Office of the Corrections OMBUDS

Monthly Outcome Report

July 2025

Unexpected Fatality Reviews: 1

Case Investigations: 134

Assistance Provided: 23

Information Provided: 58

DOC Addressed the Complaint: 19

Insufficient Evidence to Substantiate: 11

No Violation of DOC Policy: 22

Substantiated: 1

Intake Investigations: 100

Declined: 16

No Jurisdiction: 14

Complaint Withdrawn: 39

Technical Assistance Provided: 31

Total Resolved Investigations: 235

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Complaint Withdrawn	The incarcerated individual did not provide permission to proceed with an investigation or asked OCO to close the complaint, or OCO staff opened the complaint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.

Monthly Outcome Report: July 2025

	Complaint Summary	Outcome Summary	Case Closure Reason
Unexpected Fatality Reviews			
1.	Person 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-24-021 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.	Unexpected Fatality Review
Case Investigations			
Airway Heights Corrections Center			
2.	Incarcerated person reported concerns about DOC staff and using force on him during an incident in the living unit. He ended up receiving an infraction that he would like to get dismissed.	The OCO assisted by reviewing all use of force documentation including video evidence and requesting DOC review the infraction for dismissal. The OCO had conversations with DOC leadership about the use of force and the lack of adequate camera footage of the incident. Conversations about use of force prevention and best practices are ongoing, and DOC did not agree to dismiss the infraction.	Assistance Provided
3.	Person reports struggling with substance use and chronic pain. They have requested to be placed on Medication Assisted Therapy (MAT) to treat both conditions.	The OCO assisted by contacting DOC Health Services staff. OCO staff asked what is available to the patient and were informed of a different treatment that could be approved for the patient. OCO staff later reviewed the person's specialist consultation and found that they were approved for the treatment stated by the provider that is currently pending scheduling. OCO staff will monitor this appointment as a closed case to ensure it is scheduled. The OCO provided information about the Medication Assisted Therapy (MAT) program and specialist consultation process. OCO staff reviewed the person's record and found that they are outside the current protocol timelines for the MAT program.	Assistance Provided
4.	Person reports that DOC staff did not allow him to have his durable medical equipment in segregation. The person reports that when they requested to be allowed the machine, he was told that he would be fine without it.	The OCO assisted by elevating the concern to DOC Health Services Leadership. OCO staff contacted Health Services leadership at the facility who confirmed the patient's report and that those machines were not going to be permitted in restrictive housing. OCO staff brought this concern to DOC leadership at headquarters and the ban on durable medical equipment was clarified to indicate that the decision would be made on a case-by-case basis with consideration of the individual patient's condition. OCO staff are in ongoing discussion with Health Services Leadership regarding updates to the health status report protocol, including how durable medical equipment is handled in restrictive housing.	Assistance Provided

5.	Person reports a need for a lower bunk, lower tier health status reports due to a diagnosis known to the DOC. The person is concerned about the amount of time they have had to wait to see a provider.	DOC staff addressed this concern prior to OCO action. OCO staff contacted DOC Health Services staff and were informed the patient was already scheduled to see their provider. OCO staff reviewed the person's appointments and verified the primary care appointment was scheduled. OCO staff monitored the appointment until it was confirmed to have been attended and verified the health status reports were ordered.	DOC Addressed the Complaint
6.	Person reports he fell on the stairs in the unit and there were no staff present to call for medical attention. The person reports he has been dealing with a joint issue and had to wait for approval of durable medical equipment (DME) that could have prevented this fall. The person is requesting to be placed on the lower tier and receive the DME that was approved for him.	DOC staff addressed this concern prior to OCO action. OCO staff reviewed the person's record and found the housing request had been ordered as a health status report. OCO staff contacted DOC Health Services staff to confirm that patient had physical possession of the durable medical equipment (DME). DOC staff response was significantly delayed despite several attempts to contact health services staff. DOC Health Services leadership was notified of this delay. OCO staff confirmed that the staff conduct was addressed by leadership.	DOC Addressed the Complaint
7.	Person reports that they are in safe harbor and apparently DOC is clearing out his unit to make it into a violator pod. Person says DOC is sending him and a bunch of other people to CRCC despite any of their safety concerns.	The OCO verified with DOC that this plan was cancelled.	DOC Addressed the Complaint
8.	Incarcerated individual shared concerns regarding not being provided care for their leg pain.	DOC staff addressed this concern prior to OCO action. After speaking with DOC staff, this office was able to confirm that this individual has been seen regarding their concern.	DOC Addressed the Complaint
9.	Person reported concerns regarding an infraction he received. The person stated that he has a medical condition that impacts his ability to comply with UAs within the allowed timeframe. The person is requesting that they be issued a Health Status Report (HSR) so they will not be infracted again.	DOC staff addressed this concern prior to OCO action. OCO staff reviewed the person's available records and noted that the person was able to receive the requested Health Status Report (HSR) shortly after reporting the concern to the OCO. OCO staff monitored the infraction for an appeal result and found that the infraction was removed from the person's record.	DOC Addressed the Complaint
10.	External person reports that their loved one is experiencing multiple health concerns that have not been addressed by DOC medical. The person is requesting to see a specialist and get a treatment plan.	The OCO provided information to the patient about their specialist consultations. OCO staff reviewed the person consultations and contacted DOC Health Services staff. OCO staff confirmed that the person has received specialist evaluations for the reported issues and they have further appointments scheduled.	Information Provided
11.	External person reports that their loved has received inadequate treatment for an injury he has been dealing with for several months. The external person is requesting that their loved one receive follow up care.	The OCO provided information to the patient about their consultations. OCO staff reviewed this person's specialist consultations and provided the patient with information about the recommendations made to DOC by the specialist.	Information Provided
12.	Incarcerated person reported concern about DOC moving him to a different unit. The person reports the move was due to staff disliking him.	The OCO provided information about the unit move, specifically we shared why DOC moved him to a different unit. This office spoke with DOC staff at the facility that explained this person and others were moved because of a proposed plan to change the use of the unit to something	Information Provided

		different. DOC then cancelled that plan. This person was not moved back, because the new unit has more space to house people. The OCO was unable to verify that the person was moved due to staff disliking him.	
13.	Person reported that he had not received the durable medical equipment that was approved as a result of a prior OCO case.	The OCO provided information about filing tort claims. OCO staff reviewed the person's records and contacted DOC Health Services staff. OCO staff contacted the patient to confirm receipt of the durable medical equipment (DME). OCO staff were informed that the DME that was received did not match the patient's expectations with consideration of the severity of the diagnosis. The delay in delivery of the DME caused this person's follow up with the specialist to be delayed. 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
14.	Person reports multiple health concerns that have not been addressed by DOC medical. The person is requesting to see a specialist and get a treatment plan.	The OCO provided information about their specialist consultations. OCO staff reviewed the person consultations and contacted DOC Health Services staff. OCO staff confirmed that the person has received specialist evaluations for the reported issues and they have further appointments scheduled.	Information Provided
15.	Person states he has been told by the facility events coordinator that he cannot participate in the upcoming API event including helping with planning due to a general infraction form 2024.	The OCO reviewed the resolution request the individual submitted and confirmed that it stated the individual was allowed to go to the event; they just could not set up for the event due to an infraction from last year. Our office shared that information with the facility leadership who stated they would be meeting with the group to address these concerns.	Information Provided
16.	Person reported that they want to be transferred back to their home state.	The OCO provided information about the transfer. The Women's Division has contacted DOC HQ Classifications to ask for a transfer back to the state of origin.	Information Provided
17.	Person reported that he experiences severe opioid addiction and wants to be placed on the MAT program.	The OCO provided information about the Medication Assisted Therapy (MAT) program. OCO staff reviewed the person's record and found that they are outside the current protocol timelines for the MAT program. OCO staff are in ongoing discussion with DOC Health services leadership regarding the expansion of the MAT protocols to cover more patients and will provide the current MAT expansion information with people who are requesting admission to the MAT program.	Information Provided
18.	Person reports that that he has been requesting additional imaging to figure out the source of a medical issue he experiences. The person states that he is being told there is not anything wrong with him. The person is requesting to see a specialist for evaluation and treatment.	The OCO provided information about the patient's care plan to the patient. OCO staff reviewed the patient's consultation reports and contacted DOC Health Services staff. OCO staff were unable to substantiate that DOC had not made efforts to find the cause of the patient's symptoms. OCO staff noted the patient has received multiple clinical evaluations and the patient's situation has been reviewed by a specialist and recommendations have been made for what the provider should next consider for treatment. Medical issues that have no clear direct cause often require trialing different treatments to ascertain the cause. The DOC utilized multiple	Information Provided

