Office of the Corrections OMBUDS

Monthly Outcome Report

August 2025

Unexpected Fatality Reviews: 5

Case Investigations: 159

Assistance Provided: 16

Information Provided: 68

DOC Addressed the Complaint: 34

Insufficient Evidence to Substantiate: 11

No Violation of DOC Policy: 30

Substantiated: 0

Intake Investigations: 112

Declined: 20

No Jurisdiction: 8

Complaint Withdrawn: 33

Technical Assistance Provided: 51

Total Resolved Investigations: 276

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	Complaint Summary	Outcome Summary	Case Closure Reason
	Unexpected Fatality Reviews		
1.	Incarcerated individual passed away in DOC custody.	This case was reviewed by the Unexpected Fatality Review Committee, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A public report regarding UFR-24-024 was delivered to the Governor and state legislators this month. It is also available in prison Law Libraries and at the end of the OCO's Monthly Outcome Report. The committee recommended DOC submit a proposal to improve CPR team synchronization; track compliance rates for nursing emergency response training; and establish tier check benchmarks and reinforce consistency. The OCO provided feedback about topics and recommendations missing from the final UFR report, however, DOC did not make those corrections prior to publication. This office tracks these and similar concerns for the OCO UFR Annual Report.	Unexpected Fatality Review
2.	Incarcerated individual passed away while in DOC custody.	This case was reviewed by the Unexpected Fatality Review Committee, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A public report regarding UFR-24-022 was delivered to the Governor and state legislators this month, including recommendations from the UFR Committee. It is also available in prison Law Libraries and at the end of the OCO's Monthly Outcome Report.	Unexpected Fatality Review
3.	Incarcerated individual passed away in DOC custody.	This case was reviewed by the Unexpected Fatality Review Committee, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A public report regarding UFR-25-010 was delivered to the Governor and state legislators this month. It is also available in prison Law Libraries and at the end of the OCO's Monthly Outcome Report. The UFR Committee recommended DOC integrate structured safety screening questions into the Health Services visit process to proactively identify housing-related safety concerns and support early intervention.	Unexpected Fatality Review
4.	Incarcerated individual died in DOC custody.	This case was reviewed by the Unexpected Fatality Review Committee, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A public report regarding UFR-25-011 was delivered to the Governor and state legislators this month. It is also available in prison Law Libraries and at the end of the OCO's Monthly Outcome Report. The committee recommended DOC sustain and expand efforts to strengthen medical emergency response readiness through standardized staff training, scenario-based drills, and routine inspections of emergency medical supplies to ensure availability and functionality; and explore feasibility of predictive modeling and AI solutions to assist with identifying medically complex individuals who may benefit from enhanced care coordination.	Unexpected Fatality Review
5.	Incarcerated individual passed away in DOC custody.	This case was reviewed by the Unexpected Fatality Review Committee, consisting of the OCO, DOC, Department of Health,	Unexpected Fatality Review

		and Health Care Authority. A public report regarding UFR-25-015 was delivered to the Governor and state legislators this month. It is also available in prison Law Libraries and at the end of the OCO's Monthly Outcome Report. The committee recommended DOC establish tier check benchmarks and reinforce consistency; and establish care delivery requirements for individuals who require medical isolation regardless of housing location.	
Case Investigations			
Airway Heights Corrections Center			
6.	External person reported concerns about an incarcerated person after force was used on them. The external person asks the OCO to verify the person received medical care. The incarcerated person reported concerns about an infraction they received after the use of force.	The OCO assisted by reviewing the use of force documentation and finding evidence that refutes claims from DOC staff that resulted in the serious infraction. After OCO review, DOC agreed to dismiss the infraction from the person's record. The OCO verified DOC took action to address the staff action. The OCO verified the incarcerated person received medical care for their injuries.	Assistance Provided
7.	A loved one made a complaint on behalf of an incarcerated individual regarding their CPAP machine not functioning properly and DOC not providing them with assistance.	DOC staff addressed this concern prior to OCO outreach. After reaching out to DOC regarding this concern, DOC staff shared they are actively working to resolve this concern.	DOC Addressed the Complaint
8.	Person reports that he is being punished for having a mental health disorder. The person stated that his mental health is declining due to being assigned to an active yard and needing to request protective custody. The level system that DOC uses forces people with protection concerns to be kept at level one in solitary confinement, further negatively impacting his mental health.	DOC staff addressed this concern prior to OCO action. OCO staff reviewed the person's records and found that DOC had approved an override and he was moved to a lower custody level and different facility. The OCO is in ongoing discussions with DOC regarding the use of solitary confinement for nonviolent offences.	DOC Addressed the Complaint
9.	Incarcerated individual shared concerns regarding DOC infracting them and holding them in segregation due to a dirty UA (urine analysis) from a documented medication they are taking.	DOC staff addressed this concern prior to OCO action. After review of DOC records, this office was able to confirm that this individual has been released from segregation, and the infraction was dismissed.	DOC Addressed the Complaint
10.	Individual reports that DOC is transferring him to Washington State Penitentiary, and the last time	The DOC addressed this concern when the individual's new custody facility plan was finalized. DOC determined that this person would be staying at Airway Heights Corrections Center.	DOC Addressed the Complaint

	he was at that facility, he was assaulted.		
11.	Incarcerated person reported concerns about accessing the graduated reentry program (GRE).	The OCO provided information about GRE and reentry center transfers. The OCO verified the person was not given an assessment to determine GRE eligibility because they are too close to release. This person was denied transfer to a reentry center due to programming needs that could not be met in a reentry center.	Information Provided
12.	Person reported concern about DOC not updating his Earned Release Date (ERD).	The OCO provided information about delays in this individual's release related to the Indeterminate Sentencing Review Board (ISRB). RCW 9.95.0002(8) states that "the members of the indeterminate sentence review board will possess and shall exercise independent judgment when making any decisions concerning offenders. These decisions include, but are not limited to, decisions concerning offenders' release, revocation, reinstatement, or the imposition of conditions of supervision".	Information Provided
13.	Person reports that DOC was not letting him release on his earned release date (ERD), despite his 35-day notifier being completed on time.	The OCO provided information about DOC policy 320.100 to the person which states the ISRB retains the sole authority to approve or deny a release plan. OCO staff verified the planned release date (PRD) was decided by the ISRB.	Information Provided
14.	Person reported concerns regarding a DOC staff member asking him to sign paperwork that he did not understand. When he requested copies, he was met with delays and excuses. The person is requesting that the staff member's conduct be investigated.	The OCO provided information about filing HIPAA and staff conduct complaints. OCO staff were unable to confirm that the person had reported his concerns with the paperwork to DOC.	Information Provided
15.	A loved one reports that an individual is being harassed by DOC staff who are also taking his property.	The OCO confirmed this individual is no longer housed where the DOC staff member works and that the resolution request was closed at level zero. This office provided additional information regarding filing a resolution request for staff conduct concerns.	Information Provided
16.	Individual reports that he is classified as a sexually violent predator (SVP) and DOC is not working to finalize his release plans. He has had numerous release dates that keep getting changed because DOC says they cannot secure housing for him.	The OCO provided information regarding this person's forensic psychological evaluation and the recommendations that DOC must follow for his release address. DOC does not create the stipulations of his release, and there are limited housing options in Washington state that will accept SVPs.	Information Provided
17.	Person reports that the current source of religious items often runs out of the materials they are trying to buy. The person is requesting that DOC use a different vendor so they have more access to religious materials.	The OCO provided information about state contracting to the person. To do business with the State of Washington and the Department of Corrections, a company must be an approved vendor with Department of Enterprise Services (DES). The vendor must seek approval through DES before DOC can determine if they offer appropriate items within DOC security rules.	Information Provided
18.	Person reports that he declared a medical emergency	The OCO reviewed UA (urinary analysis) procedures and the level 1 and level 2 resolution requests. The OCO cannot substantiate what	Information Provided

	because his kidneys were causing him excruciating pain, but a nurse accused him of drug seeking to get on the MAT line and stated that to an officer. He had expressed interest in the MAT line to his provider and thinks the provider told that to the nurse resulting in her biased statement.	the nurse said during this encounter. This office does not have the authority to force a DOC staff member to apologize to anyone, which was the requested resolution. The OCO did verify that the nurse was provided coaching on professional and respectful communication and provided this information to the individual.	
19.	Person reports that he was told he would be placed on the Medication Assisted Therapy (MAT) program months ago but that has not happened. He reports that he had a Health Status Report (HSR) for mouth swabs that was discontinued because of an infraction he received.	The OCO provided information about the current MAT protocol to the person. OCO staff contacted DOC Health Services staff. There was insufficient evidence to substantiate that a provider discontinued a HSR as a result of an infraction as there was no historical HSR on record. HSR's are medical records and become inactive if they are discontinued, they cannot be deleted by staff once created.	Information Provided
20.	Incarcerated person reported concerns about DOC staff behavior and concerns about a general infraction they received.	The OCO provided information about general infractions and how to address staff concerns through the resolution program.	Information Provided
21.	Incarcerated individual shared concerns regarding DOC not providing them access to a specific color of medical shoes.	At this time, the OCO was unable to substantiate the concern due to limited evidence. After reviewing DOC records, this office was able confirm that this individual has an HSR (Health Status Report) for medical shoes. Further review indicates that this individual stated the concern is related to personal shoes.	Insufficient Evidence to Substantiate
22.	Person reports that his girlfriend was denied visitation because of a previous no-contact order between them that was dropped.	DOC policy 450.300 says that a victim of an incarcerated individual's current offense or any previous adjudicated offense is ineligible to participate in visits. The DOC's decision is within policy, and the visitor has the option to resubmit a visit application next year.	No Violation of DOC Policy
23.	Person reported concern about the sanction for an infraction.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 460.050. The OCO found that this individual was found guilty of the infraction and that the sanction is allowed per policy.	No Violation of DOC Policy
24.	Person reported receiving an infraction for contraband. Person said that the contraband was not his and that staff did not conduct a sweep of the cell before he moved in.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy. The OCO reviewed infraction materials and found that the “some evidence” standard was met for this infraction because the contraband found tested positive in a lab test.	No Violation of DOC Policy
25.	Person reported concerns about a job referral list and said that the jobs coordinator is biased.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 700.000. The OCO reviewed DOC records, including a resolutions request in which DOC acknowledged that there was confusion about what he was asking for and that the job coordinator answered his questions about the	No Violation of DOC Policy

		job he was seeking. The OCO also found that this individual got a new job but then left that job and has a current job referral open.	
Cedar Creek Corrections Center			
26.	Person reports that DOC is unnecessarily requiring him to get an assessment despite him completing treatment twice. The person states that DOC is using this assessment to prevent him from releasing to a reentry center.	DOC staff addressed this concern prior to OCO action. OCO staff reviewed the person's record and found the person was moved to the requested reentry center.	DOC Addressed the Complaint
27.	Person reports he is at a facility that does not have good dental access. The person has dental needs that that facility cannot accommodate but not urgent enough for him to be transferred for care. The reporting person is requesting that their loved one be transferred for dental care and allow him to return to camp.	The OCO provided information to the impacted person about requesting dental care at his current facility. OCO staff reviewed the person's record and found that he was already transferred to a facility with more dental access.	Information Provided
28.	Person reports he is at a facility that does not have good dental access. The person has dental needs that that facility cannot accommodate but not urgent enough for him to be transferred for care. The person is worried that if they request a transfer for dental care that he will lose his camp placement.	The OCO provided information about requesting dental care at his current facility. OCO staff reviewed the person's record and found that he was already transferred for a different reason to a facility with more dental access.	Information Provided
29.	Incarcerated person reported concerns about DOC not allowing them to transfer to graduated reentry (GRE) or a reentry center (RC).	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 390.590 and 300.500. The person was denied due to community concerns that were not mitigated by treatment during their incarceration.	No Violation of DOC Policy
Clallam Bay Corrections Center			
30.	Incarcerated individual reports concerns related to someone passing away in DOC custody.	This case was reviewed by the Unexpected Fatality Review Committee, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A public report regarding the UFR was delivered to the Governor and state legislators this month. It is also available in prison Law Libraries and at the end of the OCO's Monthly Outcome Report.	Assistance Provided
31.	Incarcerated person reported they felt unsafe in the unit they were in and asked to	The OCO assisted by immediately reaching out to the facility and requesting DOC speak with him. DOC agreed to talk to the person.	Assistance Provided

	speak with DOC staff but no one responded.		
32.	Person reported safety concerns about being housed at his current facility.	DOC staff addressed this concern prior to OCO action. The OCO reviewed DOC records and found that DOC acknowledged that this individual does not have any housing options at that facility and moved him to a different facility.	DOC Addressed the Complaint
33.	Incarcerated person reported concerns about their placement and requested assistance in accessing a safe housing assignment.	DOC staff addressed this concern prior to OCO action. The OCO reviewed the person's recent custody facility plan and confirmed DOC is planning to transfer the person.	DOC Addressed the Complaint
34.	External person reported concerns about an incarcerated person's placement and reported safety concerns.	The incarcerated individual said they did not want the OCO to further investigate the complaint. The incarcerated person reported that they are fine in the current unit they are housed in. At the time of the call with the incarcerated person, they reported concerns about 2 infractions, the OCO provided information about how to appeal the infractions with DOC.	Information Provided
35.	Person reports that DOC is not following the correct timeline for getting him access to the Medication Assisted Therapy (MAT) program. The person stated that he is 3 months from release but has not been scheduled to start the medication.	The OCO provided information about the current Medication Assisted Therapy (MAT) protocol. OCO staff reviewed the current protocol and noted that it states that patients can kite their medical provider at 90 days to release to request initiation to the MAT program, but medication administration does not begin until 60 days to release at the soonest for the medication requested by the patient. The OCO is in ongoing discussion with DOC Leadership regarding the expansion of the MAT program.	Information Provided
36.	Person reported that his property was lost when he went to segregation.	The OCO provided information about filing a tort claim. The OCO reviewed this individual's resolution request and found that DOC acknowledged that they could not find his property. DOC policy 120.500 states "all incarcerated individual tort claims alleging personal property damage/loss must be filed by the individual with the Washington State Department of Enterprise Services (DES) Risk Management Division". RCW 4.92.100 states, "(1) All claims against the state, or against the state's officers, employees, or volunteers, acting in such capacity, for damages arising out of tortious conduct, must be presented to the office of risk management."	Information Provided
37.	Incarcerated individual reports concerns related to another person passing away in DOC custody.	The OCO provided information about the case being referred for an Unexpected Fatality Review (UFR). This case was reviewed by the Unexpected Fatality Review Committee, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A public report regarding the UFR was delivered to the Governor and state legislators this month. It is also available in prison Law Libraries and at the end of the OCO's Monthly Outcome Report.	Information Provided
38.	Incarcerated person reported safety concerns related to their placement.	The OCO provided information about how to report concerns to DOC about placement. The OCO verified the person has not provided information required to validate safety concerns. The OCO shared what to provide and encouraged the person to continue working with DOC staff.	Information Provided
Coyote Ridge Corrections Center			
39.	A loved one expressed concern for an incarcerated individual's safety and wants	The OCO provided assistance by sharing concerns about his placement with DOC Headquarters and Intelligence and Investigations. The OCO reviewed DOC documents and reached out	Assistance Provided

