The mail requested by this individual directly violates guidelines provided by DOC.	No Violation of Policy

108.	This person reports that he was given a negative behavior observation entry (BOE) for something he did not do.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the BOE and confirmed that the individual was provided access to appeal the BOE and the appeal was given to DOC staff. DOC policy 300.010 states, "Individuals may challenge the content in a BOE by submitting a written request identifying the information the individual believes to be inaccurate/incomplete.... The CPM/CCS will make the final determination concerning content in a BOE and whether it will be updated, deleted, or remain the same." DOC staff chose to uphold the BOE, and that decision is within policy.	No Violation of Policy
109.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
110.	Incarcerated individual shared concerns regarding their mail being incorrectly rejected.	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 the mail violated DOC policy 450.100.	No Violation of Policy
111.	Incarcerated individual relayed concerns about an infraction and a PREA investigation.	The OCO reviewed the infraction materials and the PREA investigation. The OCO confirmed that the PREA was deemed unsubstantiated. The OCO found no violation of DOC policy 460.000 as there was evidence showing the individual was involved in a fight with a weapon.	No Violation of Policy
112.	Incarcerated individual relayed concerns about getting an infraction and feeling like they did not get a fair hearing because the person who handled the appeal was involved in the investigation.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual engaged in a fight and refused officer's orders. The OCO informed the individual that DOC policy 460.000(II)(D) states the hearing officer must be impartial and not have any personal involvement in the violation being considered but is silent on the appeal reviewer’s impartiality.	No Violation of Policy
113.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
114.	Incarcerated individual relayed concerns about an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual allowed another individual to be in their cell.	No Violation of Policy
115.	Incarcerated individual shared concerns regarding DOC staff not providing them with their tablet.	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 infracted for utilizing their tablet for prohibited purposes. Their tablet was initially taken per DOC policy 460.050. The tablet was then deemed unsafe for reissue by DOC staff, and this individual must buy a new tablet.	No Violation of Policy
Washington Corrections Center			
116.	Incarcerated individual relayed concerns about not having tablet access.	The OCO continuously elevated this concern to various DOC staff members and confirmed the individual has received their tablet.	Assistance Provided
117.	External person reported concerns regarding the incarcerated individual's infractions, the appeal going unaddressed, and the impact the	The OCO contacted the DOC about this concern, and DOC confirmed there was a delay in processing the appeal due to a staffing shortage. DOC reviewed and overturned one infraction, including the sanctions, which ultimately made	DOC Resolved

	sanctions were having on this person's earned release date (ERD).	this person's ERD sooner than what it was changed to after the original sanctions were applied.	
118.	External person reported concerns regarding the incarcerated individual's infractions, the appeal going unaddressed, and the impact the sanctions were having on this person's earned release date (ERD).	The OCO contacted the DOC about this concern, and DOC confirmed there was a delay in processing the appeal due to a staffing shortage. DOC reviewed and overturned one infraction, including the sanctions, which ultimately made this person's ERD sooner than what it was changed to after the original sanctions were applied.	DOC Resolved
119.	Incarcerated individual relayed concerns about being in IMU and not being able to get their property.	The OCO reviewed the individual's placement and confirmed that they have been released from IMU and should have access to all their property again.	DOC Resolved
120.	Incarcerated individual shared concerns regarding DOC staff not exchanging their linens for an extended period of time.	DOC staff resolved this concern prior to the OCO taking action on this complaint. After speaking with DOC staff, DOC staff shared that when they were made aware of the concern internally, they immediately took action to correct the error prior to the OCO's outreach.	DOC Resolved
121.	Incarcerated individual relayed concerns about being level 1 only due to violent infractions but state the infractions are not violent.	The OCO reviewed the individual's record and confirmed the individual has released from IMU.	DOC Resolved
122.	The individual reports that he is back in prison due to a community custody revocation and was never found guilty of absconding for a certain number of days. After he was found not guilty, his records were not updated to reflect that he should not have lost those days.	The OCO provided this individual with information encouraging him to contact the community corrections officer who was supervising him at that time and asking them to update the records in his electronic file.	Information Provided
123.	The incarcerated individual reported that the linens in his unit had not been swapped for clean ones in over three weeks.	The OCO contacted the facility about this concern. DOC staff confirmed that the most recent linen change in that unit had occurred two days prior to OCO outreach and pointed out that sometimes individuals miss linen exchange because they are on a callout or programming. DOC staff report that if an individual misses linen exchange, they can communicate this information to DOC staff, and DOC will do their best to accommodate an off-cycle exchange if supplies are available.	Information Provided
124.	Person reports that she has been getting sexually harassed.	The OCO reviewed this concern and found there were no resolution requests on file for any of the concerns reported nor a filed PREA. The OCO provided information on how to file a PREA.	Information Provided
125.	Incarcerated individual relayed concerns regarding a potential transfer due to safety reasons.	The OCO contacted DOC about this concern and confirmed that the individual's safety concerns were only validated at the facility level and not at any other facilities. The OCO informed the individual that if they have concerns at their new facility, they will need to reach out to the local IIU and have those concerns validated there.	Information Provided
126.	Person reports multiple delays in medical appointments and a lack of accommodations for a progressive disability. The person requested information on how to report a care	The OCO provided information to the person. Licensure complaints involving medical providers are investigated by the Department of Health, Washington Medical Commission or Nursing board depending on the provider license type. HIPPA complaints are investigated by the	Information Provided