		avenues of receiving specialist consultation that do not always require a trip to the community.	
19.	Person reported that he experiences severe opioid addiction and wants to be placed on the MAT program.	The OCO provided information about the Medication Assisted Therapy (MAT) program. OCO staff reviewed the person's record and found that they are outside the current protocol timelines for the MAT program. OCO staff are in ongoing discussion with DOC Health leadership regarding the expansion of the MAT protocols to cover more patients and will provide the current MAT expansion information with people who are requesting admission to the MAT program.	Information Provided
20.	Incarcerated individual reported concerns regarding previously being allowed to have multiple special visits a month but now this is not allowed.	The OCO provided information about special visits and shared visiting resources. The OCO spoke with headquarters visitation staff and found that the facility was providing more than one special visit a month in error. Once DOC fixed the error, this person had special visits with his family once a month because of the number of people in his family. Currently the facility only allows 4 people per regular visit. DOC Headquarters staff are working to update this protocol and agreed that the rule creates hardship for large families to visit as frequently as smaller families.	Information Provided
21.	Person reports having received inadequate treatment for an injury he has been dealing with for several months. The patient states that he has been seen and given treatment options, however his provider has not made an effort to figure out the underlying issue causing the pain.	The OCO provided information about the patient's consultations. OCO staff reviewed this person's specialist consultations and monitored internal appointments that had been cancelled for rescheduling. OCO staff noted a specialist appointment had been cancelled by the outside clinic for a patient with more urgent needs. OCO staff confirmed that DOC had the appointment rescheduled without delay and monitored the appointment until it was attended. OCO staff provided the patient with information about the recommendations made to DOC by the specialist.	Information Provided
22.	Person reports that he has requested Medication Assisted Therapy (MAT) to treat a substance use disorder. The person states he has requested assessment for the program but has not yet received it.	The OCO provided information about the Medication Assisted Therapy (MAT) program and specialist consultation process. OCO staff reviewed the person's record and found that they are outside the current protocol timelines for the MAT program. OCO staff are in ongoing discussion with DOC Health leadership regarding the expansion of the MAT protocols to cover more patients and will provide the current MAT expansion information with people who are requesting admission to the MAT program.	Information Provided
23.	Incarcerated individual shared concerns regarding being infracted for a medical concern and DOC refusing to accommodate them. Individual also requested being provided with an oral mouth swab HSR (Health Status Report).	The OCO provided information regarding how they can potentially obtain their desired HSR. After reviewing DOC records, this office was able to confirm that this individual had been infracted and the circumstances met the elements required to be infracted per DOC 460.050. This individual did not appeal the infraction guilty finding.	Information Provided
24.	Incarcerated individual shared concerns regarding DOC staff lying about them and losing their job over the incident.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC 460.050. This office reviewed DOC records and was able to confirm that this individual had been infracted and found guilty. Due to the circumstances of the infraction, this individual lost their job.	No Violation of DOC Policy
25.	Person reports adverse side effects of taking his medication crushed. The	The OCO reviewed the complaint and found that DOC actions are currently allowed within DOC 600.000. OCO staff	No Violation of DOC Policy

	person has a condition that affects their throat and are requesting an exception to the crush protocol.	contacted the person's medical provider, asking if he had been evaluated and considered for an exception to the crush protocol. OCO staff were informed that the patient had been considered; however, there was no clinical indication for an exception to be made. OCO staff reviewed the manufacturer's information and could not confirm the patient's condition is a contraindication for that medication with the information available.	
Cedar Creek Corrections Center			
26.	Person reported that he was fired from his Department of Natural Resources (DNR) job because of missing days due to medical appointments, which were excused absences. Person said he was infracted for losing his job and that he appealed the infraction but never got a response back.	DOC staff addressed this concern prior to OCO action. The OCO reviewed DOC records and found that this infraction was reduced to a general infraction, which the OCO does not work to overturn. The OCO found that this individual now has a new job.	DOC Addressed the Complaint
Clallam Bay Corrections Center			
27.	Person reports they have been housed in restrictive housing for over a year on level 2 only. He has been positively programming and is awaiting out of state transfer.	The OCO assisted by contacting DOC HQ Classifications and asking for a meeting to discuss the level system. The department is currently looking at the level process and is considering a modified level 3 without the communication app. He would be eligible for this at his next review.	Assistance Provided
28.	Person reports issues with getting the correct substitutions for his therapeutic diet. The person states he has filed over twenty resolution requests for this due to not being provided enough food or the correct items.	The OCO provided assistance by notifying DOC leadership of issues found in the persons related resolutions. OCO staff contacted the person's current provider and was informed the diet had been changed since he transferred. OCO staff found that there were several resolutions that had been held up at his previous facility. OCO staff contacted leadership in the resolutions program who got DOC staff to move the resolutions forward.	Assistance Provided
29.	Person reports that he has been in restrictive housing for over a year now at level one only. He has completed seven programs and would like a level promotion.	The OCO reviewed the custody facility plan and verified he was placed on level 1 only due to an infraction. That infraction is not included in DOC 320.250 as a level 1 only infraction. This office contacted DOC Classifications and asked for it to be changed. DOC agreed to adjust his level per DOC policy.	Assistance Provided
30.	Individual reported they are not safe in close custody general population.	The OCO reviewed the custody facility plan and saw that the individual was transferred from one close to custody to the other. The safe harbor committee denied safe harbor placement. They currently have an open custody facility plan. The OCO provided information by telling the individual they can appeal placement after the plan is finalized.	Information Provided
31.	Incarcerated person reported concern with how DOC staff responded during a controlled movement. The person reports DOC did not follow protocol when restraining him.	The OCO provided information about how DOC responded to the incident and the findings of the OCO investigation. The OCO reviewed all available evidence and found DOC staff did not follow DOC protocol. Further documentation shows DOC substantiated this protocol was not followed and action was taken to prevent this from occurring further. The OCO shared this information with the person and shared how to access resolution request documents.	Information Provided

32.	An individual reported that the guards are beating up an inmate, making him sleep on concrete without a mattress and not feeding him.	The OCO did an in-person monitoring visit to see this individual. The individual was actively smearing feces and the OCO was unable to speak with him at the time. This office did review his recent incident reports and found there have been recent uses of force. He is often moved from cell to cell due to feces smearing and DOC must follow hygiene protocols regarding his food when his cell is in an unsanitary condition. The OCO could not identify video recordings showing this individual being beaten. This office will reach out to the individual by letter to ask if he needs assistance from our office.	Insufficient Evidence to Substantiate
33.	Incarcerated individual shared concerns regarding DOC not promoting their IMU (Intensive Management Unit) level for more privileges despite their infraction being non-violent.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC 320.250. This office reviewed documents relevant to this concern and was able to confirm that this individual had been infracted with a serious infraction and failed to appeal the infraction. Due to the infraction being on their record, this infraction history was utilized to determine their IMU level.	No Violation of DOC Policy
Coyote Ridge Corrections Center			
34.	An external person reported concerns regarding her loved one's safety in a political unit.	The OCO assisted by contacting the facility and reporting this safety concern. The facility took action and spoke with the individual about this situation. The DOC followed up with the OCO and confirmed that the individual had been moved to protective custody and will be going to another facility.	Assistance Provided
35.	Incarcerated individual shared concerns regarding DOC not responding to their medical request and failing to renew their HSRs (Health Status Reports).	DOC staff addressed this concern prior to OCO action. After speaking with DOC staff and reviewing DOC records, this office was able to confirm that DOC medical staff are updating this individual's HSR request when it is deemed clinically necessary.	DOC Addressed the Complaint
36.	Incarcerated individual shared concerns regarding DOC wrongfully trying to demote them.	DOC staff addressed this concern prior to OCO action. After review of DOC records, this office was able to confirm that this individual received an override to maintain the custody level they are at.	DOC Addressed the Complaint
37.	An external person reports that their unit has been on lockdown for days, and it has been almost 72 hours since anyone was allowed to leave their cell and shower.	The OCO contacted DOC about this concern. The DOC reported that this unit will have access to a shower before the end of the day.	Information Provided
38.	Person reports he is going to be tapered off a medication because he changed his mind about the treatment course he wanted to take. The person is requesting to stay on the medication he is currently on because he will be within protocol timelines within a few weeks of the taper ending.	OCO staff provided information about the patient's treatment plan. OCO staff contacted DOC Health Services leadership and were informed that patients will be tapered off the initial medication if they decide that they do not want to receive the treatment that was being initiated. Patients are educated on this prior to starting treatment and exceptions are not currently being made.	Information Provided
39.	Person reports they attempted to pick up their medications but was told they were not due for a refill. The person states that the prescription label states that he should have a refill due at that time. The person is requesting	The OCO provided information that was requested by the person. OCO staff contacted DOC Pharmacy staff and were informed that due to multiple early refills, the person had depleted the quantity of pills due for the total order before the order was complete by date. OCO staff reviewed the pharmacy data and confirmed this information.	Information Provided

	information to understand how this happened.		
40.	Incarcerated individual shared concerns regarding DOC charging them excessively for shipping their property.	The OCO provided this individual with tort claim information. This office was able to see that DOC has provided this individual with dates and reasons for charges or return of funds.	Information Provided
41.	Incarcerated person reported they do not have access to their tablet and need access to contact a county agency and report information.	The OCO provided information about how to contact the county agency and report information. The OCO also spoke with the unit supervisor who shared that this person recently was able to access their tablet prior to transferring to another facility.	Information Provided
42.	An individual reports that DOC staff searched his cell and took his fan because they said it had been altered. DOC staff did not provide him with a property disposition form and instead hot trashed the item.	The OCO spoke with DOC about this concern and the correctional unit supervisor (CUS) said he was unaware that staff were hot trashing property. The CUS stated that if an individual experiences this issue, they may come directly to him and report the concern so the CUS can resolve the situation.	Information Provided
43.	External person reported due to unnecessary physical force by staff, her loved one does not feel safe. He was put in the hospital due to this situation with head injuries. When DOC staff entered his cell there was no announcement and he woke with a CO touching him. He should not get an infraction and should be sent to a different facility.	The OCO reviewed all the evidence that was available related to this concern. The individual was found unresponsive during count. Based on unit footage it looks as if staff were attempting to dialogue with him for at least five minutes while waiting for more officers to help. A use of force did occur in the cell, and it cannot be seen on unit video. According to the UOF report the individual would not cooperate, could barely stand and was slurring his speech. Staff put him in a WRAP restraint to get him to medical for evaluation, and then he was taken to the hospital. Once he was in medical, handheld camera video shows staff getting him ready for transport. This office confirmed that he did sustain an injury. The OCO also confirmed that he received a CT scan at the hospital. Record review noted that this individual denied substance use but the UA test contradicted that claim. This individual was not infracted, he did not lose custody points, and he was transferred to a new facility. The OCO could not substantiate that this incident was an excessive use of force.	Insufficient Evidence to Substantiate
44.	Incarcerated person reported a concern about a staff member. The person reported the concerns were not investigated by DOC.	The OCO reviewed existing evidence and was unable to substantiate the concern. The evidence reviewed was inconsistent and the lack of camera footage in the unit creates barriers to substantiating what occurred. The OCO spoke with DOC facility leadership about the concern and the facility agreed to speak with the person more frequently to address any further issues with staff.	Insufficient Evidence to Substantiate
45.	A loved one reported concern with her visitation with an incarcerated individual being denied.	The OCO reviewed the complaint and found DOC actions or inactions are currently allowed within DOC 450.050 and DOC 450.300. The OCO reviewed DOC records and reached out to DOC staff and confirmed that DOC is within policy to deny visitation with this individual.	No Violation of DOC Policy
46.	Individual reported safety concerns related to the general population at their current facility and medical problems. They requested a transfer	The OCO contacted the health services manager at that facility, Headquarters Classifications, and the facility's medical director. This office also reviewed this individual's custody facility plans and infraction history. The DOC has maintained that this individual can receive appropriate	No Violation of DOC Policy