	him to be moved to a different facility.	to staff, both at the facility and at Headquarters, asking about this individual's safety concerns. The OCO found that this individual made a protective custody request and that he was reviewed by the Safe Harbor committee who could not validate his concerns. The OCO found that this individual was given an override and transferred to a different facility.	
40.	Individual reports they have asked for safe harbor and keep getting placed on mainline as they have safety issues.	The OCO reviewed the individual's current custody facility plan and found they have been transferred to a safe harbor prior to OCO involvement.	DOC Addressed the Complaint
41.	Incarcerated individual shared concerns regarding DOC not providing them with a new CPAP machine.	DOC staff addressed this complaint prior to OCO action. After speaking with DOC staff, this office was able to confirm that this individual has received a new CPAP machine.	DOC Addressed the Complaint
42.	Person reports he is camp eligible and wants to go to a Department of Natural Resources (DNR) work camp. DOC has not completed his custody facility plan and he wants them to complete it and send him to DNR camp.	The OCO reviewed this concern and found he was sent to a DNR eligible camp.	DOC Addressed the Complaint
43.	External person reports her loved one's life is in danger because he has been labeled as a security threat group (STG). She would like him to be transferred out of state.	The OCO reviewed this concern and reviewed this individual's current housing. They are currently housed on administrative segregation in a single cell. This office provided information to the individual regarding how to request a review of current STG status and how to request a Prisons Compact via DOC policy 330.600.	Information Provided
44.	Person reports that he was ordered to receive an additional evaluation before he could be released. The person is currently past his early release date and would like to get the assessment done so that he can release.	The OCO provided information to the person regarding how the evaluations are done. Per DOC policy 350.500 the evaluation is assigned by the prosecuting court.	Information Provided
45.	Incarcerated individual shared concerns regarding DOC not providing them with glasses despite stating they would.	The OCO provided information regarding why their glasses have been delayed. After reviewing DOC records and speaking with DOC staff, this office was informed that medical personnel had missed filling out the form for the glasses order. This was caught by DOC medical staff and the glasses were ordered immediately upon discovering this. The glasses are currently enroute to the individual.	Information Provided
46.	Person reports he received recommendations from a specialist that were denied by his DOC medical provider.	The OCO provided information about the approval process for specialist recommendations. Per the DOC Health Plan, prescription orders from outside source must be reviewed by a DOC provider for coverage. OCO staff also provided self-advocacy information about the Care Review Committee process.	Information Provided
47.	Person reported they had a family emergency and would like to go out on GRE. However, they were infracted and they need it removed.	The OCO reviewed the infraction and discovered the individual had never appealed against the guilty findings. This office cannot assist with an infraction that was not appealed; however, this office did provide the information on how to contact the Prisons Disciplinary	Information Provided

		Program Manager at DOC Headquarters for a review and provided the address.	
48.	Person reports that a time restriction in policy prevents him from accessing court ordered treatment which is keeping him from participating in early release options.	The OCO provided information about the DOC's policy review process. OCO staff confirmed that DOC staff followed DOC policy 100.100 by forwarding the person's requested policy change to the policy author.	Information Provided
49.	Person reports that he has received testing for a medical condition but DOC medical has not been able to diagnose him or provide treatment. The person is requesting more testing to be completed.	OCO staff provided information to the person about their active specialist consultation. OCO staff reviewed the person's records and found that he is already scheduled to see a specialist who will determine the next steps for this person's care.	Information Provided
50.	An individual reports that he is not guilty of an infraction he received, and DOC did not have the evidence to uphold his infraction.	The OCO reviewed the infraction materials, the incident report, listened to the hearing audio, and contacted DOC about this concern. When the OCO spoke with DOC about this issue, the Department held firm in their initial guilty finding. At this time, DOC staff testimony is enough evidence to uphold an infraction decision. The OCO encouraged the individual to contact the Prison Disciplinary Program Manager for a final level of review.	Information Provided
51.	Incarcerated person reported retaliation from DOC staff because his single cell approval was removed and he received infractions after this occurred. The person reports that he was placed into segregation during this time as well and he feels that it was a retaliatory act.	The OCO reviewed existing evidence and was unable to substantiate the concern. To substantiate retaliation, the OCO must be able to prove that a negative action from a DOC staff member is not only linked close in time to an incarcerated individual's protected action but there must be evidence of a clear relationship between the two acts. The OCO reviewed the person's single cell screening and found it was completed per policy and the person does not currently meet the qualifications for a single cell. The OCO could not find a link between the single cell status change and the infractions.	Insufficient Evidence to Substantiate
52.	Individual reports concerns regarding staff at several facilities treating him unfairly with facility moves, infractions, pay scale, cellmates, disciplinary hearings, and resolution responses.	The OCO reviewed existing evidence and was unable to substantiate this concern, as this person consistently has issues with custody, mental health staff, other incarcerated individuals, and protocols that everyone must follow in prison. Additionally, this office reviewed the individual's custody facility plan and confirmed that he will remain in the unit and requires HCSC screening to be transferred.	Insufficient Evidence to Substantiate
53.	Incarcerated individual shared concerns regarding DOC threatening their safety and restricting their legal access.	At this time, the OCO was unable to substantiate the concern due to limited evidence. After review of DOC records and speaking with DOC staff, this office was unable to see any evidence that DOC staff are threatening this individual's safety. This office was able to confirm that this individual has legal access and DOC has transferred this individual to a different facility per their request.	Insufficient Evidence to Substantiate
54.	External person reported concerns about an incarcerated person's safety. The incarcerated person reports they are not safe in	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 300.380. The OCO reviewed the person's custody facility plan and found DOC calculated the person's custody per policy and cannot provide another custody override, due to behavior. The OCO shared how to appeal the	No Violation of DOC Policy

	the custody DOC plans to house them in.	custody facility plan and how to report safety concerns if they further arise.	
55.	A loved one shared concerns on behalf of an incarcerated individual regarding being wrongfully infracted.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 460.050. After review of DOC records, this office was able to confirm that the circumstances of the situation met the requirements for the WAC (Washington Administrative Code) given.	No Violation of DOC Policy
56.	Person reports that his mail was inaccurately rejected due to DOC policy 450.100.	The OCO reviewed all of the individual's cited mail rejections and responses from DOC. This office met with DOC staff about this concern, and the initial mail rejections were upheld as the materials were intended for sexual gratification and depict a minor, or model or cartoon/anime depicting a minor, in a sexually suggestive setting/pose/attire.	No Violation of DOC Policy
Mission Creek Corrections Center for Women			
57.	Incarcerated individual shared concerns regarding the living conditions at their facility and the way they have been treated by staff, their property being lost by staff, and DOC not allowing them to complete programming.	DOC staff addressed this concern prior to OCO action. After reviewing DOC records, this office was able to confirm that this individual has been transferred to a different facility. Further review also indicates that this individual has completed their programming and has filed a tort claim to be potentially reimbursed for their property.	DOC Addressed the Complaint
58.	Incarcerated person reports concerns about staff. The person shares that DOC staff would not allow her to move rooms.	The OCO provided information about filing resolution requests to address staff behavior and information about DOC policy 420.140 regarding cell assignments. The OCO verified that this person was not moved rooms due to not meeting the DOC requirements for cell moves. The OCO also shared that this person will be transferring to a reentry center soon.	Information Provided
59.	Incarcerated person reported concerns about DOC staff.	The OCO reviewed existing evidence and was unable to substantiate the concern. The OCO reviewed relevant investigations and resolution requests and was unable to locate evidence to substantiate the claims. The OCO shared how to continue to report concerns about staff through the DOC resolution program.	Insufficient Evidence to Substantiate
Monroe Correctional Complex			
60.	Incarcerated individual reports concerns related to housing placement, staff conduct and PREA.	The OCO assisted by elevating the concern through facility, Women's Prison Division, and Health Services leadership. After OCO outreach, the individual’s housing placement was updated and the patient was approved for placement in Residential Treatment Unit (RTU). This office also reviewed the PREA investigation and continues to monitor the staff conduct concerns at the facility.	Assistance Provided
61.	Incarcerated individuals report concerns about safety and behavior of others in Residential Treatment Unit (RTU). Individuals also reported concerns about a patient in the Close Observation Area (COA).	The OCO provided assistance by elevating the concerns to DOC mental health leadership and the facility Superintendent. The individuals requested for the other person to be discharged from RTU level of care, but this is not clinically indicated. The OCO monitored the patient's COA placement and discharge.	Assistance Provided
62.	Person reports he has not seen a medical provider since	OCO staff provided assistance by contacting DOC Health Services staff. OCO staff reviewed the person's specialist consultations and	Assistance Provided

	arriving in DOC custody. The person has a terminal condition and is requesting management of the persistent symptoms.	found that the patient had multiple specialist consultations that required follow up to establish care in his current location. OCO staff brought this to the attention of DOC Health Services staff, the person's consultations were updated and the person was scheduled to speak with a medical provider. The OCO also provided information regarding extraordinary medical placement and how to get updates about his consultations from the Patient Care Navigator.	
63.	A loved one reported concern about an incarcerated individual being moved to a new cell after returning from a medical appointment and expressed concern about their new cellmate.	DOC staff addressed this concern prior to OCO action. The OCO reviewed DOC records and found that this individual was moved to a different cell and is no longer cellmates with the individual that concerns were expressed about.	DOC Addressed the Complaint
64.	Person reports that he experiences both opioid addiction as well as chronic pain. The person has requested a consultation with a pain management specialist to receive a specific medication.	DOC staff addressed this concern prior to OCO action. OCO staff reviewed the patient's appointments and found they were already scheduled with Health Services staff to start the requested medication.	DOC Addressed the Complaint
65.	Incarcerated person reports concerns about their current job.	DOC staff addressed this concern prior to OCO action. The OCO verified this person was hired for another job that addressed the concerns he had in the previous position prior to OCO outreach.	DOC Addressed the Complaint
66.	Incarcerated individual shared concerns regarding DOC not providing them with follow-up care after a surgery.	DOC staff addressed this concern prior to OCO action. After review of DOC records, this office was able to confirm that this individual was seen by their provider and have further appointments scheduled for future care.	DOC Addressed the Complaint
67.	Incarcerated individual shared concerns regarding DOC not providing them with a new mask for their CPAP machine.	DOC staff addressed this concern prior to OCO action. After review of DOC records and speaking with DOC staff, this office was informed that this individual was provided with a new mask.	DOC Addressed the Complaint
68.	Incarcerated individual shared concerns regarding DOC providing them with delayed medical treatment after a declared medical emergency.	The OCO provided information regarding why their care may have been delayed upon declaration of a medical emergency. After reviewing DOC records and speaking with DOC medical staff, this office was informed that the situation was not deemed a medical emergency by DOC medical staff. There had been a dispute between custody and medical staff on how to safely transfer the patient out of the unit which caused a minor delay in transferring to the facility's medical clinic. Following an assessment in the medical clinic, this individual was immediately sent out to the hospital to receive further care.	Information Provided
69.	Person reports that his health status reports (HSR) expired after transferring and the provider at his current facility has not scheduled him for a medical appointment. The person reports that they were moved to a top bunk and have not been given medical shoes.	The OCO provided self-advocacy information to the person. OCO staff reviewed the person's resolution requests and appointment records. OCO staff found that the patient was scheduled to see their provider after filing a resolution request. OCO staff confirmed the resolutions staff notified the person's medical provider of his needs when they received the resolution request. OCO staff monitored the appointment and verified it was attended and the Health Status reports were rewritten. The OCO also provided tort claim information to the person.	Information Provided