	provider to their licensing board and information on filing a HIPAA complaint.	U.S. Department of Health and Human Services. OCO staff provided specific contact information for those entities to the person, as requested. OCO staff verified the person received the requested accommodation.	
127.	Incarcerated individual shared concerns regarding DOC staff taking them off of a medication they require.	The OCO provided information regarding why they were taken off of their desired medication. After speaking with DOC staff and reviewing DOC records, this office was able to confirm that DOC medical staff deemed this individual has improved to a point where they no longer require the medication. Further review indicated that this individual wished to get off of certain medications.	Information Provided
128.	Incarcerated individual relayed concerns about being in IMU for several years due to security threat group (STG) activity but wanting to debrief.	The OCO spoke to DOC about this concern and confirmed that DOC did speak with the individual who committed to stopping all STG behaviors resulting in DOC recommending they be placed back in a safe harbor facility.	Information Provided
129.	Incarcerated individual shared concerns regarding DOC staff retaliating against them by wrongfully infracting them and not giving them a proper hearing.	The OCO was unable to substantiate the concern due to insufficient evidence. After review of DOC records, this office was able to confirm that this individual did receive a hearing for their infraction but were removed due to disruptive conduct. Further review indicates that this individual failed to appeal the infraction.	Insufficient Evidence to Substantiate
130.	Incarcerated individual shared concerns regarding DOC staff failing to adequately investigate their resolution requests.	The OCO was unable to substantiate the concern due to insufficient evidence. After review of DOC records, this office was able to confirm that this individual's resolution requests have been investigated when appropriate or as requested.	Insufficient Evidence to Substantiate
131.	Incarcerated individual relayed concerns about a facility keep separate impacting their placement.	The OCO reviewed the related materials and confirmed that DOC placed them in appropriate housing based on their needs.	No Violation of Policy
132.	Incarcerated individual relayed concerns about an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual was supposed to be working but was working out instead, in addition to ongoing difficulties with the individual's work performance as evidenced by behavior observation entries (BOEs) and general infractions.	No Violation of Policy
133.	Incarcerated individual relayed concerns about extended placement in IMU despite completing all the programs DOC officers while on a MAX plan.	The OCO reviewed the individual's custody facility plan (CFP) and found no violation of DOC policy 300.380 as the individual was originally put on a MAX plan in June 2023 due to staff assaults but have continued to incur serious infractions while on MAX custody resulting in getting another MAX plan.	No Violation of Policy
134.	Incarcerated individual relayed concerns about wanting to get the community parenting alternative (CPA) program or a lower custody level.	The OCO reviewed the individual's custody facility plan (CFP) and found no violation of DOC policy 300.380 as their CFP is complete and DOC decided that they cannot go to lower levels without headquarters approval due to their crime of conviction.	No Violation of Policy
135.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as a cell search resulted in the finding of drugs on the individual's assigned bunk.	No Violation of Policy

136.	Incarcerated individual relayed concerns about getting an infraction for a failure to provide a urinary analysis (UA), but state DOC did not give them a full hour.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual had a full hour to do the UA and was unable to provide the UA.	No Violation of Policy
137.	Incarcerated individual shared concerns regarding DOC staff targeting them by forcing them to condense their property including their legal property.	The OCO was unable to substantiate a violation of policy by DOC. After review of DOC records, the OCO was unable to confirm that this individual was targeted as DOC staff had directed the whole unit to condense property in compliance with DOC policy 440.000. This individual also had no open court cases and did not receive approval to have excessive legal property and was directed to condense their legal property in accordance with DOC 590.500.	No Violation of Policy
Washington Corrections Center for Women			
138.	Incarcerated individual shared concerns regarding DOC staff limiting their access to legal counsel.	OCO contacted the facility regarding legal access. The individual was able to plan a legal call with her attorney.	Assistance Provided
139.	Incarcerated individual reports that she was placed in segregation for a positive urine analysis (UA) and lost her job due to this incident. She also reported that some of her property went missing when she was transferred to segregation.	The OCO verified that this individual did not receive an infraction because the UA results were negative. However, this person was not given their old job back. The OCO spoke with DOC staff about this concern and were told that there were delays in job assignments due to staffing shortages. DOC staff arranged for this individual to get a job and the OCO confirmed she is working now. DOC staff also looked into the missing property and verified that the property matrix had items no longer in her possession. These items could not be located and she was provided with information about how to file a tort claim with the Department of Enterprise Services (DES).	Assistance Provided
140.	External person reports concerns on behalf of an incarcerated individual related to DOC's documentation of a mental health emergency that occurred.	The OCO reviewed all related incident reports and mental health records related to the mental health emergency. Since the incident occurred several years ago, the OCO was unable to obtain video footage, however, was able to review all incident reports. The OCO provided information about the investigation findings directly to the incarcerated individual. This office also provided information about releases of information (ROIs) and mental health record access, public record limitations related to incident reports, and process for accessing DOC records. The OCO followed up with the incarcerated individual and opened separate cases related to active concerns.	Information Provided
141.	External person reports concerns on behalf of an incarcerated individual related to staff conduct, specifically staff giving false and confidential information to the press about incarcerated transgender individuals at WCCW.	The OCO substantiated the media article exists, however, does not have jurisdiction over media outlets and their publications. The OCO could not identify new evidence or the particular staff member in order to follow up on a staff conduct investigation. The OCO is currently monitoring and reporting concerns related to the Disability Rights Washington (DRW) transgender settlement agreement.	Information Provided