	back to another prison for appropriate care.	medical care at their current location, and they denied the request to move to another facility. They are within DOC 300.380, as the facility's medical director confirmed, the individual can receive appropriate care there. Currently, the individual is in the IMU due to infractions per DOC 320.200, with a new custody facility plan pending. This office provided information to the individual that if they disagree with the new custody facility plan, they can appeal to Headquarters Classification per policy 300.380.	
47.	Incarcerated person reported concerns about DOC denying them access to the community parenting alternative (CPA), graduated reentry (GRE), and a reentry center (RC). The person requests OCO review the denials and request DOC reconsider them for one of these programs.	The OCO reviewed the complaint and found DOC's denials are currently allowed within DOC 390.585, 390.590 and 300.500. DOC is not willing to transfer this person to CPA, GRE or a reentry center due to community concerns.	No Violation of DOC Policy
48.	Person reports that DOC staff made an agreement that he could return to his previous unit if he withdrew a staff conduct resolution request. The person was sent back to segregation and now wants to have the resolution request reopened. The person also voiced concerns regarding the pain management options available to him and requested a specific change to his medication.	The OCO reviewed the complaint and found that the DOC actions are currently allowed within the DOC Resolution Program Manual (RPM) and DOC 600.000. OCO staff reviewed the resolution and the DOC RPM. OCO staff found that per page 9 of the RPM resolutions that have been previously withdrawn are not accepted. OCO staff could not identify any evidence that resolutions staff made an agreement with him to allow him to return to his previous unit. OCO staff could not verify that the person had requested that the concern be reopened through DOC before reporting to the OCO. OCO staff encouraged the person to file a new resolution request if the staff behavior continued to impact him after he returned to the unit since that would be within the timelines set by the RPM and should be considered a new concern rather than a duplicate. OCO staff also encouraged the person to get any agreements with DOC staff confirmed in writing. OCO staff contacted DOC Health Services staff and were informed of the pain management options currently available to the patient. The OCO confirmed the patient has access to pain management medications and the request for pain management changes needs to be handled with their medical provider. The OCO cannot compel a medical provider to order specific medications as that is a clinical decision.	No Violation of DOC Policy
49.	Incarcerated individual shared concerns regarding being wrongfully infracted and their custody override request being denied.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC 300.380. After review of DOC records, this office was able to confirm that this individual had received two serious infractions in a short duration prior to this complaint. These two infractions lowered this individual's custody score and made them ineligible for medium but they had received an override within their CFP (Custody Facility Plan) to be classified as medium custody. This individual again received two more serious infractions which further lowered their score.	No Violation of DOC Policy
50.	Incarcerated individual shared concerns regarding being wrongfully infracted.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC 460.050. After review of DOC records, this office was able to confirm that the	No Violation of DOC Policy

		circumstances of the situation met the requirements for the WAC (Washington Administrative Code) given.	
Monroe Correctional Complex			
51.	An anonymous incarcerated individual shared concerns regarding DOC transport staff being on their phones while driving.	The OCO provided assistance by sending a message to DOC leadership regarding refraining from utilizing electronic devices while driving transport vehicles.	Assistance Provided
52.	Person reports ongoing issues with DOC medical sending him to the wrong specialist to address his medical concern. The person also stated that DOC is not providing the medication that was recommended by another specialist. The patient is requesting to see a specialist for a surgical evaluation and to receive the medication that was recommended for him.	The OCO assisted by reviewing the person's consultations and notifying DOC of a mix up found in the scheduling of multiple appointments within the same clinic for different doctors. OCO staff requested review by Health Services leadership, resulting in a new consultation being opened and the medication was approved. OCO staff will monitor the specialist appointment as a closed case to confirm scheduling and attendance.	Assistance Provided
53.	Person reports that DOC medical is not following the recommendations made by a specialist. The person reports that he was recently given a serious diagnosis that his previous provider disregarded. The person requested that his specialist recommendations be reviewed for approval by the facility medical director.	The OCO assisted by reviewing the patient's specialist consultations with DOC Health services staff. OCO staff noted issues with consultations and requested that it be reviewed by the facility medical director. OCO staff provided information about the patient's cancelled appointments. OCO staff monitored the patient's appointments to confirm he was able to meet with his new medical provider and the Facility Medical Director to go over his treatment plan.	Assistance Provided
54.	During the OCO Quarterly Meeting, individuals reported that units C/D were not allowed to attend the Carnival unless they were 90 days infraction free. This is difficult for many of the individuals in those units due to metal health challenges.	The OCO contacted the Superintendent and asked if an exception could be made. The Superintendent agreed to lift the restrictions and allow all individuals from C/D to attend as long as they are not on the no mixing list. The no mixing lists consists of people who have keep separates in place.	Assistance Provided
55.	Person reports not receiving gender affirming care or health care following overexposure to heat. The person is requesting to meet with their provider to get treatment addressed.	DOC staff addressed this concern prior to OCO action. OCO staff reviewed the patient's appointments and noted that they had met with the responsible provider, started treatment and had an additional appointment scheduled with the gender affirming care team.	DOC Addressed the Complaint
56.	Person reported concern about not being seen by medical for ongoing health conditions. Person said he wrote a resolution request and multiple kites but has not been seen yet.	DOC staff addressed this concern prior to OCO action. The OCO reviewed DOC records and reached out to multiple DOC staff and confirmed that this individual has received the care he was seeking, and that he is on medication and is scheduled for ongoing care.	DOC Addressed the Complaint
57.	Person reports he has not received a response to his appeal for a Care Review Committee decision. The person states he did not have access to the legal library during the appeal timeframe. The person is requesting to	The OCO provided information about this patient's Care Review Committee appeal. OCO staff reviewed the person's consultations and contacted DOC Health Services staff regarding the plan of care for this patient. OCO staff were informed the person's CRC request was denied due to a lack of clinical indication that a second opinion was needed. OCO	Information Provided

	have his appeal reviewed and for the CRC appeal timelines to be extended.	staff noted that the person's provider has requested collaboration with the FMD for this person's care.	
58.	Person reports he was infracted multiple times for one incident that occurred. He did not hear the staff tell him to leave the shower and the staff said he was refusing. The infractions affect his ability for GRE.	The OCO reviewed the infractions and audio. The guilty finding met the some evidence standard, and the DOC will not overturn the infractions. The individual was already denied for GRE before the infractions were issued.	Information Provided
59.	Person reports that they have been delayed in getting surgery by his previous facility and further delayed by being transferred because of being assaulted. The person was told they would have to start the process over again. The person is requesting to move forward with the surgery.	OCO staff provided tort claim information and requested reentry information to the person. The person contacted the OCO and informed this office that surgery occurred shortly after reporting. The OCO also provided information to the person on the steps to request additional treatment options.	Information Provided
60.	Person reports that DOC is not following the specialists' recommendations he received while at an outside consult.	The OCO provided information to the patient regarding the process for outside specialist recommendations to be ordered within DOC. OCO staff reviewed the person's records and verified the recommendations were documented in the consultation. For recommendations to be ordered by a DOC medical provider they must be reviewed for coverage by the DOC Health plan. OCO staff confirmed that the recommendations were ordered by the responsible medical providers after they were able to meet with the patient.	Information Provided
61.	Person reports that he was removed from the MAT program due to the length of his sentence. The person stated that he sees people on the medication who are outside of the protocol timelines. The person was told that due to staffing, they cannot accept more people to the program.	The OCO provided information to the patient about the current MAT protocol and planned expansion of the program. OCO staff contacted the DOC Health Services staff to discuss the facilities capacity for treatment. OCO staff noted that the person is too far outside of protocol timelines to start on the program and confirmed that additional MAT program staffing has not yet been created. The OCO is in ongoing conversation with DOC leadership regarding the progress of the MAT program expansion.	Information Provided
62.	Person reports that the water in the CORE that comes out of the sink and shower is brown.	The OCO learned that the Department of Corrections has approved a multi-million-dollar project to replace the plumbing in this building. They have already started the project and finished in A unit. B unit will be next. The OCO provided this information to the individual.	Information Provided
63.	Person reports that the DOC will not review his request for a specific medication. The person reports that his previous facility agreed to review the medication, however the patient was transferred prior to this review taking place.	OCO staff provided information to the person about process to get formulary restricted medications approved. OCO staff reviewed the person's consultations and were not able to substantiate that the person's previous provider had submitted a review request for this medication. Medications that are restricted or not listed on the DOC formulary must go through an approval process determined by the medication and the reason for the restriction. The patient was provided with information specific to the medication requested. OCO staff also confirmed the patient had a follow up appointment with Health Services staff and monitored the appointment through two reschedules until it was attended to ensure access.	Information Provided