	The person is requesting to have his HSRs renewed until his provider can see him.		
70.	Person reported systemic concerns about delays in dental care. Person also reported issues about being able to view the OCO's report on dental care in the FYI app on his tablet.	The OCO provided this individual with a copy of the OCO's recent report on dental care. The OCO is aware of issues with viewing OCO reports on the FYI app and has been working with DOC and Securus on this issue.	Information Provided
71.	Person reports concerns with the treatment he received in the medical unit. The person states that medical staff cursed at him when he asked a question about his medical care. The person is requesting that the staff member be reassigned to another facility.	OCO staff provided information to the person about the actions taken by the DOC. OCO staff reviewed the person's resolution request and contacted DOC Health Services staff. OCO staff were informed that action has been taken and the staff conduct investigation is in progress.	Information Provided
72.	Incarcerated individual reports concerns about facility placement and a pending transfer.	The OCO provided information about facility placements and transfers. The OCO reviewed the individual's custody facility plan (CFP) and approved transfers. The OCO does not have authority to override facility placement decisions, however, this office confirmed the review and transfer had been completed.	Information Provided
73.	Person reports concerns related to release.	The incarcerated individual released prior to OCO action. While the complaint does not involve a person committed to the physical custody of the DOC, the OCO provided information about steps he can take in the community to access substance use treatment post-release. The OCO provided additional information via hotline.	Information Provided
74.	Person reports that pill line sometimes run when people are supposed to be at programming or visiting. The person is requesting that pill line be run with mainline so it does not interfere with programing.	The OCO provided information about pill line scheduling to the person. The DOC staff that administer medications are the same staff that have to respond to emergencies across the facility. Pill line is scheduled for times that should not interfere with programming, but staff must adjust the schedule when they are needed for emergencies. OCO staff found no evidence that the person has been punished for being late to other callouts as a result of pill line being delayed.	Information Provided
75.	Anonymous person called to report someone was brutally assaulted. The individual involved told the staff what he was going to do if the person was moved back into the cell.	The OCO visited in person and provided individuals in this unit with more information. The facility is currently investigating the incident.	Information Provided
76.	Incarcerated individual shared concerns regarding attempting to start a new job but DOC staff are not allowing them to quit their previous role unless they find a replacement.	The OCO provided information regarding how they can request a new job placement. After reviewing DOC records, this office was able to confirm that this individual has transferred facilities and is actively working in a similar role to their previous one. This office also informed this individual of the OCO process and encouraged them to follow the internal administrative process.	Information Provided
77.	Incarcerated individual shared concerns regarding wanting	The OCO provided information regarding how they can attempt to obtain their desired testing if it is deemed clinically necessary. The	Information Provided

	specific testing done for their concern.	OCO encouraged this individual to speak with their provider regarding their request to discuss some options available to them.	
78.	Incarcerated person reported concerns about retaliation from another incarcerated person and had concerns about the retaliation effecting their access to required programming. The person also reported concerns about reporting harassment from other incarcerated people.	The OCO provided information about reporting concerns regarding other incarcerated people. The OCO reviewed the DOC investigation related to retaliation about found DOC acted accordingly and separated the two people per protocol. The OCO verified the person required programming was not affected by this incident. The OCO shared how to report concerns with other incarcerated people to DOC staff directly and through the DOC resolution program.	Information Provided
79.	Incarcerated individual anonymously reported concerns about being restricted from religious programming after release from Close Observation Area (COA).	The OCO elevated this concern through DOC mental health leadership. The OCO reviewed existing evidence and was unable to substantiate the concern. There is no evidence to indicate religious programming is restricted after COA discharge.	Insufficient Evidence to Substantiate
80.	Person reported concern about receiving an infraction. Person said that he was not given a full hour to provide for a urinalysis (UA) test.	The OCO reviewed the complaint and found DOC actions or inactions are currently allowed within DOC policy. The OCO reviewed infraction materials and found that DOC documented giving this individual 59 minutes, rather than a full hour for this infraction. When the individual appealed, DOC stated that this was done in error and that he was given a full hour. The OCO found that the "some evidence" standard for this infraction was met and that the evidence met the definition of the infraction.	No Violation of DOC Policy
81.	Incarcerated individual shared concerns regarding DOC staff mistreating them and wrongfully infracting them.	The OCO reviewed the complaint and found DOC actions or inactions are currently allowed within DOC policy 460.050. After reviewing DOC records, this office was able to confirm that the circumstances of the situation warranted the WAC given by DOC staff. Further review indicates that this individual did not appeal the infraction after the guilty finding.	No Violation of DOC Policy
82.	Incarcerated individual shared concerns regarding attempting to obtain a single cell.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 420.140. After reviewing DOC records, this office was able to confirm that this individual was screened and denied for a single cell. DOC staff determined that this individual did not meet the criteria for single cell placement.	No Violation of DOC Policy
83.	Individual reported that they were told they were a victim of PREA by staff, then placed in administrative segregation. They were then told they were being transferred across the state.	The OCO reviewed the PREA allegation, segregation placement, and the current custody facility plan. This office found the PREA allegation is still under investigation. The individual was placed in Administrative Segregation per DOC policy 320.200, while IIU completed an investigation into whether it was safe to house the individual in the current facility. After investigation, the facility deemed it unsafe to continue to house them there, and per DOC policy 300.380, they were sent to a new facility.	No Violation of DOC Policy
Olympic Corrections Center			
84.	Incarcerated individual shared concerns regarding participating in programming that makes them feel sick and DOC staff not allowing them to leave the program.	DOC staff addressed this concern prior to OCO action. After reviewing DOC records, this office was able to confirm that this individual was removed from the requested program for medical reasons. DOC medical staff also provided this individual with an HSR (Health Status Report) that states this individual can avoid this type of programming.	DOC Addressed the Complaint

Other			
85.	Person reports that DOC told him that he can return to Washington state, but it has been over two months, and nothing has happened.	The OCO reviewed the individual's electronic record and confirmed that the individual has been transferred to a Washington state prison.	DOC Addressed the Complaint
Reentry Center - Ahtanum View - Yakima			
86.	Individual reported that they were given infractions at the reentry center, but the reports had the wrong dates and times. They wanted to verify if the infractions could be dismissed over that.	The OCO reviewed these infractions and found that the individual did not appeal. This office provided the individual more information about the appeal.	Information Provided
Reentry Center - Reynolds - King			
87.	External person reported concerns about programming at the DOC Reentry Centers. The external person reported people were being placed on work crews if they could not find employment after a certain timeframe. The incarcerated person reported the same concerns and later reported concerns about being removed from the reentry center after an incident that resulted in DOC issuing them multiple infractions.	The OCO provided information about how the OCO addressed the concerns regarding the work crew assignments and provided information about the infractions and how he could request further review with an appeal. The OCO spoke with DOC about the use of work crews and verified people are only assigned the work crew as a means to get people out of the facility while they are looking for work. The OCO reviewed the infractions and verified with DOC that this person had adequate access to appeal the infractions. The OCO shared how to write headquarters and request that his infraction appeal be reviewed.	Information Provided
Reentry Center - Tri-Cities - Benton			
88.	Individual reports that the amount of money he received when he left work release was not equivalent to what he verified on the kiosk.	The OCO contacted DOC about this concern, and the DOC reported that there is a daily charge of $13.50 per day to live in a DOC reentry center. DOC reviewed this person's trust account statement and did not see anything that looked incorrect or out of place. The OCO provided contact information for the accounting department at DOC headquarters in case this person has additional questions for the accounting manager.	Information Provided
Stafford Creek Corrections Center			
89.	An anonymous incarcerated individual shared concerns regarding the unit kiosk machine being broken and no one attempting to fix it.	The OCO provided assistance by reaching out to the facility and having DOC staff agree to post a notice regarding repairs. This office was able to confirm that the part has been ordered and the facility is awaiting the arrival of the part.	Assistance Provided
90.	Incarcerated individual shared concerns regarding being assaulted and their glasses breaking.	DOC staff addressed this concern prior to OCO action. After speaking with DOC staff, this office was informed that this individual was seen by DOC medical staff following the incident. This office was also able to confirm that DOC medical staff are actively working to provide this individual with new glasses.	DOC Addressed the Complaint

91.	Incarcerated individual reports concerns about facility updates to visitation check in time.	DOC staff addressed this concern prior to OCO action. The OCO confirmed DOC sent updates via kiosk message on March 28th with more information. In this update, DOC stated that the proposed and previously announced visitation changes are being placed on hold and instead are being reviewed at the headquarters level to ensure visitation procedures and policies are followed statewide.	DOC Addressed the Complaint
92.	Person reports that he was told he would have to start the medical consultation process over after transferring despite already being approved for the recommended medical intervention. The person is requesting to start the medication that was recommended.	DOC staff addressed this concern prior to OCO action. OCO staff reviewed the person's resolution requests and noted that he had already been started on the medication.	DOC Addressed the Complaint
93.	A loved one reported concerns that an incarcerated individual is receiving inadequate healthcare and that the specialist's treatment plan is not being followed.	DOC staff addressed this concern prior to OCO action. The OCO reviewed DOC records and reached out to DOC staff, who provided detailed information about his specialist consults, medications, and treatment plan. The OCO found that this individual is receiving ongoing healthcare and is being seen by a specialist. Specialists' recommendations need to be reviewed and approved by a DOC Health Provider before they can be ordered, per the DOC Health Plan.	DOC Addressed the Complaint
94.	Person reports that he was denied medical care. The person states that he has kited for an appointment but was turned away at medical.	OCO staff provided self-advocacy information to the person. OCO staff reviewed the person's appointments and found that he was already scheduled for an appointment with his medical provider. OCO staff monitored the appointment and reviewed the medical record to confirm the patient was able to attend. OCO staff provided information about kite response timelines and how appointments are scheduled based on kite requests. OCO staff noted that the person was turned away from sick call for a chronic issue. Nursing staff make a determination in triage if a complaint is appropriate for sick call or if that person needs an appointment with their medical provider. Chronic medical issues need to be addressed in scheduled appointments as sick call is for acute issues or sudden negative changes to a chronic issue that cannot wait for a scheduled appointment.	Information Provided
95.	Incarcerated individual shared concerns regarding DOC staff not providing them with protective custody.	The OCO provided information regarding how they can request protective custody. This office spoke with DOC staff and were informed that this individual's safety concerns cannot be verified.	Information Provided
96.	Person reported being denied a meal twice.	The OCO provided information about this individual's resolution investigation. The OCO reviewed DOC records and found that this concern is still under DOC review. The OCO can review this concern after it is reviewed at the Headquarters level.	Information Provided
97.	Person followed up on a previous case regarding purchasing tarot decks as religious property. After the case, DOC issued a memo changing the process for	The OCO provided information about this individual's situation. This DOC memo was not retroactive, so DOC was within policy when they rejected his previous tarot deck. The OCO reached out to DOC staff, who had already explained this to the individual. This individual ordered a new deck, but it was lost in the mail.	Information Provided

	ordering tarot decks. Person reported that he ordered a tarot deck before this change and still wanted to receive that tarot deck.		
98.	Person reports that medical has not completed necessary testing for his allergy issue. The person reports he was given medications to try without any bloodwork or pictures being taken. The person is requesting that the diagnostics be completed so the issue can be treated.	The OCO provided information to the person about medical care in DOC. OCO staff verified the person is receiving conservative treatment measures for the current issue. OCO staff provided information about how to progress through conservative treatments to determine a diagnosis that cannot be determined by lab work.	Information Provided
99.	Individual reports that the hearings officer subtracted an additional five days from his good conduct time calculation due to him being in the IMU for more than 20 days.	The OCO reviewed DOC policy 350.100 regarding earned release time, which says that individuals will be ineligible for earned time if they serve 20 consecutive days or more in restrictive housing for negative behavior. This office verified that the individual had been in restrictive housing for more than 20 consecutive days, allowing the Department to take their earned time for that month.	Information Provided
100.	Individual reports that he received an infraction for sexually explicit materials when the mailroom approved all of the items.	The OCO could not find sufficient evidence that this individual did not possess sexually explicit materials. This OCO encouraged this person to contact the Prison Disciplinary Program Manager to review his infraction and appeal.	Information Provided
101.	Incarcerated person reports DOC staff targeting them after filing a complaint.	The OCO reviewed existing evidence and was unable to substantiate the concern. The OCO reviewed the DOC investigation related to the complaint filed by the person and found DOC completed the investigation per policy.	Insufficient Evidence to Substantiate
102.	Incarcerated person reported concerns about an infraction and requested OCO review the infraction.	The OCO reviewed existing evidence and was unable to substantiate the concern. The OCO reviewed the infraction and found DOC met the some evidence standard used in serious infraction hearings. The OCO was unable to locate evidence to substantiate the infraction had grounds for dismissal.	Insufficient Evidence to Substantiate
103.	Person reported concern about staff harassing him.	The OCO reviewed existing evidence and was unable to substantiate the concern. The OCO conducted an extensive review of his resolution requests, Behavioral Observation Entries (BOE), and infractions, and were unable to substantiate a pattern of harassment or violations of DOC policy.	Insufficient Evidence to Substantiate
104.	Incarcerated person reports DOC staff targeting them after filing a complaint.	The OCO reviewed existing evidence and was unable to substantiate the concern. Based on the evidence available, the facility began facility wide compliance checks shortly after the person filed the complaint about DOC staff. The DOC staff reported has no authority to begin facility wide compliance checks. Multiple incarcerated people were affected by the compliance checks. The OCO reviewed the DOC investigation related to the complaint filed by the person and found DOC completed the investigation per policy.	Insufficient Evidence to Substantiate
105.	External person reports that their loved one was infracted and visitation was terminated between them for an	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 450.300. Per DOC policy 450.300 the Superintendent may suspend/terminate visit privileges with a specified individual as the result of a very serious violation	No Violation of DOC Policy