142.	The individual reports that DOC is not engaging in release planning, despite her upcoming release date.	The OCO provided information regarding resources available to this person upon release.	Information Provided
143.	Person reports issues with how the therapeutic community programming is carried out. The person stated that she has been corrected for delays caused by DOC staff and she is concerned that she will be punished for these events. The caller requested that these issues be documented.	The OCO provided information to the person regarding the therapeutic community program. The OCO has documented the reported issue as requested.	Information Provided
144.	Person reports they received an infraction for threatening an anonymous person who is sending them vulgar messages on Securus.	The OCO reviewed this concern and asked the facility to dismiss or reduce the infraction due to the circumstances. This office has identified an anti-trans group that sends multiple anonymous messages to individuals living within this facility. The facility has refused to change the infraction.	Information Provided
145.	Incarcerated individual reports that part of their proposal for a Juneteenth event was not approved, and the unspent money was given to another cultural group. This person says that the black cultural group at WCCW do not get the same respect that other cultural groups receive.	The OCO was unable to substantiate the concern due to insufficient evidence. July 1, 2024 was the beginning of the new fiscal year, and the extra funds that had been appropriated to the black cultural group went back into DOC's budget, making them no longer available.	Insufficient Evidence to Substantiate
146.	Incarcerated individual relayed concerns about an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual was in an area they did not have permission to be in and previously received a negative behavior observation entry (BOE) for this same thing.	No Violation of Policy
Washington State Penitentiary			
147.	A loved one reported that an incarcerated individual is being targeted, was assaulted, and has not received care for their injuries. They wanted this individual to be transferred to a safer facility.	The OCO provided assistance. The OCO reached out to DOC staff about this individual’s injuries, and they were then scheduled for and received follow-up care. The OCO reviewed video of the incident and spoke with DOC staff about the incident and ensured that DOC followed policy in responding to this incident. The OCO is continuing to review concerns about this person’s housing and classification in a separate case.	Assistance Provided
148.	External person reported a concern about the power in the unit their incarcerated loved one lives in. The person reported people cannot charge their tablets or heat up water because this has not been addressed.	The OCO provided assistance. The OCO spoke with DOC staff and after outreach, the electrician was able to get the power back on. The OCO was informed that the power outage was due to a practice called "arcing," a way to create fire from the power outlet. When people do this, the power is disrupted until an electrician can turn the power back on. Sometimes power is disrupted multiple times a day due to "arcing."	Assistance Provided
149.	Patient reports concerns about access to supportive insole shoes and mental health treatment.	The OCO provided assistance by elevating this concern through DOC health services leadership and confirmed the shoes were ordered and provided to the patient. After OCO outreach, DOC also scheduled the individual with a mental health provider to discuss treatment options. This	Assistance Provided

		case also helped OCO identify issues within the DME order process and access for patients in solitary confinement, which this office will continue to investigate and attempt to resolve.	
150.	The incarcerated individual reports that he filed an appeal for an infraction he received, and has the appeal receipt but never received a response from DOC. The person also stated that they filed a resolution request about this situation and never received a response from the resolution department either.	The OCO contacted DOC and requested that they resend a copy of his resolution request and a copy of the appeal for his recent infraction. DOC staff agreed and confirmed they resent the requested paperwork to his living unit.	Assistance Provided
151.	Incarcerated individual relayed concerns about infraction sanctions of not being allowed to order store.	The OCO reviewed the individual's record and confirmed that they have since been released from IMU and have had no recent infractions, so any store sanctions should be complete, but informed the individual to contact the OCO if the issue persists.	DOC Resolved
152.	Person reports needing a Health Status Report for a chronic condition so he is not terminated from his education program.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff contacted DOC staff and were informed the Health Status Report was issued.	DOC Resolved
153.	The individual reports that his hotpot was taken because DOC suspected he had drugs in it. The hotpot did not test positive for drugs when it was sent to the lab, and it was never returned to him. The individual reports he “got the run around” from DOC staff and never received a property disposition form regarding the destruction of the hotpot.	The OCO reviewed this individual's resolution requests and verified that he had received a level II response from DOC. The resolution specialist confirmed that DOC policy 444.000 was not followed, and the individual did not receive a property disposition form. The DOC provided this person a tort packet with the level II resolution response.	DOC Resolved
154.	Incarcerated individual shared concerns regarding not being allowed out of their cell for extended periods of time.	The OCO provided information regarding why they were unable to leave their cell for a period of time. After review of DOC records, this office was able to confirm that there was construction going on in the unit which hindered movement for individuals in that unit. Another issue also came up that posed a threat to the security of the individuals and staff which further limited movement. Despite these concerns, DOC staff were able to provide out-of-cell opportunities to individuals when appropriate.	Information Provided
155.	Incarcerated individual relayed concerns regarding not getting a custody facility plan done.	The OCO spoke to DOC about this concern and confirmed that they are currently being held at the facility due to medical issues and will need to be transferred to WCC for a new intake review but until medical closes their hold, they cannot be transferred.	Information Provided
156.	Person reports that he reported PREA but no one investigated it. The person stated that he was told he had to accept a cellmate or he would face an infraction. The person is requesting a single cell assignment.	The OCO provided self-advocacy information to the person. There was insufficient evidence to support that a PREA was reported; OCO staff provided information to the person regarding using the PREA hotline or how to report a PREA concern to DOC staff. OCO staff noted that the person was not filing appeals or rewrites for resolution requests. OCO staff provided information regarding the DOC Resolutions program process and how an individual can participate in the resolution process. OCO staff also provided information to the person regarding how to	Information Provided