64.	Person reports issues with how DOC medical has decided to treat his complaints of pain. The person is requesting a new medication.	The OCO provided information to this person regarding the status of their treatment plan. The OCO cannot compel a medical provider to order different medications. OCO staff noted that the person is scheduled for specialist evaluation for the reported issue and that the patient is receiving treatment for the reported issue. OCO staff confirmed that the patient's primary provider has placed the pertinent specialist referrals and has consulted with the Facility Medical Director about this person's care. OCO staff also provided the person with information about the restrictions on a medication that the patient stated they wanted to try. OCO staff will monitor the authorized consults as a closed case to ensure they are scheduled and attended.	Information Provided
65.	An incarcerated person requested information from the OCO.	The OCO provided information regarding where to mail the resolution request forms that they are trying to file.	Information Provided
66.	Incarcerated person reports concerns about an infraction they received and asked OCO review the infraction and assist them in obtaining property DOC confiscated as a result of the infraction. The person reported concerns about the DOC investigation that led to the infractions and confiscated items.	The OCO provided information about DOC's decision to confiscate the property and the OCO findings after reviewing the infraction. The OCO found DOC had evidence to confiscate the property. DOC had sufficient evidence to uphold the infraction. The OCO shared more information about the use of the "some" evidence standard and the DOC serious infraction process.	Information Provided
67.	Person reports the officer in the medical clinic tried to get him to sign a medical document without any medical staff present to answer questions. The document was related to an injury the patient sustained during a routine procedure. The person reports that the same officer turned him away from medical when he requested to have a bandage changed. The person is requesting the staff member be investigated for malpractice.	The OCO provided information about the process to have a malpractice investigation completed by the Department of Health (DOH). OCO staff thoroughly reviewed the person's concern and found the officer was asked to have the patient sign the form by the provider. OCO staff did note documentation concerns with this form in addition to there not being any medical staff being present for this form, which is required. OCO staff confirmed that the provider is no longer with the Department. OCO staff confirmed that DOC substantiated the issue; both custody and medical leadership were made aware of the error and retraining occurred. OCO staff provided the patient with tort claim and DOH complaint process information. Regarding the second issue of being turned away from medical, OCO staff found that the person was turned away because he was not scheduled at that time and staff were too busy to see him as a walk-in. OCO staff confirmed the person was seen later that day.	Information Provided
68.	Person reports he received a negative BOE but hasn't been given a paper copy and is worried about being able to appeal it on time. Also reports several issues with the behavior of the CO who wrote the negative BOE says the cell search resulted in him removing all his towels.	The OCO provided information about how to kite or kiosk message the CPM if they never received a paper copy and the opportunity to appeal. This office did not see a resolution in the system regarding this staff member's behavior and asked the individual to write a resolution if they are still having issues.	Information Provided
69.	Person reports that he has been kept in the COA for a very long time because the DOC does not know	The OCO provided information about the person's housing situation. OCO staff reviewed the person's records and found that his permanent housing situation is being carefully	Information Provided

	where to put him. The person is requesting an override to a medium unit. The person also voiced concerns about not receiving treatment for an advanced medical condition.	considered to ensure his safety, but he has been moved out of the COA. OCO staff also provided information to the person about the treatment of his advanced disease; typical treatment focuses on managing complications and slowing disease progression.	
70.	Person called to report someone was brutally assaulted. The individual involved told staff what he was going to do if the person was moved back into the cell.	The OCO provided information to the individual in person. This incident is under DOC investigation.	Information Provided
71.	Anonymous person reported safety concerns about another person.	The OCO reviewed existing evidence and was unable to substantiate the concern. The OCO verified the person is in another housing. The OCO could not verify any concerns that would have jeopardized his safety.	Insufficient Evidence to Substantiate
72.	An incarcerated individual reports that he received an infraction, and the hearings department found him guilty without reviewing all the evidence.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual admitted to having a medication that is not prescribed to him.	No Violation of DOC Policy
73.	Incarcerated individual shared concerns regarding DOC staff not providing them with a single cell despite having a medical concern that disturbs their cellmates.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC 420.140. This office reviewed DOC records and was able to see that this individual was screened for a single cell by the facility and DOC HQ but was denied as the request did not meet single cell criteria.	No Violation of DOC Policy
Olympic Corrections Center			
74.	Incarcerated individual shared concerns regarding DOC medical staff not providing them with medical care despite numerous requests.	The OCO provided assistance. This office reviewed DOC records and was able to substantiate a delay of care. Upon the OCO reaching out, DOC shared they spoke with medical providers and reminded them of the importance of rescheduling canceled appointments. This office was able to confirm that this individual has been seen and is now receiving requested care.	Assistance Provided
75.	An individual reports they are getting bug bites that itch, and DOC health services has been unable to help them acquire bug spray.	The OCO contacted DOC about this concern and asked if there was a way for the population to have access to mosquito spray. At this time, individuals cannot have personal mosquito spray in their possession, but DOC has found a temporary solution. The DOC approved a mosquito spray called STEM Repels Mosquitoes that is DEET and alcohol free, has low flammability, and relatively low health hazards. This spray is approved until November 1, 2025, and then reviewed for effectiveness.	Assistance Provided
76.	Person is at Olympic Corrections Center and says that they are getting eaten alive by mosquitoes, and DOC staff are unwilling to help them.	The OCO contacted DOC about this concern and asked if there was a way for the population to have access to mosquito spray. At this time, individuals cannot have personal mosquito spray in their possession, but DOC has found a temporary solution. The DOC approved a mosquito spray called STEM Repels Mosquitoes that is DEET and alcohol free, has low flammability, and relatively low health hazards. This spray is approved until November 1, 2025, and then reviewed for effectiveness.	Assistance Provided
77.	Person reports that DOC staff at this facility are practicing discrimination by taking away his assigned housing due	The OCO reviewed the individual's FRMT, classification appeal, resolution request, and spoke with DOC staff about this concern. The OCO could not verify that staff were	Insufficient Evidence to Substantiate

	to an awareness he received in the therapeutic community (TC) program.	harassing him because there were several entries in his electronic file due to negative behavior. However, this office confirmed that this individual has been approved for graduated reentry (GRE) and will be leaving the facility in the near future.	
	Reentry Center - Brownstone - Spokane		
78.	An individual reports that Brownstone Reentry Center is run by contract staff who are writing behavior observation entries (BOE) and not following DOC policy. Additionally, the individual reports that contract staff tell the incarcerated population that DOC does not hold them accountable because they are not DOC staff.	The OCO provided information regarding DOC policy 300.010 to the incarcerated person via the OCO hotline, and this office reported the issue to DOC staff at the facility. The OCO encouraged this person to file an appeal for any recent BOEs so they can be reviewed by the Reentry Center Manager (RCM).	Information Provided
	Stafford Creek Corrections Center		
79.	Person states that he has been trying to see a specialist after being injured in an assault several years ago. The person states that DOC medical did not treat his pain or concussion symptoms until he was transferred to a different facility. The person is requesting to see a specialist and for emergency medical protocols to be improved.	The OCO assisted by contacting DOC Health Services staff. OCO staff reviewed the person's consultation referrals and contacted DOC Health Services staff when a delay was noted. OCO staff confirmed the person is scheduled to see a specialist for their reported issue. OCO staff provided information to the patient about their current specialist consultations and the steps required to see the specialist the patient requested.	Assistance Provided
80.	Person reports issues with his medical provider and is requesting to be on a different provider's caseload. The person states that he is not being adequately treated for pain or stomach issues.	The OCO provided assistance by contacting DOC staff and requesting a review of a specialist consultation that had not been scheduled. OCO staff reviewed this person's consultations, medical appointments, and resolution requests. OCO staff monitored the specialist appointment to confirm it was attended. The OCO provided information about the person's request for a new provider and how medical refusals work. OCO staff noted that the person declined to see their assigned provider at a scheduled appointment. That is considered a refusal of that appointment because the appointment is provider-specific. OCO staff confirmed the person's request to change providers was reviewed by the FMD.	Assistance Provided
81.	Incarcerated individual shared concerns regarding DOC forcing them to take education programming that they're not prepared for.	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 removed from the programming per their request.	DOC Addressed the Complaint
82.	Person reports he has been in restrictive housing for months for an infraction but has not had hearing and is being told that he is going to lose points and be demoted to close. He has asked DOC to get the infraction hearing over with so he can go back to living units.	The OCO reviewed this concern and found he did have a hearing. He currently has an open custody facility plan to move back to the general population.	Information Provided

83.	Person reported that DOC staff did not bring his medical insoles with him from the jail to DOC custody.	The OCO provided information about DOC policy and how to get new medical shoes in DOC. The OCO reviewed this individual's resolution request, which was reviewed at the Headquarters level, and found that DOC policy only covers transfer between DOC facilities, not between a jail and DOC. The OCO reached out to DOC staff and found that this individual has not reached out to Health Services about getting new medical shoes.	Information Provided
84.	Individual reports that he was suspended from work for receiving an infraction that was ultimately dismissed, and now he cannot get his job back. The individual states that he has a new job but makes less money in his current position than he did as an access assistant.	The OCO reviewed this person's infraction history and spoke with DOC staff about this concern. The Department agreed that individuals should not be suspended from their jobs without having an FRMT. The DOC confirmed that this person is on the wait list to be an access assistant and sent out a reminder to staff about suspending individuals from their jobs before conducting an FRMT. DOC reports that an individual can kite the correctional program manager CPM and request a review if this situation occurs in the future.	Information Provided
85.	An individual reports that he has a security threat group (STG) affiliation in his DOC electronic file that is inaccurate and would like his record corrected.	The OCO provided information regarding this person's electronic file and confirmed that he has no STG affiliations noted in OMNI. The OCO verified that there is an intelligence only marker, but that does not indicate a person is connected to a security threat group. The OCO encouraged the individual to contact DOC headquarters if they had additional questions.	Information Provided
86.	An individual reports that DOC is not giving him his prescribed medication regularly.	The OCO contacted DOC health services about this concern. DOC confirmed that this individual is regularly receiving his medication and has not missed any doses. Additionally, the DOC reported that his dosage was increased recently from two to three pills per day.	Information Provided
87.	Individual reports he was in restrictive housing for 30 days and was supposed to have his final segregation hearing. However, DOC decided to just release him, but he is worried for his safety due to drugs. Now he has to wait 30 days to get his radio and player because his time started over.	The OCO reviewed the individual's custody facility plan and found that the facility attempted to place him back in the general population. However, he refused housing multiple times and received two 724 infractions. In May after the individual filed this concern, he did receive his level 3. He currently has an open custody facility plan to determine his next placement. If he disagrees with that decision, the OCO provided information on how to file an appeal.	Information Provided
88.	Person reports he is not getting his medication at the correct time, impacting its effectiveness. The person states he has filed many resolution requests but has not received any responses.	The OCO provided information to the person about his request to change the dosing times. OCO staff contacted DOC Health Services staff and were informed that the dose time was not specified on the order, only that it was to be given once daily. OCO staff were informed of custody staff issues with changing the administration timing that the DOC is working to resolve.	Information Provided
89.	Person reports he was assaulted by another incarcerated person, and he was infracted for defending himself because the other person had to go to the hospital for his injuries. However, the other person swung at him first. He says that he has 8 witness statements from other people saying that he did not bring a weapon to the	The OCO reviewed the hearing audio, infraction packet, confidential informant information and all video evidence. After review, this office contacted DOC HQ for an additional review of the findings. The DOC maintains that the individual kept hitting the person who attacked him after he was told to stop and that is why he was charged with an assault versus fighting. The DOC also maintains the scissors can be seen in his hand in the video. This office verified through video evidence review that the individual did continue hitting the	Information Provided