	unverified accusation. The incarcerated person is requesting a review of the infraction and to have visitation restored.	or multiple violations. OCO staff reviewed the person's infraction and found that the evidence meets the criteria for the WAC received.	
106.	Person reported concern about being found guilty of an infraction and stated that a similar infraction was dismissed.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy. The OCO reviewed infraction materials and found that the “some evidence” standard was met for this infraction.	No Violation of DOC Policy
107.	Incarcerated person reported concerns about DOC not addressing their appeal within the timeframes directed in policy. The person requests assistance in having the infractions dismissed due to administrative errors.	The OCO reviewed the complaint and found DOC actions are currently allowed within WAC 137-28-400 which states, "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." DOC responding to an appeal outside of the policy timeframes is not grounds for dismissal per the WAC.	No Violation of DOC Policy
Washington Corrections Center			
108.	Incarcerated person reported delays in response to his serious infractions appeals. The person requested the infractions be dismissed due to timelines not being followed.	The OCO assisted by continued follow up with the facility to verify the person received the infraction appeal responses. Per WAC 137-28-400, "the time limitations expressed in these regulations are not jurisdictional and failure to adhere to any particular time limit shall not be grounds for reversal or dismissal of a disciplinary proceeding." The OCO reviewed the infractions and found they met the elements of the some evidence standard used by DOC.	Assistance Provided
109.	Incarcerated person reports DOC denied him breakfast and was not providing follow-up care after a medical event he endured that morning. The person in currently in segregation and reported DOC staff told him he would not be issued lunch.	The OCO assisted by immediately following up with facility leadership to verify the person received follow-up medical care and was fed lunch. DOC leadership shared with OCO the person was seen by DOC medical staff. DOC also shared the person missed breakfast on their own volition, and that they would be issued lunch.	Assistance Provided
110.	Incarcerated individual reports concerns about delayed classification.	DOC staff addressed this concern prior to OCO action. The incarcerated individual called the OCO hotline to report his custody facility plan had been completed and closed the case.	DOC Addressed the Complaint
111.	Incarcerated person reports concerns about an infraction sanction.	DOC staff addressed this concern prior to OCO action. The person called the OCO hotline and reported DOC resolved their concern and reversed the sanction.	DOC Addressed the Complaint
112.	Incarcerated individual shared concerns regarding being assaulted and DOC not providing them with new glasses despite them breaking during the assault.	DOC staff addressed this concern prior to OCO action. After reviewing DOC records and speaking with DOC staff, this office was able to confirm that this individual has been provided with new glasses. DOC staff have also investigated the assault and dealt with the incident per DOC policy.	DOC Addressed the Complaint
113.	Person reports that he received an infraction for a positive drug screen for a substance that he had a	DOC staff addressed this concern prior to OCO action. OCO staff reviewed the person's records and found that DOC had requested the records that confirmed the person's prescription. OCO staff confirmed the infraction was dismissed.	DOC Addressed the Complaint

	prescription for prior to entering incarceration.		
114.	A loved one expressed concern about their visit with an incarcerated individual being cancelled.	The OCO provided information about this situation. The OCO found that DOC made public announcements about visitation being cancelled due to an IT issue that brought down DOC computers. Visitation was reopened later that day.	Information Provided
115.	Incarcerated person reported concerns about DOC changing his custody level to not allow him to transfer to a reentry center or graduated reentry.	The OCO provided information about why DOC made this decision and how to address the issue. DOC cannot promote him to graduated reentry or a reentry center until after he addresses an active detainer. People can work with the court the detainer is from to address it and possibly get it resolved.	Information Provided
116.	Person reports being taken off a medication based on incorrect information. The person stated that after DOC received his records from the jail, DOC's story changed about why he could not be on the medication. The person is eligible for the medication by DOC policy and he had an active prescription prior to entering DOC custody.	The OCO provided information to the person. The person released shortly after reporting the issue to the OCO. Based on the concern reported by the person, information about filing tort claims was provided. Individuals who have been harmed or who have suffered a loss as a result of negligent actions by a state employee or agency can submit a tort claim to the Office of Risk Management (ORM). ORM is required by law (RCW Chapter 4.92) to receive these claims.	Information Provided
117.	Person reported concerns about charges on his record and wanted those charges removed.	The OCO provided information about reaching out to the courts regarding this concern. Per RCW 43.06C.040(2)(e), the OCO lacks jurisdiction over incarcerated individual's underlying convictions and cannot take action.	Information Provided
118.	Person reported concerns about DOC not providing dental care. The person stated that he has a dental infection but was refused treatment and told that the dentist wanted to let his body fight the infection.	OCO staff provided information regarding current dental scheduling process. OCO staff reviewed the person's appointments and noted that they had missed two dental appointments without notifying Health Services staff that he was not going to be able to attend. If a patient does not come to a dental appointment they are rescheduled behind other patients who are also awaiting scheduling. OCO staff previously substantiated dental delays statewide and continue discussions with DOC Health Services Leadership regarding changes to the dental program.	Information Provided
119.	Individual reports they have been falsely tagged as a security threat group (STG) and would like their record fixed.	The OCO reviewed the resolution request response from the DOC and found they provided the individual with the information they needed to request for their record to be fixed. The OCO provided this information to the individual again.	Information Provided
120.	Individual reports that he requested evidence to be sent to the lab for confirmation. This person reports that DOC remanded his infraction and gave him a new hearing. However, the DOC officer who conducted the hearing was the person who found him guilty the first time.	The OCO reviewed the infraction materials and determined that this person admitted to having drugs in the infraction report, and DOC remanded his hearing while they sent the drugs to the lab for additional testing. The lab report came back positive for drugs, and the DOC found him guilty a second time. The identity of the hearings officer has no bearing on the outcome of his infraction hearing since he admitted to having drugs in his possession when the incident occurred.	Insufficient Evidence to Substantiate

121.	Incarcerated person reported concerns about how DOC conducted an investigation and requested the OCO review.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 490.860. The OCO reviewed the investigation and found it was completed per policy.	No Violation of DOC Policy
122.	Individual reported they were denied Extended Family Visits (EFV) with their wife and they are worried it is due to a medical condition.	The OCO reviewed the complaint and found when the EFV application was reviewed, the family member had not visited in almost a year. The applicant must be on the approved visitors list per DOC policy 450.300 and have previously visited a minimum of six times, to include video visits within the last 12 months. They do have the option to reapply after six months. The OCO verified that medical authorized the EFVs if they were approved by headquarter visitation.	No Violation of DOC Policy
Washington Corrections Center for Women			
123.	A loved one shared concerns on behalf of an incarcerated individual regarding being wrongfully terminated from their job.	The OCO provided assistance by reaching out regarding this individual's job and requesting this individual be reinstated in their job. DOC staff agreed to provide this individual with their job back following the OCO's outreach.	Assistance Provided
124.	Individual reports that she was suspended from her position, and no one was communicating when or if she would get her job back.	The OCO reviewed the individual's resolution requests and determined that the DOC response was outside of timeframes. The OCO contacted DOC headquarters and asked for an additional review of this person's resolution request response. Additionally, the OCO contacted the facility about the individual's programming concerns, and DOC reported that they worked with the individual and are looking to place her in a new position.	Assistance Provided
125.	Incarcerated individual shared concerns regarding being wrongfully terminated from their job.	DOC staff addressed this concern prior to OCO action. After review of DOC records, this office was able to confirm that this individual has been given their job back.	DOC Addressed the Complaint
126.	Person reports that she needs more pain management available to her while she waits for a procedure to treat the issue causing the pain.	The OCO provided information to the person about the Medication Assisted Therapy (MAT) program. OCO staff reviewed the person's recommendations from pain management and confirmed that the recommended procedure had been scheduled and taken place.	Information Provided
127.	Incarcerated individual shared concerns regarding DOC infracting them with false evidence.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 460.050. After reviewing DOC records, this office was able to confirm that DOC staff provided the evidence utilized to infract the individual at the hearing. Additionally, the circumstances of the situation rose to the level of the WAC provided. This individual is actively appealing one of the infractions.	No Violation of DOC Policy
128.	Individual reported there is favoritism with an individual who attacked her including being punched in the face and states that she was maced more than the girl who attacked her.	The OCO reviewed the use of force incident during the fight and found the DOC followed policy 410.200. This office did meet with this individual in person to discuss concerns. The individual has since left DOC custody.	No Violation of DOC Policy
Washington State Penitentiary			
129.	Patient reports concerns about access to pain	The OCO assisted by elevating the concerns through DOC Health Services leadership. After continued OCO outreach, DOC health	Assistance Provided

	medication which was recommended by a specialist and denied by the DOC Care Review Committee (CRC).	services reviewed and prescribed medication for inflammation and pain.	
130.	Person reports having chronic pain for 8 years. The person states that he has tried several different medications and is requesting to see a pain management specialists to receive a specific medication.	OCO staff provided assistance by contacting DOC staff. OCO staff reviewed the person's resolution requests, medical records and appointments. OCO staff found a resolution request had not been opened at the next level after an appeal was accepted. OCO staff contacted DOC resolutions staff and requested the resolution be move forward. OCO staff found the patient had received a transfer evaluation and follow up was ordered for chronic pain; OCO staff confirmed this appointment is pending scheduling. OCO staff provided information to the person regarding the upcoming appointment and encouraged the person to reach out to the patient care navigator with updates about scheduling.	Assistance Provided
131.	Incarcerated person reported they needed to speak with the investigation unit at the facility and was not getting an answer from them.	The OCO assisted by verifying the investigations unit was planning to speak with the person. The OCO also verified the person is currently in segregation due to safety concerns.	Assistance Provided
132.	Individual reports that he was written up for an incident and DOC staff lied in the infraction narrative. Additionally, the individual states staff made demeaning remarks when he was escorted back to his cell.	The OCO was unable to review the individual's infraction because he did not submit an appeal after he was found guilty. However, the OCO reviewed the staff misconduct and spoke with DOC, who confirmed that the resolution request was not responded to correctly. DOC stated they will meet with the individual to get a rewrite of his concern regarding DOC staff behavior when he was escorted back to his cell.	Assistance Provided
133.	Person reports experiencing a delay in receiving surgery. The person stated he was told surgery would be fast but has not gotten any updates about the surgery.	DOC staff addressed this concern prior to OCO action. OCO staff reviewed the person's appointments and verified the surgery is scheduled. OCO staff will monitor the appointment as a closed case.	DOC Addressed the Complaint
134.	Incarcerated individual shared concerns regarding not being provided with the proper sentencing timeframe.	DOC staff addressed this concern prior to OCO action. After speaking with the incarcerated individual, this office was informed that the complaint has been taken care of.	DOC Addressed the Complaint
135.	Incarcerated individual shared concerns regarding DOC not promoting their IMU level and being held in IMU despite no infractions being on their record for that placement.	DOC staff addressed this concern prior to OCO action. After review of DOC records, this office was able to confirm that this individual has been promoted out of IMU.	DOC Addressed the Complaint
136.	Incarcerated individual shared concerns regarding being sexually assaulted by another incarcerated individual.	DOC staff addressed this concern prior to OCO action. After review of DOC records and reaching out to DOC staff, this office was able to confirm that DOC investigated this concern and found the incident to not be a sexual assault. Further review of DOC's investigation found that the concern was deemed unsubstantiated.	DOC Addressed the Complaint
137.	Incarcerated person reports concerns about the custody level he is housed in and wants to be promoted custody levels.	DOC staff addressed this concern prior to OCO action. The OCO reviewed the person’s custody facility plan, including historic plans and found DOC has housed the person in unit that meet their custody level at the time. Recently, this person was promoted.	DOC Addressed the Complaint

138.	Incarcerated individual shared concerns regarding DOC not allowing them to promote levels despite completing their programming plan within their MAX program.	DOC staff addressed this concern prior to OCO action. After reviewing DOC records, this office was able to confirm that DOC staff promoted this individual following a CFP (Custody Facility Plan) completion recently.	DOC Addressed the Complaint
139.	Individual reports that DOC is making the recommendation for him to complete substance abuse treatment when he just completed it at ABHS. This decision is impacting his ability to be approved for graduated reentry (GRE).	The OCO confirmed the individual has been approved for graduated reentry (GRE), and DOC developed a plan so that he may complete programming while he is a GRE participant.	DOC Addressed the Complaint
140.	A loved one shared concerns on behalf of an incarcerated individual regarding being placed in IMU (Intensive Management Unit) despite sharing concerns regarding their safety.	The OCO provided information regarding how they can request safe harbor. After review of DOC records, this office was able to confirm that this individual refused their housing assignment and DOC was unable to verify their safety concerns. This office encouraged this individual to work with DOC staff to find adequate housing.	Information Provided
141.	An external person reports that her loved one has been refused food and has not received his property since transferring to the IMU.	The OCO provided information to this person by informing him that he needs to file a resolution request about his missing property and staff misconduct concerns.	Information Provided
142.	External person reported concerns regarding medical care and classification decisions. The person stated that there are facility safety concerns that are not being considered in their loved one's classification review.	The OCO provided information to the impacted person. OCO staff contacted Health Services staff and were informed that the condition reported by the patient is not treatable. OCO staff reviewed the person's classification review and determined the classification review was completed per DOC 300.080. OCO staff informed the person of the ways to appeal a classification decision.	Information Provided
143.	External person reported concerns about an incarcerated person's safety specifically related to their placement.	The OCO provided information about how to report concerns to DOC about placement. The OCO verified the person has not provided information required to validate safety concerns. The OCO shared what to provide and encouraged the person to continue working with DOC staff.	Information Provided
144.	Person reported concerns regarding the treatments being made available to them. The person reported that a medical provider told them that their treatment would not change after transfer however their new provider did change their treatment plan.	The OCO provided information about the medications the patient requested. OCO staff reviewed the person's records and contacted multiple medical providers. OCO staff were unable to find evidence that the reported conversation occurred.	Information Provided
145.	Individual reports that he was written up for refusing a UA, but the person says that he never refused to take a UA.	The OCO reviewed the infraction report and appeal response from DOC. The hearings officer reviewed the video, but there was no audio to confirm the conversation. At this time, DOC staff testimony is enough evidence to uphold an infraction decision. The	Information Provided