		request a single cell recommendation from Health Services providers and a single cell review from Classification.	
157.	Incarcerated individual shared concerns regarding their unit being provided limited opportunities to see medical despite other units having numerous encounters when requested.	The OCO provided information regarding why their unit has limited medical encounters within the week. This office was able to confirm that this procedure is due to safety concerns and that the unit still has access to medications daily and emergency services when required.	Information Provided
158.	Person reports that he has not been given access to programming required for his release. The person also requested information regarding the policy limiting incarcerated people's access to social media.	The OCO provided information. OCO staff reviewed the person's records and provided information regarding DOC's social media and programming limitations.	Information Provided
159.	Person anonymously reported concerns about the kitchen and kitchen workers tampering with food.	The OCO provided information. The OCO conducted a monitoring visit of the kitchen. The OCO met with DOC staff, including facility leadership, about ongoing concerns about the kitchen and kitchen workers. This office is continuing to review systemic concerns about food, both at this facility and statewide.	Information Provided
160.	Person reports safety concerns and says that he has written two statements to the intelligence and investigations unit (IIU), but DOC is not addressing his concerns.	The OCO reviewed this person's records and verified that he is safe. The OCO found no violation of DOC policy 300.380 in the individual's placement and informed the individual that, for their safety concerns to be validated, they must provide all details to the intelligence and investigations so that they can be verified. If this person is given a max program, they can appeal that classification decision to the Superintendent using form DOC 320.250.	Information Provided
161.	Incarcerated individual relayed concerns regarding extended placement in IMU.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed the individual remains in IMU for infraction holds due to recent infractions.	Information Provided
162.	The individual reports that there was a fire in his unit, and all of his property was destroyed. The individual submitted a tort claim and believes that DOC gave bad information to the Department of Enterprise Services (DES) regarding his claim, which is why he is not getting any paperwork about the tort finding.	The OCO contacted the facility about this concern. DOC staff confirmed they have no records or communications regarding a tort claim for this individual. The OCO encouraged this person to continue working with DES and provided their contact information: Office of Risk Management, Department of Enterprise Services, PO Box 41466, Olympia, WA 98504-1466	Information Provided
163.	Person reported that the kitchen is not giving him his medical special diet.	The OCO provided information about recent changes in process with the facility kitchen. The OCO reviewed this individual's resolution requests and found that his concerns were substantiated at the facility level and that the facility reached out to the statewide dietician and received an updated menu for the special diet tailored to the facility. This individual also received a copy of the menu and was told to inform staff when he receives the incorrect items. The OCO spoke with DOC staff, who acknowledged that the kitchen was going through staffing and process changes at the time of this complaint. DOC staff said that Correctional Industries leadership visited the kitchen and implemented an audit process to ensure that the correct food items are going to out to individuals	Information Provided

		with special diet. DOC staff said that they have received less complaints about incorrect items in special diets since implementing the audit, and said they regularly speak with this individual about his concerns. The OCO is continuing to review systemic concerns about special diets.	
164.	Incarcerated individual shared concerns regarding DOC staff taking their photographs before they could view them.	The OCO was unable to substantiate the concern due to insufficient evidence. After speaking with DOC staff and reviewing DOC records, this office was unable to confirm that DOC ever received the alleged photographs.	Insufficient Evidence to Substantiate
165.	Incarcerated individual relayed concerns about an infraction where they did not get a search report.	The OCO spoke to DOC about this concern and confirmed that policy states individuals will be given a copy of the search report, but it has been determined by headquarters that not receiving a copy of the search report is not cause for dismissal as long as the “some evidence” standard is met, which was met in this instance.	No Violation of Policy
166.	Loved one relayed concerns about a delayed infraction appeal response.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as a cell search resulted in finding burnt items and an improvised paper pipe used for drug paraphernalia. WAC 137-28-400 states “the time limitations expressed in these regulations are not jurisdictional and failure to adhere to any particular time limit shall not be grounds for reversal or dismissal of a disciplinary proceeding.”	No Violation of Policy
167.	Incarcerated individual relayed concerns about an infraction and not getting a search report.	The OCO reviewed the infraction materials and confirmed that policy states individuals will be given a copy of the search report, but it has been determined by DOC headquarters that not receiving a copy of the search report is not cause for dismissal as long as the “some evidence” standard is met, which was met in this instance.	No Violation of Policy
168.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as an investigation found that the individual previously introduced narcotics and was attempting to introduce narcotics again as their visitor was intercepted with bundles of drugs.	No Violation of Policy
169.	Incarcerated individual relayed concerns about an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as a loose razor blade was found in the individua's cell.	No Violation of Policy
170.	Incarcerated individual relayed concerns regarding an infraction	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the infraction is a valid cell tag as the Suboxone was found on the base of the TV on the shared cell desk.	No Violation of Policy
171.	Incarcerated individual relayed concerns about a delayed infraction appeal response.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as a cell search resulted in finding burnt items and an improvised paper pipe used for drug paraphernalia. WAC 137-28-400 states “the time limitations expressed in these regulations are not jurisdictional and failure to adhere to any particular time limit shall not be grounds for reversal or dismissal of a disciplinary proceeding.”	No Violation of Policy
172.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as a cell search resulted in	No Violation of Policy

		finding burnt rolled joints below the shared bunks that tested positive for spice and was confirmed by laboratory testing	
Intake Investigations			
Airway Heights Corrections Center			
173.	An incarcerated person reported that an infraction appeal took five months to process and wants the infraction reviewed for possible dismissal based on time frames.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint.	Person Declined OCO Assistance
174.	A loved one reported a concern related to an incarcerated person's eligibility for Drug Offender Sentencing Alternative (DOSA).	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 which are endangering their eligibility for DOSA.	Technical Assistance Provided
175.	An external person reported on their loved one's behalf that during a disciplinary hearing the hearings officer made a biased comment before the recording began.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about appealing an infraction and using the resolution program to address staff conduct concerns.	Technical Assistance Provided
176.	Person reported that DOC is intentionally delaying his infraction hearing to target and harass him and keep him from promoting to work release.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about appealing an infraction.	Technical Assistance Provided
177.	Person reports that he is missing legal documents and the phone numbers to both his attorney and the Social Security Administration are restricted.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program.	Technical Assistance Provided
178.	External person reported that their loved one is being denied treatment for opioid use disorder because his release date is not within two years.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about the Medication Assisted Treatment (MAT) program and filing a resolution request to address the concern.	Technical Assistance Provided
179.	An incarcerated reported a concern related to loss of points due to infractions.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal infractions.	Technical Assistance Provided
180.	Person reported that DOC is not following the law and applying the appropriate earned time credits while he was in the Graduated Reentry (GRE) program.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about records corrections and time calculations.	Technical Assistance Provided
181.	An incarcerated person reported a concern related to the behavior of a DOC staff member or contracted staff member.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to report and escalate their concern internal to DOC.	Technical Assistance Provided
182.	Person reported that DOC did not give him credit for time served on a global	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical	Technical Assistance Provided