	fight. Person reports that he was charged with a weapon when there was a pair of scissors on the ground. He was found guilty despite the witness statements he brought to the hearing. He appealed the infraction but has not heard back from DOC.	other individual after staff got involved; however, this office was unable to verify DOC's claim about the scissors because the video was extremely grainy. The DOC is unwilling to overturn the infractions.	
90.	Person reports he was placed on administrative segregation regarding 3 intoxication protocols. The issue is that he has not been on 3 intoxication protocols, he has only been on one. DOC staff are adding more intoxication. He was taken from his cell because a breaker popped in 4 houses, but they chose to take him. He passed UA through intoxication protocol but they still placed him in IMU and he has been there ever since.	The OCO did confirm that he was placed on two intoxication protocols not 3, however he has been demoted due to infractions. He received 3 different 603 infractions months apart before he was demoted. The DOC gave him multiple overrides before he was closed out. This office did review the infractions; however, the DOC is unwilling to overturn them. The individual has since transferred to a new facility.	Information Provided
91.	Person reported that they received a 603 infraction yesterday and feels like their rights have been violated. Person reported that DOC staff opened his legal mail without him being present, stuffed other documents in the legal mail and then did a cell search without giving him the report so he could see what was taken.	The OCO reviewed existing evidence and was unable to substantiate the concern. The OCO reviewed the infraction report and evidence and found that the legal mail was from an attorney that is not on the facilities list of known attorneys. The DOC contacted the attorney listed on the legal mail addressed to this individual and was told this individual was not a client. Once it was determined it was not legal mail, it was opened and tested. Contraband was found in the letter.	Insufficient Evidence to Substantiate
92.	An anonymous friend or family member shared concerns about the policies and practices at SCCC under the current leadership such as access to legal mail, reduced visiting hours, and property searches.	The OCO reviewed existing evidence and was unable to substantiate the concern. This was an anonymous concern with no other details given.	Insufficient Evidence to Substantiate
93.	Person reported that a staff member is targeting him by denying legal envelopes that he is allowed as an indigent incarcerated individual.	The OCO reviewed existing evidence and was unable to substantiate the concern. The OCO reviewed multiple resolutions requests about this staff member and found that this individual was not indigent at the time of requesting the legal envelopes. The OCO also found that his other resolution requests about this staff member were also unsubstantiated.	Insufficient Evidence to Substantiate
94.	External person reports concerns about recent infractions her loved one received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as there was substantial evidence to infract this person.	No Violation of DOC Policy
95.	An external person reports concerns regarding receiving an infraction for an incident of which there is no evidence.	The OCO reviewed the complaint and found the reported DOC actions are currently allowed within DOC 460.000. OCO staff contacted DOC staff and requested a headquarters level review of the infraction and related evidence. OCO staff found that there is no violation of DOC 460.000 as the infraction elements are met for the infraction that was received.	No Violation of DOC Policy
96.	Incarcerated individual shared concerns regarding DOC staff deleting their HSR (Health Status Report),	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC 420.320. This office spoke with DOC staff who informed the OCO that this individual was	No Violation of DOC Policy

	searching their cell, and infracting them.	provided with the clinical treatment for a duration that was deemed clinically appropriate. Upon completion of the treatment, their HSR was removed. This office was able to confirm that this individual had acquired excess medical supplies and was infracted for deceiving staff. DOC medical staff confirmed that this individual's medical concern has been taken care of.	
97.	An individual reports that he has not received the outcomes of several infraction appeals and has concerns about losing custody points and being closed out.	The OCO reviewed the infraction materials, appeals, associated incident reports and contacted DOC staff about this concern. This office did not identify a violation of DOC policy 460.00 because the individual was documented numerous times in possession of drugs and under the influence.	No Violation of DOC Policy
Washington Corrections Center			
98.	Incarcerated person reported they have a Health Status Report (HSR) directing they be housed in a lower bunk. DOC housed this person in an upper bunk and were unwilling to move him after reporting the issue to them.	The OCO assisted by immediately reaching out to the facility and requesting the person be moved to a bunk that met their HSR requirements. DOC moved the person to a bunk that met their HSR the same day the office contacted the facility.	Assistance Provided
99.	Individual reports that staff searched him and confiscated his address book while he was out at yard. This individual asked DOC to return his address book repeatedly and was given the run-around regarding the location of his address book.	The OCO contacted the facility and asked about the location of the address book. The DOC reported that it was being tested for contraband and was waiting for the results. The OCO followed up with DOC, who confirmed that the lab results came back negative, and DOC would be returning the address book to this person.	Assistance Provided
100.	Incarcerated individual shared concerns regarding requesting protective custody.	The OCO provided information regarding how this individual can request protective custody. This office spoke with DOC staff who were unable to verify any safety concerns or that this individual has reached out to DOC staff to share these concerns.	Information Provided
101.	Person reported that their earned time was not being given back, and they would like to go to GRE, but they are in a substance use disorder class that needs to be completed before release.	This office reviewed the individual's custody facility plan and contacted Headquarters Classifications. Headquarters Classifications stated the individual would receive a significant amount of time back; however, they could not restore all the time because it placed them within 120 days of the adjusted ERD. This office confirmed he has a new release date coming up within the next few months and a new CFP is currently in development by their counselor, requesting approval for a Reentry Center.	Information Provided
102.	Individual reports that a DOC officer closed the door on his leg and left a bruise. The individual states that the officer told him he would be written up if he filed a resolution request about this issue.	The OCO confirmed the individual filed a resolution request and spoke with DOC staff in the R-units about this concern. The OCO provided the individual with information about how to file a tort claim with the Department of Enterprise Services (DES). 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

103.	Person called to request placement on the Medication Assisted Therapy Program (MAT) program.	The OCO provided information about the current Medication Assisted Therapy Program (MAT) protocols and status of the expansion project. OCO staff reviewed this person's record and noted that they are outside the current protocol timeline by a large margin.	Information Provided
104.	Person reported that his Health Status Reports (HSR) were not honored by DOC staff when he returned to the unit after surgery. This resulted in the patient getting reinjured after taking a fall, requiring him to be sent to emergency room. The person is requesting an investigation into the DOC staff involved.	The OCO provided information to the person about the investigation completed at his request. OCO staff reviewed video of the incident, resolution requests, and the person's medical records. OCO staff noted that the person was not issued an HSR that would have resulted in being moved to a different tier, preventing the incident. OCO staff contacted DOC staff and were informed of changes made on the unit as a result of DOC's review of the incident, including direction to move people with mobility aids to a ramped tier even if a "no stairs" HSR was not ordered by medical.	Information Provided
105.	Person reported that he experiences severe opioid addiction and wants to be placed on the MAT program.	The OCO provided information about the Medication Assisted Therapy (MAT) program. OCO staff reviewed the person's record and found that they are outside the current protocol timelines for the MAT program. OCO staff are in ongoing discussion with DOC Health leadership regarding the expansion of the MAT protocols to cover more patients and will provide the current MAT expansion information with people who are requesting admission to the MAT program.	Information Provided
106.	An individual reports that for several weeks, there has been no hot water in the showers.	The OCO contacted the facility, and DOC said there had been no reports of issues with the plumbing or water. Additionally, this office followed up about this issue while conducting a monitoring visit, and individuals in the living units said the shower water was not cold. The OCO encouraged the individual to submit a resolution request the next time this incident occurs.	Insufficient Evidence to Substantiate
107.	Incarcerated individual shared concerns regarding DOC staff infracting them numerous times and not allowing them to appeal it.	The OCO reviewed existing evidence and was unable to substantiate the concern. After reviewing DOC records, this office was able to confirm that this individual was given the opportunity to appeal their infractions. This individual did not appeal all of their infractions within the timeframe provided.	Insufficient Evidence to Substantiate
108.	A loved one shared concerns on behalf of an incarcerated individual regarding DOC not allowing them to visit the incarcerated individual over an incident that took place a long time ago.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC 430.200. This office reviewed DOC records and was able to confirm that this individual's wife took part in an incident that resulted in an infraction for the individual. Due to the circumstances of the incident, that individual is not allowed to visit the incarcerated individual. This office informed this individual that they can resubmit the visitation request annually, but there is no guarantee the decision by DOC will change.	No Violation of DOC Policy
109.	Incarcerated individual shared concerns regarding DOC not allowing their wife to visit them over an incident that took place a long time ago.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC 430.200. This office reviewed DOC records and was able to confirm that this individual's wife took part in an incident that resulted in an infraction for the individual. Due to the circumstances of the incident, that individual is not allowed to visit the incarcerated individual. This office informed this individual that they can resubmit	No Violation of DOC Policy