		OCO encouraged the individual to contact the Prison Disciplinary Program Manager, Michael Hathaway, for a final level of review.	
146.	Individual reports that an officer was harassing him by making homosexual jokes and calling him names.	The OCO contacted DOC about this concern, and DOC reported that they would look further into this situation. This office verified that the individual submitted a resolution request, and the OCO encouraged this person to continue escalating the complaint through the resolution process.	Information Provided
147.	Incarcerated individual reports concerns about facility placement safety and requested a keep separate.	The OCO confirmed the individual does have an active quad level separatee. This office provided information about the process for requesting a higher level of separatee at his upcoming review, as outlined in DOC 320.180 Separation and Facility Prohibition Management.	Information Provided
148.	Individual reports that he was infracted for a staff assault while at a juvenile facility but did not receive a hearing once in DOC custody.	The OCO reviewed the person's custody facility plan and DOC's reasons for giving them a max custody program. These DOC decisions comply with DOC 300.380 Classification and Custody Facility Plan Review. DOC 320.250 says that individuals who wish to appeal a headquarters max custody committee decision must complete DOC 07-037 Classification Appeal and submit it to the Assistant Secretary for Prisons within 72 hours of the final classification decision.	Information Provided
149.	Incarcerated individual shared concerns regarding DOC losing their property upon transfer.	The OCO provided information regarding tort claims. After review of DOC records, this office was able to confirm that this individual received their property upon transfer. A few of these items were denied. Following an appeal, this individual is free to file a tort claim to attempt to recuperate any potential lost cost.	Information Provided
150.	Individual reports that he had a t-shirt wrapped around his head and DOC infracted him for destruction of property because they thought he ripped the shirt. Additionally, when DOC staff asked for the shirt back he refused and in response, DOC did not give him lunch or dinner.	The OCO reviewed the infraction materials and contacted DOC about this concern. This office confirmed that there was no evidence of a ripped t-shirt, and the guilty finding was based on staff testimony, which meets the "some evidence" standard. DOC was not willing to overturn the infraction. The OCO provided contact information for Michael Hathaway, the Prisons Disciplinary Manager. The OCO also reviewed the resolution request about this person not receiving meals and encouraged the individual to escalate their resolutions through level three so there can be multiple levels of review.	Information Provided
151.	Incarcerated individual shared concerns regarding DOC staff not providing them with an appointment to obtain DME (Durable Medical Equipment) shoes despite DOC stating they will.	The OCO provided information regarding working with their provider at their current facility to ensure they have access to DME shoes. After reviewing DOC records and speaking with DOC staff, this office was able to see that DOC medical staff spoke with this individual regarding their concern and provided them with shoes at their previous facility as it was deemed clinically necessary.	Information Provided
152.	Incarcerated person reported concerns about being placed on the out of state transfer list and no movement occurring with the transfer out of state.	The OCO provided information about the out of state transfer process and how to reach DOC staff that can answer questions about his transfer. In this person’s situation, he had a court matter to attend that delayed his transfer to an out of state prison. Once he returns to DOC custody they will finalize his transfer. The OCO shared how to reach the DOC unit that handles these transfers for more information.	Information Provided
153.	Person reports concerns regarding the medical care they have been receiving. He is requesting treatment for his	The OCO provided information to the person. OCO staff contacted Health Services staff and were informed that the condition reported by the patient is not treatable. OCO staff reviewed the person's classification review and determined the classification	Information Provided

	skin. The person also requested a review of their classification situation as he believes he should be placed in a safe harbor unit.	review was completed per DOC 300.080. OCO staff informed the person of the ways to appeal a classification decision.	
154.	An external person reported that Extended Family Visits were terminated for three years due to an infraction, which is a Category B level 3, and that is not in policy. They should not have lost their EFVs.	The OCO reviewed the infraction packet, evidence, EFV termination, appeal and DOC policy and verified that the DOC did make a mistake, stating that the termination is for three years. The DOC sent new information informing the individual that they can submit a new application in one year. The DOC maintains that there is a documented reason to believe that that the individual may be a danger to themselves, visitors, or the orderly operation of the facility, due to the details of the infraction. The decision for the termination is supported by DOC 590.100 Extended Family Visit Eligibility.	No Violation of DOC Policy
155.	An external person reports that she has not been able to visit with her incarcerated loved one for multiple years.	The incarcerated individual's loved one was denied visitation because they have an unresolved criminal history. The eligibility requirement in DOC 450.300 attachment 1 says that a person is ineligible to visit if the visitor has pending/open felony and/or misdemeanor charges, is on community custody, or has a deferred sentence.	No Violation of DOC Policy
156.	Incarcerated person reported concerns about DOC placing them in segregation and reported that it was a result of DOC staff targeting him for sharing information about them.	The OCO reviewed the complaint and found DOC actions or are currently allowed within DOC 320.200 Administrative Segregation. DOC placed this person in segregation as a result of an investigation they conducted. The investigation resulted in the person being transferred to another facility. The person is currently in a housing assignment that matches their custody level.	No Violation of DOC Policy
157.	Incarcerated individual reports concerns about being denied for Graduated Reentry (GRE).	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC 390.590 Graduated Reentry.	No Violation of DOC Policy
158.	Person reported safety concerns, including being assaulted at a previous facility, and said he was being denied Safe Harbor.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC 300.380. The OCO conducted an extensive review of this individual's classification records and could not substantiate any record of this individual being assaulted. The OCO found that DOC could not validate this individual's safety concerns. This office found that this individual received multiple infractions recently and that DOC is within policy to demote him to a higher custody level.	No Violation of DOC Policy
159.	Incarcerated individual shared concerns regarding losing their visitation and tablet for six months.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC 450.300 and 460.050. After review of DOC records, this office was able to confirm that this individual was infracted and found guilty following the hearing. Due to the circumstances of the infraction, a sanction was imposed that restricted this individual's visitation and usage of a tablet.	No Violation of DOC Policy
160.	Incarcerated individual shared concerns regarding DOC not promoting their level within the IMU (Intensive Management Unit) despite having a non-violent infraction.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC 320.255. After review of DOC records, this office was able to confirm that this individual threatened a staff member to alter their housing. Due to this, this individual was demoted to Max custody and is being retained at the current level they are at as the circumstances of the incident meets the criteria for their level.	No Violation of DOC Policy

161.	Person reports that DOC is denying his girlfriend for visitation which is preventing them from being able to move forward with the marriage process.	The OCO reviewed the complaint and found that the visitation denial is currently allowed within DOC 450.300. OCO staff confirmed the visitation appeal was reviewed by DOC and the denial was upheld. Per DOC 450.300, people identified as being a safety concern may be denied all facility visit privileges. OCO staff also verified that the termination of video visits was also allowed within policy 450.300.	No Violation of DOC Policy
162.	Incarcerated individual reports concerns about facility placement.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC 300.380 Classification and Custody Facility Plan Review. This office confirmed the CFP was completed within policy and the person promoted custody levels and transferred to a new facility that can meet his classification and safety needs.	No Violation of DOC Policy
163.	Individual reports that his room was searched, and DOC did not leave a search report or provide him with a copy right away.	The OCO reviewed the complaint and found that DOC 420.320 says a copy of the completed form will be left in the cell or handed directly to the individual as a receipt. The policy does not establish a specific timeframe that DOC is supposed to follow when they deliver a search report.	No Violation of DOC Policy
164.	Person reported safety concerns with being sent to close custody.	The OCO reviewed the complaint and found DOC actions or inactions are currently allowed within DOC 300.380. The OCO reviewed DOC records and found that this individual was demoted due to multiple infractions and that his safety concerns could not be validated by DOC. The OCO encourages this individual to discuss his concerns with the Intelligence and Investigations Unit (IIU). This individual is currently under a classifications review and the OCO found that he refused to participate or make a statement about his concerns.	No Violation of DOC Policy
Intake Investigations			
Airway Heights Corrections Center			
165.	A family member reported concerns that this person has not been receiving adequate healthcare for pain management and other medical needs.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
166.	Someone reported a concern that this person was terminated from his job after contraband was found in the area he was working. Although he was not involved nor infracted for the contraband, he was not able to get hired in any other position at the facility and staff were instructed not to hire him.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
167.	Someone reported concerns about an infraction he received.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn

168.	This person reported concerns that his ex-fiancé wanted to be removed from his visitors list, however, there was a prohibited contact order put in place instead and neither party had asked for that.	The incarcerated individual said they did not want the OCO to further investigate the complaint and closed the case.	Complaint Withdrawn
169.	A friend or family member reported concerns about this person's well-being and safety.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
170.	An incarcerated person reports a concern related to DOC not disciplining another incarcerated person.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because of other reasons the ombuds deemed relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors.	Declined
171.	Incarcerated individual shared concerns regarding DOC staff not providing them with medical care following an assault.	This person was released prior to the OCO taking action on the complaint.	Declined
172.	A loved one reported a concern regarding an incarcerated person's custody facility plan.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about how to utilize the resolution program.	Technical Assistance Provided
173.	This person reported concerns that he suffers from severe chronic pain, but DOC says that he does not qualify for long term pain management because he does not have enough time left on his sentence.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about using the resolution program and contacting Health Services to access Medication Assisted Treatment (MAT).	Technical Assistance Provided
174.	An incarcerated person reports a concern related to DOC mail room returning mail for them causing them to lose money.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about using the resolution program and how to file a tort claim.	Technical Assistance Provided
175.	An incarcerated person reported a concern related to the behavior of a Community Custody Officer.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about steps they can take to report their concern to DOC.	Technical Assistance Provided
176.	This person reported that he did not receive his property when he arrived at the facility.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about how to file a tort claim and general property information.	Technical Assistance Provided

177.	This person reported that he was given permission to fill in as a pusher for a person in a wheelchair whose assigned pusher was not available. When staff later reviewed cameras, it was noticed this person was not on the correct side of the mainline chow hall. Staff further investigated the situation and the DOC staff member who originally gave him permission to push the wheelchair denied giving him permission and he was infracted.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about appealing a serious infraction.	Technical Assistance Provided
178.	An incarcerated person reported a concern related to the behavior of a DOC staff member.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about how to file resolution requests regarding the behavior of a DOC staff member.	Technical Assistance Provided
179.	An incarcerated person reported that they need an HSR and DOC is not issuing it.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about how to request an HSR.	Technical Assistance Provided
180.	An incarcerated person reports a concern related to the behavior of the DOC contract lawyer.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about using the resolution program and general information on legal resources available in the state of Washington.	Technical Assistance Provided
181.	An incarcerated person reported that DOC lost some craft items that they mailed out. The person stated that they wanted to be financially compensated for the loss.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the tort claim process.	Technical Assistance Provided
182.	An incarcerated person reports their time is not calculated correctly.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about using the resolution program to address the concern with DOC prior to reaching out to the OCO.	Technical Assistance Provided
183.	An incarcerated person reported a concern regarding the behavior of a DOC staff member.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for	Technical Assistance Provided

		assistance. The OCO provided technical assistance about how to use the resolution program to report staff behavior concerns.	
Clallam Bay Corrections Center			
184.	Someone reported concerns about this person's safety while housed at Clallam Bay Corrections Center.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
185.	Someone reported concerns about visitation issues and staff conduct.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
186.	Someone reported that this person has not been moved out of the Intensive Management Unit (IMU) although their infraction was overturned on appeal.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
187.	Someone reported concerns about this person's placement in close custody.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
188.	An external person reported a concern about this person's release date and that he is still incarcerated.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
189.	An external person reported that this person is not receiving the appropriate level of medical care.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
190.	Someone reported that this person was sanctioned to a loss of phone privileges, and is not able to call their family.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
191.	An incarcerated person reports DOC delayed issuing them a medication and verifies that the medication has now been provided.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because of other reasons the ombuds deemed relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors.	Declined
192.	A loved one reported a concern regarding an infraction & accessing health care.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about steps to follow before contacting the OCO.	Technical Assistance Provided
193.	A loved one reports a concern regarding a missed scheduled video visit and requests that the incarcerated person be compensated.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about how to file a tort claim, and how to use the resolution program to report staff behavior concerns.	Technical Assistance Provided

194.	A family member reported concerns that an individual is being threatened and extorted by other incarcerated individuals.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about appealing a finalized Custody Facility Plan to Classification.	Technical Assistance Provided
195.	This person reported concerns that his wife was denied visitation after an incident that occurred over five years ago with another individual. No charges or infractions were accrued from the incident.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about appealing visitation.	Technical Assistance Provided
196.	An incarcerated person reports a concern related to the behavior of a DOC staff member.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about how to use the resolution program to report their concern to DOC prior to reaching out to the OCO.	Technical Assistance Provided
Coyote Ridge Corrections Center			
197.	External person reports concerns about her loved one's STG status and getting placed on the out-of-state transfer list.	This case was a duplicate of one that already existed from the same complainant for the same concerns.	Complaint Withdrawn
198.	External person reports concerns about her loved one's STG status and getting placed on the out of state transfer list.	This case was a duplicate of one that already existed from the same complainant for the same concerns.	Complaint Withdrawn
199.	A friend or family member reported concerns about this person's treatment by DOC staff members at the facility he is housed in.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
200.	A friend or family member reported concerns about this person's well-being and safety. They also reported that he did not receive five boxes of property that was shipped to him when he was transferred to another facility.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
201.	This person reported concerns that DOC staff are not getting people to their scheduled video court hearings intentionally which creates negative consequences such as warrants being issued for failure to appear.	The incarcerated individual said they did not want the OCO to further investigate the complaint and closed the case.	Complaint Withdrawn