	plea agreement. He was only given credit for one cause number.	assistance about records corrections and time calculations.	
183.	Incarcerated individual shared concerns regarding DOC staff not providing them with the proper medical procedure.	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 utilizing the internal administrative processes provided by DOC. This office also provided information regarding steps this individual could take to potentially obtain the medical care they desire.	Technical Assistance Provided
184.	An incarcerated person reported a concern related to legal boxes not transferring with them when DOC moved them.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to utilize the resolution program.	Technical Assistance Provided
185.	Person reported that a DOC staff member made the individual do a strip search without any reason.	The OCO provided technical assistance about filing a PREA concern and a resolution request for staff conduct concerns.	Technical Assistance Provided
186.	Person reported concerns about how DOC handled money that was sent to him from his family members.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program and provided banking information.	Technical Assistance Provided
187.	Person who has a life without parole sentence reported they would like to get a job with Correctional Industries (CI).	The OCO provided technical assistance about the DOC policy change process.	Technical Assistance Provided
188.	Person slipped coming off his bunk and messed up his shoulder. This individual is requesting a lower bunk health status report (HSR) until his shoulder heals.	The OCO confirmed this individual submitted a resolution request regarding this concern. DOC responded and gave him the next steps to follow up with his provider, as health services staff had written a report regarding this incident. The OCO provided technical assistance regarding HSRs.	Technical Assistance Provided
Clallam Bay Corrections Center			
189.	An external person reported that she was terminated from her loved one's visitation list and blocked from communication with him after being questioned by the Intelligence and Investigations Unit (IIU) staff during an investigation.	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 visitation.	Technical Assistance Provided
190.	An incarcerated person reported a concern related to their earned good conduct time.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about custody facility plan (CFP) processes and when DOC will consider recalculating their good conduct time.	Technical Assistance Provided
191.	Person was infracted for coming out of his cell to alert staff that he was having a mental health crisis because the cell he was in does not have an emergency call button.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about appealing an infraction.	Technical Assistance Provided
Coyote Ridge Corrections Center			

192.	Incarcerated individual relayed concerns regarding an infraction they pled guilty to.	The OCO declined to investigate the concern per WAC 138-10-040(3)(g) as the individual admitted guilt to the infraction.	Declined
193.	Person is requesting assistance to obtain diabetic glucose meter or pro bono council.	The OCO followed up with this person, asking for clarity about this concern, and he reported that it is not what he said. The incarcerated individual advised the OCO that he did not want the OCO to investigate the complaint. However, he did have a new concern that the OCO opened.	Person Declined OCO Assistance
194.	Individual reports concerns about his safety and mental health status.	The OCO spoke to this individual numerous times and had worked on a previous concern for this person related to the same topic. The incarcerated individual was released prior to the OCO taking action on this complaint.	Person Released from DOC Prior to OCO Action
195.	An external person reported staff conduct concerns on the incarcerated person's behalf. During a recent medical transport, the accompanying DOC officers were rude and made racist and homophobic comments.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about appealing an infraction and using the resolution program to address staff conduct concerns.	Technical Assistance Provided
196.	Person reported that they were served expired food multiple times in a week.	The OCO provided technical assistance about utilizing the resolution program.	Technical Assistance Provided
197.	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.	Technical Assistance Provided
198.	Person reported concerns about DOC staff disclosing his medical and EFV information in front of other staff.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about addressing staff conduct concerns.	Technical Assistance Provided
199.	An incarcerated person reported a concern related to deductions being taken out of his earnings.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about the resolution program.	Technical Assistance Provided
200.	An incarcerated person reported a concern related to DOC staff 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 how to report and escalate their concern using the resolution program.	Technical Assistance Provided
201.	Person reported that money is missing from their commissary account.	The OCO provided technical assistance about the banking process.	Technical Assistance Provided
202.	Person reported concerns regarding DOC staff behavior.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
203.	An incarcerated person reported the behavior of a DOC staff member.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance regarding the resolution program.	Technical Assistance Provided

204.	Person asked for information on how to order new headphones.	The OCO provided technical assistance about utilizing the resolution program and Securus.	Technical Assistance Provided
205.	An incarcerated person reported a concern related to limitations on property being allowed in their cell.	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
206.	Person reported that they are being retaliated against and sexually harassed by a DOC staff member.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided

Monroe Correctional Complex			
207.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and declined to further investigate the concern as the individual admitted to possessing drugs and signed DOC form 14-021 admission of drug possession.	Declined
208.	Individual relayed concerns regarding returning to prison.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
209.	Person reports that DOC medical is not making any effort to diagnose the cause of his pain. The person reported two medical emergencies but has not been given any other tests to figure what is going on. The person requested follow up testing.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
210.	Incarcerated individual shared concerns regarding DOC revoking their release plan after a phone call with another person.	This person was released prior to the OCO taking action on the complaint. This office reviewed the revoked ORP (Offender Release Plan), and DOC had concerns with the initial plan due to their phone call. DOC has the ability to revoke completed ORP's if safety concerns arise.	Person Released from DOC Prior to OCO Action
211.	Person reported that their incarcerated loved one's new release address was denied by DOC because they received an infraction.	The OCO provided technical assistance about appealing an infraction and filing a resolution request for staff conduct concerns.	Technical Assistance Provided
212.	An incarcerated person reported a concern related to a delayed infraction hearing.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about the infraction processes and how to appeal.	Technical Assistance Provided
213.	Individual reports concerns regarding medical billing and transportation costs when he goes to the hospital.	The OCO provided technical assistance regarding DOC banking concerns.	Technical Assistance Provided
214.	Person reported concerns that the facility mailroom is taking a month to process incoming mail and is rejecting mail for sexually explicit content that is not sexually explicit.	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 resolving mail rejections.	Technical Assistance Provided