		the visitation request annually, but there is no guarantee the decision by DOC will change.	
110.	Individual reports that he received a 603 infraction, and DOC staff refused to send the evidence for testing.	The OCO reviewed the evidence used in the infraction summary and found no violation of DOC policy 460.000, as the confiscated items were clearly paraphernalia.	No Violation of DOC Policy
Washington Corrections Center for Women			
111.	Person reports she is upset that the Washington Way Team was disbanded. She was working with WA Way team building rapport, was making progress and felt like she was getting the help she needed. There is now a new WA Way team that she does not trust and feels like she has lost a resource that was helping her with her trauma and PTSD. The current team are people who are not trusted by the population and who don't have the best interests of the incarcerated population at heart. Says there are people now on the team who are "known problems" and who treat incarcerated people like they're numbers not people.	The OCO received multiple concerns from the population regarding this issue. This office contacted the DOC Women's Division regarding the original team being disbanded, and the Women's Division stated they had issues with that team and would not bring them back. Unfortunately, the OCO does not have the authority to force the DOC to change the team back to the original participants.	Information Provided
112.	Person reports that they need a surgery that is listed in the DOC Health plan under covered services. The person states they requested it be reviewed by the Care Review Committee who also denied it. The person is requesting that DOC confirm their appeal was reviewed and to have the surgery.	The OCO provided information to the person about the DOC Health plan. Medical interventions that are listed as Level 3 in the DOC Health plan are not covered services. The DOC Health plan states that treatments determined to be level 3 are not considered medically necessary.	Information Provided
113.	Person reported that they did not want to move to the general population. They want to be transferred to mental health housing.	The mental health providers stated that this individual can be maintained in the general population, and they are not going to transfer them to the RTU. The OCO provided information for the individual to continue to work with their providers as they adjust to the general population.	Information Provided
114.	Individual called and stated that they have been in IMU for 14 days despite being told that if she is good, they will release her. Individual stated that this goes against some previously arranged plans made with DOC and the OCO.	The OCO was able to substantiate this concern but was unable to achieve a resolution. The facility declined to move her after she completed more than 14 days of good behavior.	Substantiated
Washington State Penitentiary			
115.	External person reports their loved one has been experiencing concerning symptoms and DOC medical has not found a reason or solution for them. The person is requesting that their loved one get an answer for the symptoms.	OCO staff provided assistance by contacting DOC Health Services staff. OCO staff provided information to the impacted person regarding what has been done so far and what the next steps are that need to happen in his care. OCO staff reviewed the person's appointments and contacted their medical provider. OCO staff were informed that all diagnostics had returned within normal limits and there was not currently clinical indication for a specialist referral. OCO	Assistance Provided

		staff monitored the patient's appointments and found that a primary care appointment had been scheduled after OCO outreach.	
116.	Person reports concerns regarding the response he receives when he tries to address his pain with medical staff. The person is requesting a referral for pain management and medical treatment.	The OCO provided assistance by contacting DOC Health Services and requesting a review of a closed consultation. OCO staff reviewed the person's specialist consultations and noted that there may be follow-up indicated that would get this person on the correct pathway to receive a referral to a pain management specialist. The DOC Health Plan requires certain conservative measures be attempted prior to approving a specialist referral. DOC Health Services agreed to schedule the patient with their provider and physical therapy to discuss the consultation and possible continuing care. OCO staff also provided the patient with information on the referral approval process.	Assistance Provided
117.	Incarcerated person reports concerns about an infraction and requests OCO review. The person reports concerns with the sanctions and wants to appeal them, but was not given the opportunity.	The OCO assisted by speaking with DOC about the sanction appeal process for this type of infraction, requesting DOC look for the persons filed appeal and asking DOC to accept another sanction appeal. The OCO reviewed the infraction and found that a sanction appeal was noted in the electronic system. DOC explained the process for entering the specific sanction in this infraction makes it unclear if an appeal was filed. The persons filed appeal was not located, and DOC agreed to accept another sanction appeal. The OCO provided the person with the DOC contact to submit the appeal.	Assistance Provided
118.	Person reports that the DOC Headquarters Max committee is keeping him on level 2 only program based on two infractions that were dismissed and taken off of his disciplinary record. He states this violates his due process rights.	The OCO assisted by contacting DOC HQ Classifications and asking for a meeting to discuss the level system. The department is currently looking at the level process and is considering a modified level 3 without the communication app. He would be eligible for this at his next review.	Assistance Provided
119.	Person reports he has been in restrictive housing almost 16 months. He has a review 2 months ago and he is still on level 2 only. He is in there because there is nowhere to place him due to STG. He's been programming with Washington Way and working to better himself and has not been getting in trouble. He appealed his classification, but they said they never received his appeal and that he was outside timelines.	The OCO assisted by contacting DOC HQ Classifications and asking for a meeting to discuss the level system. The department is currently looking at the level process and is considering a modified level 3 without the communication app. He would be eligible for this at his next review.	Assistance Provided
120.	A loved one expressed concern for the safety of an incarcerated individual and wanted him to be moved to a different facility.	DOC staff addressed this concern prior to OCO action. The OCO reviewed DOC records and found that this individual was moved to a different facility due to safety concerns.	DOC Addressed the Complaint
121.	Incarcerated individual shared concerns regarding DOC staff jeopardizing their safety.	DOC staff addressed this concern prior to OCO action. This office reviewed DOC records and was able to confirm that DOC provided this individual with their recommended remedy and placed them in a location they are safe.	DOC Addressed the Complaint

122.	Person wants assistance to overturn the max custody in part (Level 2 only) and get to Level 3 so he can do release planning with his loved ones.	The OCO reviewed current custody facility plan. He was promoted to level 3.	DOC Addressed the Complaint
123.	An external person reports that her loved one is on a hunger strike in an attempt to get his tablet back.	The OCO followed up with the facility about this concern. DOC staff reported that they were monitoring the situation, but ultimately, it was up to the incarcerated to stop the food strike. DOC also confirmed that health services staff visited the living units daily and performed welfare checks. The OCO cannot force DOC to comply with the demands presented by the population participating in the food strike.	DOC Addressed the Complaint
124.	Person reports that they have been in the IMU since 2024 due to a riot. They have been level two the entire time, and DOC just keeps giving them another max program every time they go see classifications. He says he has completed every class that they have given him, and he has not gotten in any more trouble. He has not received any infractions since Jan 2024 and does not understand why he is still in the IMU.	The OCO reviewed his current custody facility plan and he has been promoted off Max custody.	DOC Addressed the Complaint
125.	An external person reports that her loved one is on a hunger strike and is concerned about the living conditions people are experiencing at this facility.	The OCO followed up with the facility about this concern. DOC staff reported that they were monitoring the situation, but ultimately, it was up to the incarcerated to stop the food strike. DOC also confirmed that health services staff visited the living units daily and performed welfare checks. The OCO cannot force DOC to comply with the demands presented by the population participating in the food strike.	DOC Addressed the Complaint
126.	An individual reports that a hunger strike has been going on for multiple days at his facility.	The OCO followed up with the facility regarding this concern, and DOC staff reported that they were monitoring the situation; however, ultimately, it was up to the incarcerated individuals to end the food strike. DOC also confirmed that health services staff visited the living units daily and performed welfare checks. The OCO reviewed communications between the population and DOC staff who were responsive to the situation.	DOC Addressed the Complaint
127.	Person reported concern about not receiving a promotion and said that he is owed backpay.	DOC staff addressed this concern prior to OCO action. The OCO reviewed DOC records and reached out to DOC staff and confirmed that this individual's previous backpay concerns were addressed. DOC staff found that this individual had some confusion about the job class system and explained it to him, which addressed his concern.	DOC Addressed the Complaint
128.	An external person reports that their loved one is not receiving care for a severe gastrointestinal issue. They are requesting that their loved one see a specialist.	The OCO provided information about the person's medical referral. OCO staff reviewed the person's appointments and specialist consultation requests. OCO staff noted that the person was referred to the requested specialist based on a primary care appointment that was attended shortly before this concern was reported to the OCO. OCO staff confirmed the specialist appointment was scheduled and will monitor this appointment as a closed case to verify it is attended.	Information Provided

129.	Incarcerated individual shared concerns regarding DOC wrongfully deducting funds from their account.	The OCO provided information regarding circumstances when DOC will deduct money from their account.	Information Provided
130.	Person reported that his religious group is not allowed to bring oils back to their cell and that DOC is not following their own policy.	The OCO provided information about a recent memo regarding oils for religious practices. The OCO reached out to DOC staff, who said that the specific oils in question are from a recently allowed vendor, HalalCo, and are of higher quality. Per a 2024 memo, the HalalCo oils are only allowed to be group property and are not allowed back to the units. DOC staff confirmed that the HalalCo oils are available for the religious group's gathering, and that individuals are given a few drops of the oil before returning to their cells. The OCO is in ongoing conversations with DOC HQ about essential oils for religious purposes in DOC facilities.	Information Provided
131.	This person reports that second shift never takes him out to the yard, he is only offered yard in the morning. This is a problem because he cannot talk to his kids in the morning because they are in school. He reports that the second shift officers do not care and never offer to let him have yard in the afternoon/evening time.	The OCO reviewed existing evidence and was unable to substantiate the concern. The OCO contacted the facility leadership and verified that staff alternate between AM and PM yard every week for each unit. This office also reviewed this individual's logbook and found he has had PM yard.	Insufficient Evidence to Substantiate
132.	Person reported that he was promoted to a lower level of custody but is still being held in a medium custody setting. Person said that other people in his situation have been transferred out and that he wants to transfer to be closer to his family.	The OCO reviewed the complaint and found DOC actions or inactions are currently allowed within DOC 300.380. The OCO reviewed DOC records and his Custody Facility Plan (CFP) and verified that he was promoted and approved to be transferred to a different facility, but was still in his previous medium custody unit. This office reached out to DOC Headquarters staff in classifications, who declined the OCO's request to transfer him to the facility he was approved for. DOC staff said that a medium custody setting was still appropriate for his custody level.	No Violation of DOC Policy
133.	An individual reported that he received an infraction for clenching his fists and acting aggressively towards a DOC staff member. The individual reports that DOC did not follow the established timeframes, causing him to spend additional time in the IMU and a loss of custody points.	The OCO reviewed the infraction materials and found no violation of DOC 460.000 as the individual did initially argue with staff when they were directed to evacuate the building. DOC not following the timeframes established in policy does not mean they will restore custody points or reverse sanctions. WAC 137-28-400 states, "the time limitations expressed in these regulations are not jurisdictional and failure to adhere to any particular time limit shall not be grounds for reversal or dismissal of a disciplinary proceeding."	No Violation of DOC Policy
134.	An individual reports he was accused of threatening DOC staff and filing a PREA in retaliation.	The OCO reviewed the individual's recent infractions, resolution requests, and PREA concerns. The OCO found no violation of DOC 460.000, as this person has had numerous negative interactions with DOC staff in a short period of time.	No Violation of DOC Policy
135.	Incarcerated individual relayed concerns regarding changes in their job wages.	The OCO reviewed the grievance responses and confirmed that DOC substantiated that work assignments in the kitchen have been reclassified, but it was unsubstantiated that the compensation can be equal as the funds are from different sources as the pay is dictated by job class per DOC policy 700.000. The West Complex kitchen moved the workers to	No Violation of DOC Policy