202.	This person reported a complaint that he mailed a speedy disposition document to the Spokane County Court, but the Spokane County prosecutor and clerk's offices claimed to have not received it.	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint relates to an action taken by an agency other than the Washington State Department of Corrections.	No Jurisdiction
203.	An incarcerated person requested more information on Classification and Facility assignment processes in DOC.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about how to appeal classification and facility assignment.	Technical Assistance Provided
204.	This person reported concerns that a DOC staff member with whom he has had issues with completed his Custody Facility Plan (CFP). This staff member is not his assigned counselor, and he is worried this was done in retaliation.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about how to address staff conduct concerns using the resolution program.	Technical Assistance Provided
205.	An incarcerated person asked for specific contact information for legal resources.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about general legal resources available in the state of Washington.	Technical Assistance Provided
206.	An incarcerated person reported a concern related to their SecurUs tablet.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about contacting SecurUs.	Technical Assistance Provided
207.	This person reported that DOC is not letting him have access to the legal law library or a tablet.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about using the resolution program and how to access legal resources.	Technical Assistance Provided
Mission Creek Corrections Center for Women			
208.	Incarcerated individual shared concerns regarding getting sick due to consuming contaminated water at a DOC facility and there being delays in receiving medical care.	This person was released prior to the OCO taking action on the complaint.	Declined
Monroe Correctional Complex			
209.	A family member reported a concern that they previously reported regarding an	This case was a duplicate of one that already existed from the same complainant and for the same concern.	Complaint Withdrawn

	infraction that the appeal is pending.		
210.	A friend or loved one reported a concern via the OCO's online submission form that was a duplicate of another concern previously received.	This case was a duplicate of one that already existed from the same complainant and for the same concern.	Complaint Withdrawn
211.	Someone reported concerns about this person's well-being and safety.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance. The OCO reviewed the individual's electronic file and spoke with DOC about this person's well-being.	Complaint Withdrawn
212.	Incarcerated individual shared concerns regarding DOC limiting their access to education courses, stealing their intellectual property, and extorting them.	The incarcerated individual said they did not want the OCO to further investigate the complaint and closed the case.	Complaint Withdrawn
213.	A family member reported a concern related to the sanctions given out to a person due to an infraction that has not yet been appealed.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because of other reasons the ombuds deemed relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors.	Declined
214.	A family member reported a concern related to the sanctions given out to a person due to an infraction that has not yet been appealed.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because of other reasons the ombuds deemed relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors.	Declined
215.	A loved one reported a concern related to a cell assignment.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because of other reasons the ombuds deemed relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors.	Declined
216.	An incarcerated person reported an issue with the mailroom.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because of other reasons the ombuds deemed relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors.	Declined
217.	An individual reports that the Securus liaison accused him of altering his tablet and has threatened to give him an infraction.	The OCO reviewed the individual's records and confirmed that he received an infraction for destruction of property along with a $130 restitution. Per WAC 138-10-040(3)(a), the ombuds lacks jurisdiction over the complaint because the concern is related to an action made by Securus, not DOC.	No Jurisdiction
218.	An incarcerated person reports that they received an infraction and their tablet has been confiscated.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about how to appeal infractions.	Technical Assistance Provided

219.	You report that your ERD is not correct, and you are not sure where the extra time DOC added to your sentence came from.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about using the resolution program and writing to DOC Headquarters to address time calculation concerns.	Technical Assistance Provided
220.	This person reported concerns that the water at his facility was recently repaired but the cold water is not running clear and smells like gasoline. He is concerned that DOC is targeting the cold water or something this wrong and DOC is not fixing it.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about using the resolution program.	Technical Assistance Provided
221.	An incarcerated person reports a concern related to frustration that staff appreciation often means lockdowns which is a punishment for the incarcerated population.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about how to use the resolution program to report this concern to DOC prior to reaching out to the OCO.	Technical Assistance Provided
Other			
222.	A community member reported a concern about the behavior of police officers and jail staff in a county jail.	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint relates to an action taken by an agency other than the Washington State Department of Corrections.	No Jurisdiction
223.	A concern was misdirected to OCO regarding the behavior of Wyoming State Penitentiary staff.	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint relates to an action taken by an agency other than the Washington State Department of Corrections.	No Jurisdiction
224.	Someone reported concerns regarding individuals who are not under the jurisdiction of the Department of Corrections and reports to the Kittitas County Sheriff's Office.	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint relates to an action taken by an agency other than the Washington State Department of Corrections and the complaint does not involve a person committed to the physical custody of the DOC.	No Jurisdiction
225.	This person reported delays in receiving records from the Benton County Jail after submitting a public records request.	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint relates to an action taken by an agency other than the Washington State Department of Corrections and the complaint does not involve a person committed to the physical custody of the DOC.	No Jurisdiction
Stafford Creek Corrections Center			
226.	A friend or family member entered a case on the OCO webform with the stated intention of adding information to a case that already exists in the OCO system.	This case was a duplicate of one that already existed from the same complainant and for the same concern.	Complaint Withdrawn

227.	Someone reported concerns about this person's safety and need to be transferred to a safe harbor facility.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance. The OCO confirmed this individual was transferred and is safe.	Complaint Withdrawn
228.	A loved one reported several concerns related to an incarcerated person being denied access to hygiene, property, and a mattress. The same loved one also submitted a concern several days earlier regarding a more serious issue.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because of other reasons the ombuds deemed relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors.	Declined
229.	An incarcerated person reported a concern related to being unable to find a job in the facility after an infraction.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because of other reasons the ombuds deemed relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors.	Declined
230.	An incarcerated person reported a concern related to not being able to change their meal plan more frequently than every 6 months.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because of other reasons the ombuds deemed relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors.	Declined
231.	A loved one reported a concern regarding the behavior of a Community Custody Officer and regarding an infraction.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about using the resolution program to report the behavior of DOC staff members and information on how to appeal an infraction.	Technical Assistance Provided
232.	An incarcerated person reports they were infracted incorrectly.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about how to appeal an infraction.	Technical Assistance Provided
233.	An incarcerated person reported that one of their regular visitors has been rejected. The person later called and reported that the person is no longer blocked.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about visitation rejections, denials, and terminations and how to appeal rejections.	Technical Assistance Provided
Washington Corrections Center			
234.	An external person submitted an additional web form to add notes for an existing case.	This case was a duplicate of one that already existed from the same complainant and for the same concern.	Complaint Withdrawn
235.	A family member reported a concern that is a duplicate of a concern previously reported.	This case was a duplicate of one that already existed from the same complainant and for the same concern.	Complaint Withdrawn
236.	Someone reported concerns about this person's safety being housed in a facility	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within	Complaint Withdrawn

	where they have been harmed in the past.	30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	
237.	This person requested that the OCO contact the court on his behalf to explain why a deadline was missed and request a new virtual hearing.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because the requested resolution was not within the ombuds' statutory power and authority.	Declined
238.	An incarcerated person reports a concern related to the quality of the food being served.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because of other reasons the ombuds deemed relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors.	Declined
239.	An incarcerated person reported a concern related to their classification and the level system in restrictive housing.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because of other reasons the ombuds deemed relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors.	Declined
240.	This person reported a complaint that a conviction from 2005 did not include probation or registration requirements, however, DOC served him with papers requiring him to register and DOC added those requirements to his Judgement and Sentence.	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint relates to the person's underlying criminal conviction.	No Jurisdiction
241.	An incarcerated person reports a concern related to the behavior of a DOC staff member.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about using the resolution program to report to DOC the behavior of DOC staff members.	Technical Assistance Provided
242.	This person reported concerns that DOC did not calculate his sentence correctly and his ERD is not accurate.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about using the resolution program and who to contact at DOC Headquarters to address concerns about time calculations.	Technical Assistance Provided
243.	This person reported concerns about being targeted by a DOC staff member.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about using the resolution program to address staff conduct concerns.	Technical Assistance Provided
244.	An incarcerated person reports that DOC is not calculating their time correctly.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about using the resolution program to attempt to resolve this concern with DOC prior to reaching out to the OCO.	Technical Assistance Provided

245.	An incarcerated person reports a concern related to a pending re-classification.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about how to appeal a classification decision.	Technical Assistance Provided
246.	An incarcerated person reports a concern related to not receiving responses from kites and letters sent to DOC staff.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about using the resolution program to attempt to resolve the concern with DOC prior to reaching out to the OCO.	Technical Assistance Provided
247.	An incarcerated person reports that their time is not being calculated correctly by DOC.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about steps to take prior to reaching out to the OCO.	Technical Assistance Provided
248.	This person reported concerns about being infracted with a cell tag although his roommate admitted to the contraband.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about appealing infractions.	Technical Assistance Provided
249.	An incarcerated person reports a concern related to the denial of a visitor.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about steps available to appeal the visitor's rejection or denial.	Technical Assistance Provided
250.	Individual reports that they have not had bedding exchange for two weeks because their unit was locked down and skipped.	The OCO provided technical assistance regarding how to file a resolution request.	Technical Assistance Provided
251.	An incarcerated person reports that they disagree with classifications assessment of their safety.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about what steps to take to ensure their safety concerns are reported to DOC and classifications staff.	Technical Assistance Provided
252.	This person reported concerns about being targeted by DOC staff members.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about using the resolution program to address staff concerns.	Technical Assistance Provided

253.	This person reported concerns that DOC is not following their policy guidelines regarding infractions.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about appealing infractions and contacting the OCO when the appeal outcome is complete.	Technical Assistance Provided
254.	This person reported that he recently detoxed off of Suboxone and is not able to access the Medication for Opioid Use Disorder (MOUD) program or any other alternative treatment substance use disorder.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about accessing the Health Services: Medication Assisted Treatment (MAT) program.	Technical Assistance Provided
Washington Corrections Center for Women			
255.	A loved one opened a new OCO complaint via web form to provide an update for another existing OCO case.	The OCO is closing this case because the information from this case has been added to the existing case for this person regarding the same concern.	Complaint Withdrawn
256.	An individual reports that she is past her release date and is looking for help with her release.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because the person released from DOC custody prior to OCO action.	Declined
257.	The individual reports that last night, an officer would not give her supplies and called her a snitch This person is being targeted by DOC staff, and they are going to lock her down all weekend because of a negative BOE.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO did not find a resolution request or negative BOE appeal. This office did meet with this individual in person to provide technical assistance. This individual has since left DOC custody.	Technical Assistance Provided
258.	An incarcerated person reported a concern related to the behavior of a DOC staff member.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about how to use the resolution program to report a concern related to the behavior of the DOC staff member.	Technical Assistance Provided
259.	An incarcerated person reported a concern related to the behavior of a DOC staff member.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about how to use the resolution program to report concerns related to the behavior of a DOC staff member.	Technical Assistance Provided
260.	An incarcerated person reported a concern related to the behavior of a DOC staff member whose name they are not sure of.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about using the resolution program to report concerns related to the behavior of DOC staff members.	Technical Assistance Provided

Washington State Penitentiary			
261.	A loved one of family member reported additional information related to a concern they previously reported which is still being investigated.	This case was a duplicate of one that already existed from the same complainant and for the same concern.	Complaint Withdrawn
262.	A friend or family member reported concerns about experiencing challenges when scheduling video visits, the quality of the video visits as well as phone calls. They also reported frequently not being on the approved list for events and feeling generally harassed.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
263.	Someone reported concerns that this person has been threatened and was assaulted by a DOC staff member.	The OCO investigated this same concern in another case that was made by a different complainant.	Complaint Withdrawn
264.	Someone reported that the power went out in this person's cell and DOC did not get the power restored for a few days.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
265.	An incarcerated person re-reported a concern related to getting a job in his unit.	This case was a duplicate of one that already existed from the same complainant and for the same concern.	Complaint Withdrawn
266.	An incarcerated person re-reported a concern related to two infractions.	This case was a duplicate of one that already existed from the same complainant and for the same concern.	Complaint Withdrawn
267.	An incarcerated person reported a concern related to wanting to be moved to a different facility or unit.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because of other reasons the ombuds deemed relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors.	Declined
268.	An incarcerated person reported a concern related to the custody level and facility placement of an incarcerated person.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because of other reasons the ombuds deemed relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors.	Declined
269.	An incarcerated person reported a concern related to wanting a lower bunk health status report.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because of other reasons the ombuds deemed relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors.	Declined
270.	An incarcerated person reported a concern related to wanting help with information about financial assistance for education.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because of other reasons the ombuds deemed relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors.	Declined
271.	An incarcerated person reported a concern related to	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because of other reasons the ombuds	Declined

	not being given a job in his unit.	deemed relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors.	
272.	This person reported that because of the Juvenile Point Bill he is supposed to have a new court hearing to correct his sentence but that has not happened and DOC has not talked to him about this.	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint relates to the person's underlying criminal conviction.	No Jurisdiction
273.	A loved one reported a concern related to the calculation of a person's sentence.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about how to use the resolution program to make sure DOC is alerted to the need for their record to be corrected.	Technical Assistance Provided
274.	This person reported that his glasses were broken, and he has not been able to get them replaced.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about using the resolution program and contacting Health Services to request a new pair of glasses.	Technical Assistance Provided
275.	An incarcerated person reported a concern regarding wanting financial compensation for a medication mistake made by DOC medical and a request for records from DOC.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the tort claim process and how to request records from DOC.	Technical Assistance Provided
276.	An incarcerated person reports they were recently issued used shoes.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about how to utilize the resolution program.	Technical Assistance Provided

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

Case Closure Reason	Meaning
Unexpected Fatality Review	The incarcerated person died unexpectedly and the death was reviewed by the Unexpected Fatality Review Committee, 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 individualized self-advocacy or case-specific information.
DOC Addressed the Complaint	DOC staff addressed the concern prior to OCO action.
Insufficient Evidence to Substantiate	Available evidence was insufficient to substantiate the concern.
No Violation of DOC Policy	The OCO determined that DOC did not violate DOC policy or no applicable DOC policy existed.
Substantiated	The OCO verified the concern but was unable to achieve a resolution to the concern.
Complaint Withdrawn	The incarcerated individual did not provide permission to proceed with an investigation or asked OCO to close the complaint, or OCO staff opened the complaint in error.
Declined	The OCO declined to investigate the complaint per WAC 138-10-040(3).
No Jurisdiction	The complaint did not meet OCO's jurisdictional requirements set forth in RCW 43.06C.040(2)(e).
Technical Assistance Provided	The OCO provided general self-advocacy information to resolve the concern through a DOC process prior to OCO involvement.