215.	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 and escalate their concern utilizing the DOC resolution program.	Technical Assistance Provided
216.	An incarcerated person reported a concern related to the behavior of a DOC staff member and property that has been confiscated.	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 and escalate their concern internal to DOC processes.	Technical Assistance Provided
217.	An incarcerated person reported a concern related to DOC staff behavior and mail/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 escalating their concern utilizing the resolution program.	Technical Assistance Provided
218.	Person reported that DOC is rejecting pictures of his girlfriend that are not inappropriate.	The OCO provided technical assistance about resolving mail rejection concerns.	Technical Assistance Provided
Other			
219.	Loved one relayed concerns regarding an individual housed in the Federal Bureau of Prisons	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
220.	Loved one relayed concerns regarding an individual housed in a jail facility.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
221.	Loved one relayed concerns regarding an individual housed in a jail facility.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
222.	Loved one relayed concerns regarding an individual housed in a jail facility.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
223.	Individual relayed concerns regarding community custody.	The OCO was unable to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
224.	Individual relayed concerns regarding access to medication at a Department of Social and Health Services (DSHS) facility.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
225.	Individual relayed concerns regarding a jail facility.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
226.	Individual relayed concerns regarding a jail facility.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
227.	A friend or family member shared concerns about this person being sent back to prison for absconding from supervision.	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
Reentry Center - Wenatchee Valley - Chelan			

228.	An incarcerated person reported a concern regarding DOC policies around reentry.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about DOC policy and RCW change processes.	Technical Assistance Provided
Stafford Creek Corrections Center			
229.	Person reports being held in segregation without any disciplinary reason. The person is requesting a custody override.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint.	Person Declined OCO Assistance
230.	An external person reports that she was removed from her fiancé's visitation list due to a driving infraction which has subsequently impacted their ability to get married.	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 visitation decision.	Technical Assistance Provided
231.	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
232.	An incarcerated person reported concerns related to the behavior of DOC staff members.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to report and escalate their concern internal to DOC.	Technical Assistance Provided
233.	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 appealing Infractions.	Technical Assistance Provided
234.	Person reported that they are not receiving all the digital channels as promised.	The OCO provided technical assistance about the resolution program.	Technical Assistance Provided
235.	Person reported that they received an infraction and are concerned about their classification.	The OCO provided technical assistance about the classification and facility assignment process.	Technical Assistance Provided
236.	An incarcerated person reports a concern related to the behavior of a DOC staff member.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance regarding how to file staff conduct concerns.	Technical Assistance Provided
Washington Corrections Center			
237.	External person reported that DOC staff were rude, disrespectful and unprofessional when they reached out to the facility to make arrangements for their loved one to attend his grandmother's funeral by Zoom. Additionally, their loved one's property is missing.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about property concerns and using the resolution program to address staff conduct concerns.	Technical Assistance Provided
238.	A loved one reported a concern on behalf of the incarcerated individual that they	The OCO provided technical assistance about appealing an infraction.	Technical Assistance Provided

	are being bullied and targeted by DOC staff members.		
239.	Person reported that their loved one is being transferred to another facility in retaliation for a complaint he filed against DOC staff.	The OCO provided technical assistance about appealing an infraction as well as information about the classification and facility assignment process.	Technical Assistance Provided
240.	Person reported that their incarcerated loved one's time calculation is incorrect.	The OCO provided technical assistance about the records process.	Technical Assistance Provided
241.	Person reported on behalf of their incarcerated loved one that they were infracted for not providing a urine analysis sample (UA) in a timely manner due to their health condition.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
242.	Person reports they have not been able to access dental services to obtain dentures.	The OCO provided technical assistance about getting an appointment for dental services.	Technical Assistance Provided
243.	Person reported concerns about not being able to access the law library.	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 accessing legal resources.	Technical Assistance Provided
244.	Person reported that during Ramadan, DOC staff was not preparing their food properly and getting it to them in a timely manner.	The OCO provided technical assistance about the resolution program.	Technical Assistance Provided
245.	Person reported that his release date was changed because of impending infractions, and that it was a records decision, but DOC didn't hold the hearings in a timely manner and isn't following policy by records changing his release date.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about appealing an infraction.	Technical Assistance Provided
246.	Incarcerated individual shared concerns regarding DOC staff mistreating them.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about filing staff misconduct concerns.	Technical Assistance Provided
247.	An incarcerated reached out to the OCO for help regarding 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 appealing infractions.	Technical Assistance Provided
248.	Person reported concerns about needing to replace his shoes. The soles of his current shoes are worn out.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program.	Technical Assistance Provided
249.	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 appealing infractions.	Technical Assistance Provided