		class 3 and are paid by the facility while the East Complex kitchen workers are class 2 and paid by CI. Class 3 workers are mandatory call-outs due to not having enough class 2 volunteers resulting in hours being adjusted to balance the individuals and workload.	
Intake Investigations			
Airway Heights Corrections Center			
136.	External person reported an OCO meeting link was sent out with an incorrect time.	OCO staff opened this case in error. The time was adjusted to the correct time of the OCO meeting.	Complaint Withdrawn
137.	A loved one reported a concern related to their loved one's access to health care.	This case was a duplicate of one that already existed from the same complainant and for the same concern.	Complaint Withdrawn
138.	Duplicate of another case that already exists in the OCO's case management system	This case was a duplicate of one that already existed from the same complainant and for the same concern.	Complaint Withdrawn
139.	An incarcerated person reported dissatisfaction with DOC decision to issue a unit keep separate when he asked for a facility keep separate from another incarcerated person.	This case was a duplicate of one that already existed from the same complainant and for the same concern.	Complaint Withdrawn
140.	An incarcerated person reported a concern related to not being able to get a job.	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
141.	An incarcerated person reported a concern related to the behavior of a DOC staff member.	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
142.	An incarcerated person reported a concern related to programming	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
143.	An incarcerated person reported a concern related to property that was destroyed.	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. The OCO also provided the person with information on how to file a tort claim.	Declined
144.	An incarcerated person reported a concern related to a non-emergent health concern.	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
145.	An incarcerated person reported a concern related to the behavior of a DOC staff member.	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	Declined

		limited to, the priority and weight given to these and other relevant factors.	
146.	An incarcerated person reported a concern related to 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
147.	An incarcerated person reported a concern related to accessing gender affirming care items while in IMU.	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
148.	A loved one contacted the OCO regarding a concern related to a concern related to visitation.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about Visitation Rejections, Denials, and Terminations.	Technical Assistance Provided
149.	An incarcerated person reported a concern related not being allowed to wear long sleeved shirts or a jacket in the gym.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to engage with the resolution program.	Technical Assistance Provided
Cedar Creek Corrections Center			
150.	A friend or family member reported concerns that this person was being investigated for an item that was brought to an Extended Family Visit (EFV) and DOC staff did not properly handle the investigation.	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
151.	This person reported that a DOC staff member was pushing religious beliefs on him and 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 how to file a resolution request for staff conduct concerns.	Technical Assistance Provided
152.	An incarcerated person reported a concern related to the behavior of DOC staff members.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about reporting staff conduct concerns, and how to self-advocate during the classification and Facility Assignment process.	Technical Assistance Provided
Clallam Bay Corrections Center			
153.	An external person reported concerns that DOC requires individuals to complete substance use treatment before they can participate in the Graduated Reentry Program (GRE) program but the facility their loved one is housed in does not offer treatment and he cannot receive other help for his addiction because he is not close enough to his release date.	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

154.	An incarcerated person reported a concern related to not being able to access songs that you purchased during a prior incarceration.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to contact Securus.	Technical Assistance Provided
Coyote Ridge Corrections Center			
155.	A friend or family member has reported concerns that this person was not treated fairly during an infraction hearing and would not be allowed to stay at Coyote Ridge Corrections Center until his release date.	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
156.	A friend or family member has reported concerns about this person's safety at the facility he is currently 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
157.	Individual passed away while in DOC custody.	OCO staff opened this case in error. This incident was not referred to the Unexpected Fatality Review (UFR) committee because the patient was on comfort care and his passing was expected due to chronic conditions and age. The OCO reviewed all relevant documentation and medical records.	Complaint Withdrawn
158.	An incarcerated person reported a concern related to wanting to classification and dissatisfaction with their facility placement.	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
159.	A loved one or friend reported a concern related to an infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal their infraction prior to reaching out to the OCO.	Technical Assistance Provided
GRE/CPA			
160.	An incarcerated person reported a concern related to the behavior of a Community Custody Officer.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to engage with the resolution program and contact headquarters directly for concerns about the behavior of Community Custody Officers.	Technical Assistance Provided
Mission Creek Corrections Center for Women			
161.	Duplicate of another case that already exists in the OCO's case management system	This case was a duplicate of one that already existed from the same complainant and for the same concern.	Complaint Withdrawn
Monroe Correctional Complex			
162.	A friend or family member reported a concern on their loved one's behalf that he was moved to a pod that was designated as a violator unit and he is experiencing poor conditions of confinement. Their loved one is not	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

	allowed out of cell time and showers for two full days each week. He is also not being provided with toilet paper consistently and told to wipe with his hand by DOC staff.		
163.	Incarcerated person requested the Solitary Confinement reports parts I and II. The person does not currently have access because they do not have a tablet.	The OCO staff opened this case in error. The OCO processed this as an open records request and provided the individual with the reports requested.	Complaint Withdrawn
164.	A friend or family member has reported concerns about being denied visitation with this person.	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
165.	Person reports he had a WA One assessment and appealed to the superintendent stating his violence marker is incorrect.	The incarcerated individual said they did not want the OCO to further investigate the complaint and closed the case.	Complaint Withdrawn
166.	Person reports concerns on behalf of another incarcerated person.	The OCO contacted the incarcerated person directly, who expressed that the issue had been addressed. The incarcerated individual said they did not want the OCO to further investigate the complaint and closed the case.	Complaint Withdrawn
167.	Person reported that DOC is not allowing him to access law library or see a specialist.	This case was a duplicate of one that already existed from the same complainant and for the same concern.	Complaint Withdrawn
168.	Someone reported concerns about this person being housed in segregation for an extended period of time and how that was affecting their mental health.	The incarcerated individual said they did not want the OCO to further investigate the complaint and closed the case.	Complaint Withdrawn
169.	A family member reported a concern related to PIN fraud for their loved one.	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. The OCO also sent this person information regarding how to file a tort claim.	Declined
170.	A family member reported a concern related to PIN fraud for their loved one.	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. The OCO also sent this person information regarding how to file a tort claim.	Declined
171.	A family member reported a concern related to PIN fraud for their loved one.	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. The OCO also sent this person information regarding how to file a tort claim.	Declined
172.	This person reported that they were assaulted by their community corrections officer (CCO). They also	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint does not involve a person committed to the physical custody of the DOC.	No Jurisdiction

	report other staff misconduct by that CCO.		
173.	Person reported concern about not having access to Durable Medical Equipment (DME).	This person was released prior to the OCO taking action on the complaint. This individual was in DOC custody for a short period of time as a boarder from a county jail. The OCO found that while in DOC custody, he had multiple Health Status Reports (HSRs) for Durable Medical Equipment (DME).	Declined
174.	Incarcerated individual shared concerns regarding DOC staff not providing them with mental health (MH) access.	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 requesting mental health and health services appointments.	Technical Assistance Provided
175.	Incarcerated individual shared concerns regarding DOC failing to provide them with medical treatment for their concern.	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 requesting their desired medical treatment and utilizing the resolution program.	Technical Assistance Provided
176.	An incarcerated person reported a concern related to requesting financial compensation for an event that happened in 2020.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to request records from DOC via DOC's public records process and how to file a tort claim.	Technical Assistance Provided
	Olympic Corrections Center		
177.	An incarcerated person reported a concern related to not being issued shoes that fit.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to engage in the resolution program process.	Technical Assistance Provided
178.	An incarcerated person reported a concern related to not being allowed to exercise while on lay out from work for non medical reasons.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to engage with the resolution program.	Technical Assistance Provided
	Other		
179.	This person reported concerns about community custody supervision.	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint does not involve a person committed to the physical custody of the DOC.	No Jurisdiction
180.	A friend or family member relayed concerns regarding this person's current court proceedings and assigned counsel.	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
181.	A friend or family member relayed concerns regarding this person's Community Corrections Officer (CCO) and imposed conditions of supervision requirements.	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint does not involve a person committed to the physical custody of the DOC.	No Jurisdiction
182.	An external person forwarded this person's complaint regarding medical	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint does not involve a person committed to the physical custody of the DOC.	No Jurisdiction

	neglect and medical records at a county jail.		
183.	A friend or family member relayed concerns regarding this person's ability to access ongoing healthcare appointments and medications.	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint does not involve a person committed to the physical custody of the DOC.	No Jurisdiction
184.	An external person reports that this person is not feeling safe with her assigned Community Corrections Officer (CCO).	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint does not involve a person committed to the physical custody of the DOC.	No Jurisdiction
185.	A person reported a concern for a person in Pierce County Jail.	The OCO lacks jurisdiction to investigate this complaint because the complaint relates to an action taken by an agency other than the Washington State Department of Corrections.	No Jurisdiction
186.	A friend or family member relayed concerns regarding this person's Community Corrections Officer (CCO).	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint does not involve a person committed to the physical custody of the DOC.	No Jurisdiction
187.	Person reported concerns about DOC community custody staff making false statements in a tort claim investigation and delays with a public records request.	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint does not involve a person committed to the physical custody of the DOC.	No Jurisdiction
188.	Person reported concerns about the housing that DOC approved her to live in while on community custody and the lack of concern from her community corrections officer who will not approve of an address change.	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint does not involve a person committed to the physical custody of the DOC.	No Jurisdiction
189.	This person reported complaints about medical care and staff conduct at a county jail, Clallam Bay Correctional Facility.	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint does not involve a person committed to the physical custody of the DOC.	No Jurisdiction
190.	This person reported a complaint regarding his Community Corrections Officer (CCO) making false statements that were sent to the Indeterminate Sentence Review Board (ISRB) in 2022.	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint does not involve a person committed to the physical custody of the DOC.	No Jurisdiction
	Reentry Center - Tri-Cities - Benton		
191.	An external person reported concerns about DOC not approving the submitted address for the Graduated Reentry Program (GRE).	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
	Stafford Creek Corrections Center		
192.	External person reported drug issues at a facility and how the facility has done nothing to try and stop it.	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