The OCO implemented new case closure reasons in July 2025.
This change aligns with the agency's goals of ensuring that materials are accessible and ensuring transparency in data reporting.

Monthly outcome reports are available on Securus tablets, in law libraries, and online at https://oco.wa.gov/reports-publications/reports.

Common DOC Acronyms & Glossary

ADA: Americans with Disabilities Act

ASR: Accommodation Status Report

BOE: Behavior Observation Entry

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 Closed Case Review Team.

CO: Correctional Officer

CPA: Community Parenting Alternative

CRC: Care Review Committee

CUS: Correctional Unit Supervisor

DES: Department of Enterprise Services

DOSA: Drug Offender Sentencing Alternative

EFV: Extended Family Visit

ERD: Earned Release Date

EMP: Extraordinary Medical Placement

GRE: Graduated Reentry

HCSC: Headquarters Community Screening Committee

HSR: Health Status Report

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

J&S: Judgment and Sentence

MAT: Medication Assisted Treatment

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

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

SARU: Substance Abuse Recovery Unit

SSOSA: Special Sex Offender Sentencing Alternative

SOTAP: Sex Offender Treatment and Assessment Program

SVP: Sexually Violent Predator

TC: Therapeutic Community

WaONE: Washington ONE ("Offender Needs Evaluation")

DOC Prisons

AHCC: Airway Heights Corrections Center
CBCC: Clallam Bay Corrections Center
CCCC: Cedar Creek Corrections Center
CRCC: Coyote Ridge Corrections Center
MCC: Monroe Correctional Complex
MCCCW: Mission Creek Corrections Center for Women
OCC: Olympic Corrections Center
SCCC: Stafford Creek Corrections Center
WCC: Washington Corrections Center
WCCW: Washington Corrections Center for Women
WSP: Washington State Penitentiary

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-022

Report to the Legislature

As required by RCW 72.09.770

August 8, 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-24-022 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

This report describes the results of one such review and presents recommendations.

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 July 10, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Penny Bhagia, Deputy Chief Medical Officer
- Patricia Paterson, Chief of Nursing
- Dr. Rae Simpson, Director – Quality Systems
- Darren Chlipala, Administrator
- Shane Evans, Administrator
- Dr. Rainey-Gibson, Director – Mental Health
- Dr. Ashley Espitia, Psychologist – Suicide Prevention Specialist
- Arpan Aulakh, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- Eric Jackson, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Rochelle Stephens, Men's Prisons Project Manager

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

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

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

Fatality Summary

Year of Birth: 1969 (55 years old)

Date of Incarceration: April 2024

Date of Death: December 2024

At the time of death, this incarcerated individual was housed in a Washington State Department of Corrections facility.

His cause of death is asphyxia due to ligature hanging. The manner of his death is suicide.

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

Day of Death	Event
21:52 – 04:25 hours	• Video review showed movement or lights turned on and off in the incarcerated individual's cell. • All required tier checks were conducted.
05:26 – 05:39 hours	• While conducting tier check, the Officer knocks on the incarcerated individual's cell door, does not receive response, and radios for the Sergeant (Sgt.) to report to the unit. • Additional custody and medical staff responded to the unit and began assessment of the incarcerated individual. • Due to the complex ligature apparatus the incarcerated individual was found in, responding staff initially had concerns of a possible homicide and a crime scene was declared rather than rendering immediate aid.
05:40 hours	• Shift Lieutenant (Lt.) leaves the incarcerated individual's cell and posts an officer.
05:53 – 06:05 hours	• Facility Medical Director (FMD) was notified that life-saving measures were not performed because the incarcerated individual had not been cut down. • FMD contacts Lt. and advised life-saving measures must be initiated until death could be declared.
06:14 – 06:32 hours	• Incarcerated individual is cut down.

	• Community Emergency Medical Services arrives on scene, conducts assessments, and declares incarcerated individual deceased. • Cell then secured.

UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee (MRC) and the DOC Critical Incident Review (CIR). The UFR Committee considered the information from both reviews and offered no recommendations for corrective action pertaining to direct cause of death.

A. The DOC conducted a CIR to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operational procedures.

    a. The incarcerated individual completed suicide between unit tier checks.

    b. The CIR identified policy and procedure concerns which did not directly correlate to the cause of death. These concerns are being remediated per DOC Policy 400.110 – Reporting and Reviewing Critical Incidents.

        i. The officer was uncertain how to appropriately notify and request help when he discovered the incident.

        ii. On arrival at the scene, responding staff assessed that the incarcerated individual was beyond the window of resuscitation and believed him to be deceased. Additionally, the complex ligature apparatus in which he was found caused staff to have concerns of a possible homicide. Based on these perceptions, responding staff initially secured the cell as a crime scene rather than immediately rendering aid.

B. The DOC MRC reviewed the health record, the delivery of medical and mental health care, and the concerns identified by the CIR. They did not identify any additional recommendations to prevent a similar fatality in the future.

    The MRC found:

    1. The incarcerated individual received appropriate care for his chronic medical conditions.

    2. He reported previous suicide attempts, denied current suicidal thoughts or plans, received appropriate mental health screenings and was being seen by a psychiatrist for medication management.

    3. He did not consistently attend the pill line to receive his medication, and the prescriber was not

notified of missed doses.

4. The incident occurred in the early morning hours, and some staff were unclear on roles and responsibilities during the emergency response.

5. The MRC recommended:

    a. Nursing will review the cause of absent notification when the patient did not attend pill line and improve the process so that notifications are made timely and according to DOC Policy 650.020 - Pharmaceutical Management and Nursing Procedure N-306.

    b. DOC conduct joint drills with a self-harm scenario on all shifts which would reinforce policy requirements, previous training, facilitate communication, and build rapport between custody and clinical staff for future responses.

C. The UFR Committee reviewed the unexpected fatality and discussed the following topics.

1. Pill line management.

    a. Members reviewed possible changes to improve safety and support individuals receiving pill line medications. These include ensuring overhead pages are clear and audible and prescribers are notified when an individual is not attending the pill line.

    b. DOC is implementing an electronic medication administration record which will facilitate communication and monitoring for incarcerated individuals receiving medications.

2. DOC emergency response procedures and staff training.

    a. UFR Committee members reviewed proposed updates to DOC's annual staff training, including updated content for suicide risk detection, responding to self-harm events, roles and responsibilities during an emergency, and procedures for pronouncement of death within a DOC facility.

3. Support for staff and incarcerated individuals following the incident.

    a. Tier checks and check-ins with mental health staff were completed for those incarcerated individuals who were affected by the death. Impacted staff members are proactively offered peer support through the DOC Employee Resilience Team and have access to the Employee Assistance Program (EAP).

UFR Committee Findings

The incarcerated individual died of asphyxia due to hanging. The manner of death is suicide.

UFR Committee Recommendations

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

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 write and carry out a series of drills and training that normalize the role of Health Services clinical staff directing the medical components of an emergency response.
2. DOC should provide additional training for nursing staff to emphasize the requirements of the medication administration policy and protocol.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-024

Report to the Legislature

As required by RCW 72.09.770

August 15, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Tim Lang, Secretary
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Unexpected Fatality Review Committee Report

UFR-24-024 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

This report describes the results of one such review.

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on July 10, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Poonam Bhagia, Deputy Chief Medical Officer
- Patricia Paterson, Chief of Nursing
- Dr. Eric Rainey-Gibson, Director of Behavioral Health
- Dr. Ashley Espitia, Suicide Prevention Specialist
- Darren Chlipala, Health Services Administrator
- Shane Evans, Health Services Administrator
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- Lorne Spooner, Director for Correctional Services
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- Elisabeth Kingsbury, Acting Director
- Ollie Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

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

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

Fatality Summary

Year of Birth: 1993 (31-years-old)

Date of Incarceration: February 2017

Date of Death: December 2024

At the time of death, the decedent was housed in a prison facility.

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

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

Day of Death	Event
12:18 hours	• A peer who lives in the unit stops at the decedent's cell front and speaks with the decedent for approximately one minute.
12:19 hours	• Custody staff conducts a routine tier check.
12:22 hours	• Last observed movement noted from within the decedent's cell.
13:33 hours	• Routine tier check conducted. Custody staff observe that the decedent is not moving and initiate radio notification to respond to scene.
13:35 hours	• Custody Supervisor responds to scene, unlocks decedent's cell door, performs primary survey and discovers the ligature on decedent's neck, and goes back to booth to retrieve a cutting tool to remove ligature.
13:37 – 13:54 hours	• Ligature is removed and the decedent is repositioned out of the cell to the tier to initiate care. • Cardiopulmonary Resuscitation (CPR) is initiated and Automated External Defibrillator (AED) is applied. • On-site medical staff arrive and contribute to the response effort.
13:54 – 14:44 hours	• Community Emergency Medical Services (EMS) arrives, assumes care, and transports the decedent to the helicopter.
14:45 hours	• Life Flight staff determine that the decedent has died.

UFR Committee Discussion

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

Committee (MRC) and the DOC Critical Incident Review (CIR). The UFR Committee considered the information from both reviews in formulating recommendations.

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

    1. The MRC found:

        a. The decedent was receiving appropriate care for her medical and gender-affirming care needs.

        b. She was receiving mental health treatment and declined medication for symptom management due to fears that it would interfere with her hormone therapy.

        c. She had multiple suicide risk factors, including a history of self-harm during times of high emotion.

            i. The denial of housing with a preferred cellmate appears to have been a strong emotional stressor.

        d. During the emergency response, rescue breaths were administered by a Corrections Officer using an Ambu bag. They were not administered in coordination with chest compressions the Nurse was providing. This was not thought to contribute to the death.

            i. Custody and clinical staff receive different CPR training curricula, which may affect interdepartmental coordination during an emergency medical response.

            ii. Training for nursing staff is ongoing, focusing on emergency response documentation, proper equipment use, and role clarification.

            iii. The presence of volunteer EMT-certified employees at the facility may contribute to role ambiguity during a medical emergency response.

    2. The MRC recommended:

        a. Submission of a proposal to improve CPR team synchronization, role expectations, and common understanding of goals of CPR for all DOC staff whether this continues different training programs or unifies the training expectations.

        b. Add regular multidisciplinary CPR and Emergency drills to provide opportunities to practice and debrief together prior to real-life emergency response.

        c. Track compliance rates in the HS linked metrics venue to ensure all nursing staff complete emergency response training.

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

1. The CIR identified policy and procedure concerns which did not directly correlate to the cause of death. These concerns are being remediated per DOC Policy 400.110 – Reporting and Reviewing Critical Incidents.

    a. The decedent completed suicide between tier checks.

        i. There was one hour and 14 minutes between unit tier checks.

    b. Due to a scoring error during a compatibility housing review, the decedent was approved to house with a preferred cellmate. Prior to the housing move, the error was discovered, and the approval was rescinded.

    c. The initial radio transmission announced a "medical emergency" but did not identify the nature of the emergency (i.e. unresponsive individual).

    d. The Ambu bag for rescue breathing was used ineffectively during the response.

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

1. Response to a mental health crisis.

    a. DOC conducts annual staff training focused on reducing suicide risk and responding to mental health crises. The training encompasses the identification of warning signs and the procedures for effectively communicating with and referring individuals to mental health providers when concerns arise.

    b. DOC is nearing completion of efforts to ensure that all incarcerated individuals have free access to the 988 mental health hotline.

2. DOC housing review process.

3. Patient education on medication interactions.

    a. Health Services providers consistently communicate information about potential risks, benefits, and interactions before prescribing new medications, enabling incarcerated individuals to make informed decisions about their care options.

4. Tier Checks.

    a. DOC is working to improve the quality and consistency of tier checks through establishing benchmarks, sharing lessons learned, and opportunities for improvement from previous reviews.

UFR Committee Findings

The decedent died of asphyxia due to hanging. The manner of death was suicide.

UFR Committee Recommendations

The UFR Committee endorsed actions taken by DOC to identify and respond to a mental health crisis and reduce suicide risk. They did not offer additional recommendations for corrective action.

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

1. Submit a proposal to improve CPR team synchronization.
2. Track compliance rates for nursing emergency response training.
3. Establish tier check benchmarks and reinforce consistency.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-010

Report to the Legislature

As required by RCW 72.09.770

August 27, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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Unexpected Fatality Review Committee Report

UFR-25-010 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 UFR is to develop recommendations for DOC and the legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for incarcerated individuals in DOC's custody.

This report describes the results of one such review.

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on July 25, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Patricia Paterson, Chief of Nursing
- Dr. Rainey-Gibson, Director – Mental Health
- Dr. Ashley Espitia, Suicide Prevention Specialist
- Mark Eliason, Deputy Assistant Secretary
- Arpan Aulakh, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- Melissa Andrewjeski, Assistant Secretary
- Eric Jackson, Deputy Assistant Secretary
- Charles Anderson, Deputy Assistant Secretary
- Susan Leavell, Senior Administrator
- Lorne Spooner, Director for Correctional Services
- Rochelle Stephens, Men's Prisons Project Manager
- Paige Perkinson, Correctional Operations Project Manager

DOC Risk Mitigation

- Michael Pettersen, Director

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

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

Health Care Authority (HCA)

- Heather Schultz, Associate Medical Director

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

Fatality Summary

Date of Birth: 1984 (41-years-old)

Date of Incarceration: March 2022

Date of Death: April 2025

At the time of death, the decedent was housed in a prison facility.

The cause of death is stab wound of chest. The manner of death is homicide.

A brief timeline of events the day of the decedent's death:

Time	Event
01:00 hours	• Tier check conducted by custody staff.
01:37 hours	• The decedent's cellmate uses the emergency call button to notify staff that the cellmate believed they killed the decedent.
01:39 – 01:42 hours	• Custody staff in the control booth radio for assistance. • Custody and medical staff respond to the scene.
01:42 hours	• The decedent's cellmate is removed from the cell. • Custody staff secure the scene and staff enter the cell to render aid.
01:45 hours	• Medical staff assess the decedent and begin Cardiopulmonary Resuscitation (CPR).
01:50 hours	• Community Emergency Medical Services (EMS) called.
02:20 hours	• Community EMS arrives on scene.
02:32 hours	• Community EMS personnel pronounce the death of the decedent.