250.	Person reported that their time calculations are incorrect.	The OCO provided technical assistance about the records process.	Technical Assistance Provided
251.	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
252.	Person reported that they participated in their religious practice for Ramadan but did not get to attend the feast after the 30 days of fasting.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
253.	Person reported that he was moved to segregation rather than transfer to a reentry center. He was found not guilty of an infraction and does not understand why he is still in segregation.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. This office confirmed that the infraction hearing had not been held yet. The OCO provided technical assistance about appealing an infraction.	Technical Assistance Provided
254.	Person reported that they received an infraction for not being able to provide a urine analysis (UA) sample due to a health condition.	The OCO provided technical assistance about appealing an infraction.	Technical Assistance Provided
Washington Corrections Center for Women			
255.	A loved one shared a concern on behalf of an incarcerated individual regarding staff misconduct.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance
Washington State Penitentiary			
256.	Incarcerated individual relayed concerns regarding potential future actions of a community corrections officer.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
257.	An external person reported that DOC has denied her husband visitation with their daughter and has not provided a consistent reason for the denial.	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 visitation decisions.	Technical Assistance Provided
258.	Person reported that their incarcerated loved one received an infraction for introducing drugs into the facility.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns and appealing an infraction.	Technical Assistance Provided
259.	Person requested information on how to open a pubic records request with the Department of Corrections.	The OCO provided technical assistance about opening a public records request with the Department of Corrections.	Technical Assistance Provided
260.	Person reported concerns about his safety and that although DOC is aware of those concerns, they continue to house him in an active gang unit where he is not safe. He was told that his only option to stay out of a maximum security unit is to stay in the active gang unit.	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 classification and facility plan.	Technical Assistance Provided
261.	An incarcerated person reported a concern regarding an issue with property	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical	Technical Assistance Provided

	being damaged when they were moved by DOC from one facility to another.	assistance about rules related to property and how to escalate concerns through the resolution program internal to DOC.	
262.	Person reported that a DOC hearings officer has been handing out excessive sanctions.	The OCO provided technical assistance about appealing an infraction.	Technical Assistance Provided
263.	Incarcerated person had questions about DOC classification processes, DOC policy and other DOC protocols.	The OCO provided technical assistance over the OCO confidential hotline. The OCO answered the persons questions and provided DOC policy information to them at the time of the call.	Technical Assistance Provided
264.	An Incarcerated person reported a concern related to property being stolen and wanting to file a tort claim.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to follow the instructions already provided to them by DOC.	Technical Assistance Provided
265.	Person reported that their mail was copied and delivered in black and white when it originally came in color.	The OCO provided technical assistance about utilizing the resolution process.	Technical Assistance Provided
266.	Person reported that they believe DOC staff is trying to get them fired from their job.	The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	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-24-016

Report to the Legislature

As required by RCW 72.09.770

April 21, 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-24-016 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on April 3, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Patricia Paterson, Chief of Nursing
- Dr. Rae Simpson, Director – Quality Systems
- 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: 1986 (38-years-old)

Date of Incarceration: October 2018

Date of Death: September 2024

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

His cause of death was methamphetamine toxicity. The manner of his death was accident.

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

Day of Death	Event
0457 hours	• The incarcerated individual exited his cell. • Officers observed him acting erratically (off his baseline) and sweating profusely. He stated he had a "really hard leg day" workout. • He agreed to see medical, and a radio call was made for medical to come to the unit.
0504 hours - 0545 hours	• The nurse examines him briefly and determines he needs to go to Health Services (HS) for further evaluation. • After completing the evaluation, a report is phoned to the on-call provider who was on the way to the facility. • The provider ordered IV fluids and repeat vital signs.
0546 hours - 0606 hours	• Nurse continues to provide treatment. • The incarcerated individual's level of consciousness declined, and additional care was provided including Narcan administration and oxygen therapy.
0607 hours - 0618 hours	• The on-call provider arrived in HS. • He continued to decline and lost consciousness. • Community EMS called. • AED requested to treatment room.
0619 hours	• The incarcerated individual became pulseless, and CPR initiated.
0624 hours	• Community EMS arrived and assumed care.
0657 hours	• EMS pronounced time of death.

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 did not disclose he had ingested large amounts of methamphetamine.

        b. Nursing staff did not recognize his level of intoxication was life-threatening until he became non-responsive.

        c. Community EMS request was not made until his condition deteriorated.

        d. There is not a nursing protocol for suspected stimulant intoxication.

    2. The committee recommended:

        a. Nursing leadership review and update protocols and forms to include stimulant intoxication and guidelines for clinical instability.

        b. Facility leaders conduct drills and post-action emergency response debriefs to improve communication including the process of obtaining and interacting with community EMS.

B. Independent of the mortality review, the DOC conducted a critical incident review (CIR) to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operational procedures. The CIR did not identify factors within the scope of the critical incident review that contributed to the death of this individual. No recommendations were identified to prevent a similar fatality in the future.

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

    1. Contraband management in DOC facilities:

        a. Contraband reduction is part of DOC's strategic plan. The presence of contraband, including illegal drugs, leads to a less safe environment for those in our custody and staff.

        b. The Department takes a multipronged approach to prevent contraband, for example; education for staff and incarcerated individuals, substance use treatment, support programs, security inspections, and searches (electronic, incoming mail, pat, canine).

2. Status of DOC's plan to expand the addiction medicine program and availability of medication for opioid use disorder (MOUD) treatment:

    a. The state budget has not been finalized. DOC is continuing to move forward to align policy and protocol for more effective utilization of existing resources and optimize available treatment.

3. Processes in place to aid in the prevention of overdose deaths in DOC facilities:

    a. Launch of an interagency Fentanyl taskforce.

    b. Screen all individuals are for substance use during intake.

    c. Offer evidence-based programming and treatment to assist individuals to maintain their sobriety.

Committee Findings

The incarcerated individual died as a result of methamphetamine toxicity. His manner of death was accident.

Committee Recommendations

Table 1 presents the UFR Committee's recommendations to prevent similar fatalities and further strengthen safety and health protections for incarcerated individuals. As required, the DOC will develop, publish, and implement an associated corrective action plan within 10 days following the publishing of this report.

Table 1. ***UFR Committee Recommendations***
1. DOC Health Services should review and update nursing protocols and forms to include stimulant intoxication and guidelines for clinical instability.