193.	A friend or family member reported concerns about the need to transfer their loved one to another facility for safety reasons.	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
194.	A friend or family member has reported concerns about this person's access to medical care and being housed in solitary confinement for an extended period of time.	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
195.	An external person reported that DOC had denied their marriage and did not provide a reason for the denial.	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
196.	Person requested access to a pro bono immigration attorney who can answer his questions.	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the complaint relates to an agency other than the Washington State Department of Corrections.	No Jurisdiction
197.	Incarcerated individual shared concerns regarding losing their job over an infraction and not getting their job back despite the infraction being dismissed.	This person was released prior to the OCO taking action on the complaint.	Declined
198.	A loved one shared concerns on behalf of an incarcerated individual regarding DOC not providing them with mental health access.	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 requesting mental health access.	Technical Assistance Provided
199.	A loved one or friend reported a concern related to an issue with their tablet.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to contact Securus.	Technical Assistance Provided
200.	An incarcerated person reported a concern related to a serious infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about the serious infraction process.	Technical Assistance Provided
201.	An incarcerated person reported a concern related to not receiving the correct pay.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to report their concern to DOC and engage in the resolution program process.	Technical Assistance Provided
202.	An incarcerated person reported a concern related to an infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about the Serious Infraction Process and how to appeal infractions.	Technical Assistance Provided
203.	Incarcerated individual shared concerns regarding DOC medical staff not providing them with medication and offending them.	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 Provided

		technical assistance about reporting regarding staff misconduct.	
204.	An incarcerated person reported a concern related to the behavior of a DOC contractor.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to engage in the resolution program process.	Technical Assistance Provided
205.	An incarcerated person reported a concern related to wanting DOC to refund a lab testing fee.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to request records from DOC using DOC's public records process and how to file a tort claim.	Technical Assistance Provided
Washington Corrections Center			
206.	External person reported that their loved one was supposed to get good conduct time restored through a pathway.	The incarcerated individual said they did not want the OCO to further investigate the complaint and closed the case.	Complaint Withdrawn
207.	A friend or family member has reported concerns that DOC violated this person's due process rights regarding an infraction.	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
208.	An external person reported concerns about this person receiving threats and harassment from his cellmate. DOC denied his request to be moved to another cell.	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
209.	An external person reported concerns that this person is being targeted by a DOC staff member. The person stated DOC intentionally did not process his infraction appeal and the allegations in the infraction were false.	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
210.	A friend or family member reported concerns about the need to transfer their loved one to another facility or protective custody for safety reasons.	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
211.	An external person reported that DOC denied, without notification, marriage to their incarcerated fiancé due to an alleged Prison Rape Elimination Act (PREA) investigation that was substantiated and they are worried this will effect their ability to visit.	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
212.	An external person reported concerns about discrimination and their loved one being forced to take medication in order to live in general population.	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
213.	An individual reports that DOC staff took his ID, would not give it back, and	The incarcerated individual said they did not want the OCO to further investigate the complaint, and closed the case.	Complaint Withdrawn

	kept him from attending yard or gym for multiple days.		
214.	Person reports that he has an approved address and is in communication with the housing authority regarding his address for his upcoming release but DOC staff are not helping him get the proper documentation to finalize his housing plans.	The Department confirmed that a reentry navigator is working with this person, and the individual gave notification to the Ombuds to withdraw his complaint.	Complaint Withdrawn
215.	An incarcerated person reported a concern regarding inadequate medication management by DOC health services, and another concern which has been documented in a separate case.	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.	This person reported concerns about DOC staff making inappropriate comments to his loved one when they called to ask a question regarding visiting.	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
217.	An incarcerated person reported a concern related to not being given their tablet after releasing from the IMU.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to engage with the resolution program.	Technical Assistance Provided
218.	An incarcerated person reported a concern related to the calculation of their sentence.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to engage with the resolution program.	Technical Assistance Provided
219.	An incarcerated person reported a concern regarding a serious infraction process.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about the serious infraction process.	Technical Assistance Provided
220.	An incarcerated person reported a concern regarding laundry issues.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about resolution program processes.	Technical Assistance Provided
221.	An incarcerated person reported a concern related to their ERD.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal serious infractions which have affected their ERD calculation.	Technical Assistance Provided
222.	An individual reports that he was taking a urinalysis (UA) and he could not produce the amount required for a valid test. The officer threw out the contents of his cup, infracted him, and said in the infraction report that this individual spit in the UA cup.	The OCO provided technical assistance regarding how to appeal an infraction. An individual must appeal their infraction and receive a response from DOC before the OCO will review the infraction materials.	Technical Assistance Provided

223.	An incarcerated person reported a concern related to the calculation of their sentence.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about the records correction and time calculation process and, resolution program processes.	Technical Assistance Provided
224.	An incarcerated person reported a concern related to the behavior of a DOC staff member.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about engaging with the resolution program prior to contacting the OCO.	Technical Assistance Provided
	Washington Corrections Center for Women		
225.	An external person reported concerns that DOC is not providing this person with the appropriate medications for her healthcare 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
	Washington State Penitentiary		
226.	Someone reported concerns about the water in this person's cell not being drinkable. There had been a power outage for three days with no estimated time when it will be restored.	The incarcerated individual said they did not want the OCO to further investigate the complaint and closed the case.	Complaint Withdrawn
227.	An external person reported concerns that this person is being targeted by DOC staff. His cell was searched multiple times. An unauthorized tool was found during one of the searches, but the item had not been used or tampered with, which caused this person to question the legitimacy of the violation.	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
228.	An external person reported concerns that this person was accused of threatening staff and was placed in the IMU the day before a culture event that he had been approved to attend. This person was told he was going to have a hearing, but he did not receive an infraction and, while in IMU, he was denied needed medical equipment. The person is concerned that this may have been retaliation to avoid sending him to a medium custody 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
229.	A friend or family member reported concerns about their loved one's physical wellbeing 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
230.	A friend or family member reported that their one is experiencing	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	Complaint Withdrawn

	difficulties being able to appeal an infraction.	incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	
231.	A friend or family member reported concerns that their loved one is not receiving dental care that was pre-paid for, not receiving medical after for over an hour after a seizure, and that a female staff person touched him inappropriately during a pat-search.	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
232.	An individual called to report that they still have not received the glasses they bought back in February, and DOC has already taken the money from their account.	The incarcerated individual said they did not want the OCO to further investigate this complaint because DOC has finally provided their glasses.	Complaint Withdrawn
233.	An individual reports that he was supposed to be released on the day he called the OCO hotline; however, the DOC is releasing him tomorrow due to an incorrect time calculation.	This person was released prior to the OCO taking action on the complaint.	Declined
234.	A loved one reported a concern related to your safety in relation to the facility placement of an incarcerated person.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to self-advocate during the Classification and Facility Assignment process.	Technical Assistance Provided
235.	Incarcerated individual shared concerns regarding DOC not providing them with time served.	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 records and how to attempt to resolve time-related concerns.	Technical Assistance Provided

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-021

Report to the Legislature

As required by RCW 72.09.770

June 30, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Tim Lang, Secretary
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Table of Contents

Table of Contents 1
Legislative Directive and Governance 2
Disclosure of Protected Health Information 2
UFR Committee Members 3
Fatality Summary 4
UFR Committee Discussion 4
Committee Findings 5
Committee Recommendations 5

Unexpected Fatality Review Committee Report

UFR-24-021 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on May 1, 2025:

DOC Health Services

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

DOC Men's Prisons Division

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

DOC Risk Mitigation

- Michael Pettersen, Director

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Judy Zerzan, Medical Director

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

Fatality Summary

Year of Birth: 1965 (59-years-old)

Date of Incarceration: November 1981

Date of Death: December 2024

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

His cause of death was due to a pulmonary embolism. The manner of his death was natural.

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

Days Prior to Death	Event
15 - 0 Days	• The incarcerated individual was receiving care in a community hospital.
0 Days	• He experienced a medical emergency in his cell, was transported via ambulance to the community hospital where he was pronounced deceased.

UFR Committee Discussion

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

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

   1. The committee found:

      a. The incarcerated individual received comprehensive care from his DOC primary care team and community specialists.

      b. Upon return to the facility after an extended hospital stay, he unfortunately developed complications from a blood clot in his lung and passed away.

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

B. Independent of the mortality review, the DOC conducted a critical incident review (CIR) to

determine the facts surrounding the fatality, evaluate compliance with DOC policies and operational procedures. The CIR did not identify any operational issues that caused or contributed to the incarcerated individual's death.

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

1. Extraordinary Medical Placement:

   DOC follows RCW 9.94A.728 criteria when determining eligibility for EMP participation and internal policy 350.270 Extraordinary Medical Placement for program administration. The incarcerated individual did not meet the medical eligibility criteria prior to his death.

2. Medical care provided:

   Committee members concurred the incarcerated individual's medical needs were complex. The care provided and coordinated by DOC staff with community specialists was appropriate.

Committee Findings

The incarcerated individual died as a result of a pulmonary embolism. The manner of death was natural.

Committee Recommendations

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

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