UFR Committee Discussion

The UFR committee met to discuss the findings and recommendations from the DOC Mortality Review Committee (MRC) and the DOC Critical Incident Review (CIR). The UFR committee considered the information from both reviews and offered no recommendations for corrective action.

A. The MRC reviewed the health record and antecedent care provided by DOC and issued the following findings and recommendations. The MRC did not identify any opportunities to prevent a similar fatality in the future.

The MRC found:

1. The decedent received appropriate care and no significant care gaps were identified.
2. In addition to the physical injuries identified on the autopsy report, the decedent's postmortem toxicology was positive for methamphetamine.
3. The decedent's cellmate had no flags to indicate that they should not be housed with a roommate.
4. The MRC discussed the value of the community health care practice of routinely asking patients about their living situation and whether they feel safe at home.

While not contributory to the cause of death, the MRC identified the following opportunities:

1. Incorporating safety screening questions, such as "Do you feel safe in your living situation?" as part of the Health Services visit process.

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

1. The CIR found that the decedent was fatally injured by their cellmate.
2. The CIR did not identify any operational procedures or policy violations that caused or contributed to the decedent's death and no DOC policies were identified as needing revision or having been violated.

C. The UFR Committee reviewed the unexpected fatality and discussed the following topics:

1. Drug use in prisons.
    i. The decedent's cellmate reported being under the influence of drugs at the time of the incident and the decedent's post-mortem toxicology was positive for methamphetamine, a contraband drug.
    ii. The introduction of contraband into prison facilities remains a complex challenge. DOC has implemented multiple strategies to detect and prevent the entry of illicit substances and continues to collaborate with other corrections systems to identify and adopt best practices for improving detection methods.
2. Reporting housing safety concerns.
    i. Incarcerated individuals can report housing safety concerns to any staff member in person, by kite, or by kiosk message. Upon receipt of such a report, DOC staff will immediately relocate the individual expressing concern while the report is investigated

and appropriate action is taken.

ii. In this case, no safety concerns were reported by either the decedent or their cellmate.

UFR Committee Findings

The decedent died of a stab wound to chest. The manner of death is homicide.

UFR Committee Recommendations

The UFR Committee did not issue any recommendations for corrective action.

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

1. Integrate structured safety screening questions into the Health Services visit process to proactively identify housing-related safety concerns and support early intervention.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-011

Report to the Legislature

As required by RCW 72.09.770

August 26, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

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Unexpected Fatality Review Committee Report

UFR-25-011 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 UFR is to develop recommendations for DOC and the legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for incarcerated individuals in DOC's custody.

This report describes the results of one such review.

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on August 7, 2025:

DOC Health Services

- Dr. Poonam Bhagia, Deputy Chief Medical Officer
- Dr. Eric Rainey-Gibson, Director – Behavioral Health
- Dr. Ashley Espitia, Suicide Prevention Specialist
- Patricia Paterson, Chief of Nursing
- Dr. Rae Simpson, Director – Quality Systems
- Arpan Aulakh, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- Melissa Andrewjeski, Assistant Secretary
- Deborah Wofford, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- Susan Leavell, Senior Administrator
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Project Manager

DOC Reentry Division

- Michelle Eller-Doughty, Reentry Center Operations Administrator

DOC Risk Mitigation

- Michael Petterson, Director

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

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

Health Care Authority (HCA)

- Dr. Heather Schultz, Associate Medical Director

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

Fatality Summary

Date of Birth: 1974 (51-years-old)

Date of Incarceration: January 2024

Date of Death: February 2025

At the time of death, the decedent was housed in a prison facility.

The cause of death is hypertensive and atherosclerotic cardiovascular disease. The manner of death is natural.

A brief timeline of events on the day of death:

Time	Event
13:10 hours	• After a brief period of exercising in the outdoor yard, the decedent sat down in their wheelchair and became unresponsive.
13:11 hours	• The decedent's assigned peer therapy aid/wheelchair pusher attempts to rouse them. The therapy aid then notified custody staff that the decedent is unresponsive.
13:12 – 13:29 hours	• Custody staff initiated a medical emergency response and then used the wheelchair to move the decedent closer to medical responders. • The decedent is removed from the wheelchair, placed on the ground, and staff began lifesaving efforts. • A request for community Emergency Medical Services (EMS) is made.
13:30 – 14:05 hours	• Community EMS arrive on scene and assumed care.
14:06 hours	• The decedent's death is pronounced by community EMS.

UFR Committee Discussion

The UFR committee met to discuss the findings and recommendations from the DOC Mortality Review Committee (MRC) and the DOC Critical Incident Review (CIR). The UFR committee considered the information from both reviews and offered no recommendations for corrective action.

A. The MRC reviewed the medical record and the antecedent care delivered by DOC and provided the following findings. The MRC did not identify any additional recommendations to prevent a similar fatality in the future.

1. The MRC found:

    a. The decedent was receiving appropriate care and treatment for several medical conditions. Recommended health screenings were up to date and the decedent was seen regularly by primary care.

    b. The decedent was under the care of a community cardiologist. Documentation indicates a cardiology appointment occurred approximately one week prior to death, during which the decedent's care plan had been reviewed and updated.

    c. Available records did not indicate that the decedent was counseled on the potential cardiovascular risks associated with exercise.

2. While not contributory to the cause of death, the MRC identified the following opportunities:

    a. Enhance medical emergency response readiness through standardized staff training, drills, and quality control inspections of Health Services emergency response (Red) bags to ensure equipment availability and functionality.

    b. Evaluate the feasibility of implementing predictive analytics and AI solutions to proactively identify medically complex individuals who may benefit from targeted outreach and care coordination offered by DOC's Nurse Care Managers.

B. Independent of the MRC, DOC conducted a CIR to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operational procedures.

1. The CIR found:

    a. The decedent had a documented history of multiple chronic health conditions.

    b. The Ambu-bag mask was not present in the Health Services emergency response (Red) bag. The Ambu-bag was not needed in the response and was not contributory to the decedent's death.

    c. Review of applicable policy, procedure and staff performance did not identify any contributing factors to the decedent's cause of death within the scope of a CIR.

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

1. Emergency response training and staff readiness.

    a. DOC's nursing emergency response training has been updated to include standardized requirements for restocking and auditing emergency response supplies, hands-on instruction, and practical application assessments to evaluate employee performance on effective use of equipment.

b. UFR Committee Members also reviewed improvements that are currently underway statewide to ensure all DOC staff are trained to appropriately respond to a medical emergency.

2. Peer Support

   a. DOC is expanding its peer support programs to include training for therapy aids and wellness support groups.

3. Nursing care management team.

   a. Individuals can be connected to and treated by nurse care managers after referral from their primary care provider, through a multidisciplinary team meeting, or by direct outreach from a nurse care manager when appropriate.

UFR Committee Findings

The decedent died of hypertensive and atherosclerotic cardiovascular disease. The manner of death is natural.

UFR Committee Recommendations

The UFR Committee did not issue any recommendations for corrective action.

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

1. Sustain and expand efforts to strengthen medical emergency response readiness through standardized staff training, scenario-based drills, and routine inspections of emergency medical supplies to ensure availability and functionality.

2. Explore feasibility of implementing use of predictive modeling and AI solutions to assist with identifying medically complex individuals who may benefit from enhanced care coordination.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-015

Report to the Legislature

As required by RCW 72.09.770

August 22, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Tim Lang, Secretary
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Unexpected Fatality Review Committee Report

UFR-25-015 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 UFR is to develop recommendations for DOC and the legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for incarcerated individuals in DOC's custody.

This report describes the results of one such review.

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on July 25, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary
- Patricia Paterson, Chief of Nursing
- Dr. Eric Rainey-Gibson, Director – Behavioral Health
- Dr. Ashley Espitia, Suicide Prevention Specialist
- Arpan Aulakh, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons

- Melissa Andrewjeski, Assistant Secretary – Women's Division
- Charles Anderson, Deputy Assistant Secretary – Men's Division, Central Command
- Eric Jackson, Deputy Assistant Secretary – Men's Division, West Command
- Lorne Spooner, Director for Correctional Services
- Susan Leavell, Senior Administrator
- Paige Perkinson, Correctional Operations Program Manager
- Rochelle Stephens, Men's Prisons Project Manager

DOC Risk Mitigation

- Michael Pettersen, Director

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

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

Health Care Authority (HCA)

- Dr. Heather Schultz, Associate Medical Director

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

Fatality Summary

Year of Birth: 1956 (68-years-old)

Date of Incarceration: April 2025

Date of Death: April 2025

At the time of death, the decedent was housed in a prison facility Infirmary for medical isolation precautions.

The cause of death is hanging. The manner of death is suicide.

A brief timeline of events the day of decedent's death:

Time	Event
00:11 hours	• Custody staff are at the decedent's cell in the Infirmary for formal count.
00:45 hours	• Custody staff conduct a tier check of the Close Observation Area (COA). • No tier check of the Infirmary is completed.
01:36 – 01:51 hours	• Custody staff and a nurse are at the decedent's cell for routine check and find the decedent unresponsive. • Custody staff makes a radio call and retrieves a ligature removal device. • Responding staff put on appropriate personal protective equipment, enter cell and begin lifesaving efforts.
01:52 – 01:58 hours	• Community Emergency Medical Services (EMS) respond to scene and assume care.
02:20 hours	• Community EMS pronounce the death of the decedent.

UFR Committee Discussion

The UFR committee met to discuss the findings and recommendations from the DOC Mortality Review Committee (MRC) and the DOC Critical Incident Review (CIR). The UFR committee considered the information from both reviews and offered no recommendations for corrective action.

The MRC reviewed the medical record and the antecedent care provided by DOC and provided the

following findings and recommendations.

1. The MRC found:
    a. Medical and mental health intake screening exams were completed appropriately.
    b. The decedent had no known history of prior suicide attempts and no mental health concerns were identified during intake screening. The decedent did not request mental health treatment or declare a mental health emergency prior to death.
    c. The infection prevention screening, combined with symptom self-report, indicated that the decedent may have had active Tuberculosis disease. Therefore, they were placed in the Infirmary under medical isolation precautions to lessen the risk of transmission until results of confirmatory testing were received.
    d. The practitioner who admitted the decedent to medical isolation in the Infirmary erroneously designated an observation level of care based on the decedent's medical needs.
        i. Per DOC Policy 610.600 Infirmary/Special Needs Unit, a level of care is used to determine the service level to be provided and minimum documentation requirements for an incarcerated individual.
        ii. An observation care level may not exceed 72 hours.
            1. The decedent's care level was not changed from observation to skilled care when the admission exceeded the 72-hour time limit. The change in care level would have required increased clinical interactions with the decedent including daily practitioner rounding and nursing assessments during each shift.
    e. During nursing rounds, the decedent expressed frustration with being in medical isolation and staff provided materials to help alleviate boredom.
    f. The Infirmary call system cord was manipulated and able to be used as a ligature device.
        i. As an action item, the MRC recommended that DOC conduct a walk-through of all medical isolation rooms to identify opportunities for suicide risk reduction measures.
        ii. The MRC also recommended consideration of how to safely provide out of cell time for persons who are in medical isolation, a known risk for boredom and potentially despair.

2. Though not contributory to the cause of death, the MRC identified the following opportunities for improvement:

    a. Updating Policy 610.600 Infirmary/Special Needs Unit Care to provide additional guidance for admission levels of care and nursing practice requirements.

    b. Conducting an evaluation of the statewide Infirmary call button system to assess functionality, safety, and adherence to current standards.

    c. Developing a standardized protocol for rounding and assessments of incarcerated individuals placed in medical isolation.

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

    1. The CIR found:

        a. The decedent completed suicide within the same month of admission to a prison facility and with the use of a call button cord.

            i. No risk factors were identified from a medical or mental health perspective that would have impacted the decedent's placement into medical isolation or indicated suicidal ideation.

            ii. The Infirmary call system can be manipulated without triggering any visual or audible alarms to alert staff.

            iii. Tier checks in the Infirmary were missed prior to the incident and logbook entries were inaccurate.

    2. The CIR recommended:

        a. Updating the Post Orders/Operations Manuals and Post Logs to ensure custody staff conducting tier checks appropriately observe and assess the wellbeing of each incarcerated individual in their living area, including cells, the Close Observation Area, and the Infirmary in accordance with DOC Policy 400.200 Post Orders/Operations Manuals and Post Logs.

        b. The CIR noted that a change to call light devices has statewide implications, which requires legislative support and funding.

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

    1. Infirmary call system.

a. UFR Committee members were in support of evaluating the current call system in DOC facilities and discussed how improvements would likely require legislative funding and support.

2. Medical isolation.

    a. The UFR Committee discussed the importance of medical isolation, as well as its potential to negatively impact the mental health of the individual receiving care. Members support efforts to increase multidisciplinary communication, to proactively provide mental health outreach and to identify opportunities to lessen the impact of being isolated (i.e., phone access, outdoor time, allowable property).

3. Tier Checks.

    a. DOC is working to improve the quality and consistency of tier checks by establishing benchmarks, sharing lessons learned, and reviewing opportunities for improvement from previous reviews.

UFR Committee Findings

The decedent died as a result of hanging. The manner of death is suicide.

UFR Committee Recommendations

The UFR Committee endorsed actions taken by DOC to identify opportunities to support the mental and physical health of individuals who require medical isolation. They did not offer additional recommendations for corrective action.

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

1. Establish tier check benchmarks and reinforce consistency.

2. Establish care delivery requirements for individuals who require medical isolation regardless of housing location.