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

1. DOC should explore ways to improve communication during a medical emergency including the process of obtaining and interacting with community EMS.

Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-24- 016

Report to the Legislature

As required by RCW 72.09.770

May 1, 2025

DOC Corrective Action, Publication Number 600-PL001

Tim Lang, Secretary
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Unexpected Fatality Review
DOC Corrective Action Plan

DOC Corrective Action Publication Number 600-PL001

Legislative Directive

Engrossed Substitute Senate Bill 5119 (2021)

Unexpected Fatality Review Governance

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

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

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

Unexpected Fatality Review Committee Report

The department issued the UFR Committee report 24-016 on April 21, 2025 (DOC publication 600-SR001). This document includes the required corrective action plan. The department is required to implement the corrective actions within 120 days from the corrective action plan publication.

Corrective Action Plan

CAP ID Number:	UFR-24-016-1a
Finding:	A request for community EMS was not initiated before the incarcerated individual became non-responsive, resulting in delayed critical intervention.
Root Cause:	The evaluating nurse did not recognize the incarcerated individual's level of intoxication was life-threatening, leading to failure to escalate care in a timely manner.
Recommendations:	The Department of Corrections (DOC) Health Services should: 1. Review and update nursing protocols and forms to include the identification of stimulant intoxication symptoms.
Corrective Action:	The Department of Corrections (DOC) Health Services will: 1. Review and update nursing protocols and forms to include signs stimulant intoxication, along with specific guidelines for identifying clinical instability. 2. Implement mandatory training programs for all nursing staff focused on the updated protocols, emphasizing the importance of timely EMS requests in critical situations.
Expected Outcome:	1. DOC nursing staff will develop improved clinical skills, enabling them to recognize and respond to life-threatening intoxication promptly. 2. Enhanced quality of care for incarcerated individuals, including timely escalation and intervention in critical cases.

CAP ID Number:	UFR-24-016-1b
Finding:	A request for community EMS was not initiated before the incarcerated individual became non-responsive, resulting in delayed critical intervention.
Root Cause:	The evaluating nurse did not recognize the incarcerated individual's level of intoxication was life-threatening, leading to failure to escalate care in a timely manner.
Recommendations:	The Department of Corrections (DOC) Health Services should:

	1. Conduct targeted training sessions to improve nursing staff's ability to assess and respond to life-threatening intoxication cases.
Corrective Action:	The Department of Corrections (DOC) Health Services will: 1. Implement mandatory training programs for all nursing staff focused on the updated nursing protocols, emphasizing the importance of timely EMS requests in critical situations.
Expected Outcome:	1. DOC nursing staff will develop improved clinical skills, enabling them to recognize and respond to life-threatening intoxication promptly. 2. Enhanced quality of care for incarcerated individuals, including timely escalation and intervention in critical cases.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-020

Report to the Legislature

As required by RCW 72.09.770

April 10, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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Unexpected Fatality Review Committee Report

UFR-24-020 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

Disclosure of Protected Health Information

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

UFR Committee Members

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

DOC Health Services

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

DOC Prisons Division

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

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Heather Schultz, Associate Medical Director

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

Fatality Summary

Year of Birth: 1961 (63-years-old)

Date of Incarceration: August 2023

Date of Death: December 2024

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

His cause of death was hepatocellular carcinoma. The manner of his death was natural.

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

Months Prior to Death	Event
7 months	• He received a serious medical diagnosis
6 months	• He began testing and specialty treatment after initial diagnosis.
5 months	• He did not meet DOC Extraordinary Medical Program (EMP) medical eligibility criteria as it was not clear that his life expectancy was less than 6 months, and he did not meet the physical debilitation thresholds.
4 months	• Second request for EMP review. He did not meet medical eligibility criteria for the same reasons as the prior review.
1.5 months	• He was placed on seriously ill status by the Facility Medical Director.
1 month	• Admission to the facility infirmary. • EMP participation approved. • Transition plan developed.
0 month	• He updated his Physician Orders for Life-Sustaining Treatment (POLST) form from full treatment to comfort care, no resuscitation (DNR). • Virtual and in-person visits with family and friends in the infirmary until the time of his death.

UFR Committee Discussion

Upon 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 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 did not identify any additional recommendations to prevent a similar fatality in the future.

   1. The committee found:

      a. He was appropriately referred for advanced imaging and specialty treatment.

      b. He was approved for participation in the Extraordinary Medical Placement (EMP) when he met criteria, however DOC was unable to find a placement that could support his end-of-life care needs.

      c. The Facility Medical Director initiated a seriously ill notification (SIN) when the incarcerated individual became critically ill.

      d. End-of-life care planning and family communication were ongoing, supported his goal to remain in his housing unit as long as possible, and allowed him to specify the types of medical treatment he wished to receive.

B. Independent of the mortality review, the DOC conducted a critical incident review (CIR) to determine the facts surrounding the 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 fatality, and the following topics were discussed.

   1. Seriously Ill Notification:

      The SIN is a process used by DOC to ensure appropriate staff and the incarcerated individual's family have been informed when they have become critically ill or injured.

      A SIN is not required to allow special family visitation. DOC considers each request on a case-by-case basis.

   2. Extraordinary Medical Placement:

      The EMP program allows incarcerated individuals who meet specific criteria to serve the remainder of their sentence in home confinement, monitored electronically.

      DOC follows RCW 9.94A.728 criteria when determining eligibility for EMP participation and internal policy 350.270 Extraordinary Medical Placement for program administration.

      The approval process and placement criteria consider public safety risk and ensure the incarcerated individual has a suitable and safe community placement that can meet their care needs.

Committee Findings

The incarcerated individual died as a result of hepatocellular carcinoma. The manner of his death was natural.

Committee Recommendations

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