Office of the Corrections OMBUDS

Monthly Outcome Report

May 2025

Unexpected Fatality Reviews: 3

Case Investigations: 344

Assistance Provided: 70
Information Provided: 137
DOC Resolved: 30
Insufficient Evidence to Substantiate: 31
No Violation of Policy: 70
Substantiated: 6

Intake Investigations: 114

Administrative Remedies Not Pursued: 0
Declined: 27
Lacked Jurisdiction: 6
Person Declined OCO Assistance: 20
Person Released from DOC Prior to OCO Action: 4
Technical Assistance Provided: 57

Resolved Investigations:

461

Assistance Provided, Information Provided, or Technical Assistance Provided in

57%

of Investigations

Monthly Outcome Report: May 2025

	Complaint Summary	Outcome Summary	Case Closure Reason
	Unexpected Fatality Reviews		
1.	Incarcerated individual passed away while in DOC custody.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-24-020 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website.	Unexpected Fatality Review
2.	Incarcerated individual passed away in DOC custody.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-25-004 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The UFR Committee recommended 1. nursing leadership review and update medical emergency response form to include guidelines for clinical instability, 2. ensure health services emergency response training includes signs of clinical instability and reinforces when to request a community EMS response, and 3. facility leaders should conduct drills and post-action emergency response debriefs to improve communication including the process of obtaining and interacting with community EMS.	Unexpected Fatality Review
3.	Incarcerated individual passed away while in DOC custody.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-24-016 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The UFR Committee offered the following recommendations: DOC Health Services should review and update nursing protocols and forms to include stimulant intoxication and guidelines for clinical instability, and DOC should explore ways to improve communication during a medical emergency including the process of obtaining and interacting with community EMS.	Unexpected Fatality Review

Case Investigations

Airway Heights Corrections Center

4.	Incarcerated individual reported during a class for required programming the group was talking about blood borne pathogens and the facilitator for class said AIDS stands for, “anal intercourse death sentence.” The person said that it was a foolish statement and that someone could take offense to it. The person was kicked out of class after this interaction.	The OCO provided assistance. The OCO reviewed the resolution request that was submitted and contacted the facility leadership. After OCO involvement, this concern was administratively pulled out of the resolution process and will be investigated by the facility.	Assistance Provided
5.	An incarcerated person requires a procedure scheduled with an outside medical specialist. The person is unsure if the appointment was scheduled and has requested that the OCO confirm the appointment will happen.	The OCO provided assistance. OCO staff reviewed the person’s consultations and noted an administrative error that resulted in the consultation being closed. The OCO contacted DOC Health Services staff and requested the consultation be reviewed. OCO staff verified another consultation was opened and the requested appointment was scheduled. The OCO will continue to monitor the appointment until completion due to repeated scheduling concerns.	Assistance Provided
6.	Incarcerated individual shared concerns regarding DOC not providing them with DME (durable medical equipment) to accommodate their medical concern.	The OCO provided assistance by reaching out to DOC medical staff and requesting that they review this individual's concern again. After speaking with DOC staff, this office was informed that this individual's requested care is not clinically indicated for their diagnosed condition.	Assistance Provided
7.	Incarcerated individual reports that he was moved from camp early in the morning and asked DOC staff to secure his locker so his property would be safe. When he received his property, he was missing his headphones and other commissary items. The person reports that DOC staff were rude and told him they are not obligated to secure his locker.	The OCO verified the individual was utilizing the resolution program and confirmed the person received an inaccurate level II resolution request response. This office escalated the issue to DOC headquarters, and they verified the response was inaccurate. The OCO provided additional information regarding how to access the tort claim process through the Risk Management division at the Department of Enterprise Services (DES).	Assistance Provided
8.	Incarcerated person reports he was placed in solitary confinement and given a maximum custody (MAX) program even though he was found not guilty of infractions.	The OCO provided assistance. The OCO reviewed this person's custody facility plan, infraction history and maximum custody placement. The OCO verified he was found not guilty of his infractions. However, the DOC maintained they had evidence to suggest he was still involved in the incident. The OCO contacted DOC Headquarters to inquire about why he was found not guilty of infractions if they had evidence to support his involvement in the incident. The DOC agreed to re-review	Assistance Provided

		his max placement if he appealed to the Mission Housing Administrator and Chief of Investigative Operations.	
9.	An incarcerated individual reports that they did not receive an appeal decision for one of their infractions.	The OCO provided assistance by contacting the facility and requesting a copy of the appeal response to be forwarded to the individual.	Assistance Provided
10.	Incarcerated person said that a previous case with the OCO got him an appointment for a specialist consultation, which recommended surgery. The person reported that DOC denied the surgery saying it was not medically necessary to complete the surgery before his release.	The OCO provided assistance by continually monitoring the appointment for his surgery to ensure that it was completed. The OCO reviewed this individual's resolution request and found that DOC approved his surgery after initially denying it. The OCO monitored his appointment and confirmed that his surgery was completed.	Assistance Provided
11.	External person reports their loved one does not feel safe at the camp he was moved too.	The OCO reviewed this concern and verified the individual was moved.	DOC Resolved
12.	A loved one shared a concern on behalf of an incarcerated individual regarding DOC staff infracting them over a medical incident.	DOC staff resolved this concern prior to the OCO taking action on this complaint. After reviewing DOC records, this office was able to confirm that this individual appealed the infraction and DOC dismissed it.	DOC Resolved
13.	Incarcerated person reports having issues accessing programming that he needs to get approved for work release.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff reviewed the person's records and found he was approved for reentry center and his transfer has been ordered.	DOC Resolved
14.	Incarcerated person reports he has not received follow up care after surgery. The person stated that he still has symptoms and needs his medication orders changed.	DOC staff resolved this concern prior to OCO action. OCO staff reviewed the person consultations and noted that he was already scheduled to see a specialist for the required follow-up appointment. OCO staff verified the person did attend the appointment. The person contacted the OCO and informed this office that the medication issue was resolved.	DOC Resolved
15.	Incarcerated individual shared concerns regarding DOC staff keeping them from transferring into GRE (graduated reentry).	DOC staff resolved this concern prior to the OCO taking action on this complaint. After reviewing DOC records, this office was able to confirm that this individual has been transferred to a reentry center (RC).	DOC Resolved
16.	Incarcerated individual reported concerns regarding access to the Medication Assisted Treatment (MAT) program for shoulder pain.	The OCO reviewed the documentation related to this concern, spoke to DOC and confirmed that the individual has been approved and placed onto the MAT program.	DOC Resolved
17.	Incarcerated person reports he was injured on the job and needs to have surgery; however, the surgery was denied by his medical	DOC staff resolved this concern prior to OCO outreach. The OCO contacted DOC Health Services leadership at the facility and were informed that a surgical consult had already been approved after additional review.	DOC Resolved

	provider. The person is requesting to receive surgery.		
18.	An incarcerated person reports that DOC Health Services is not accommodating his dietary needs in relation to his medication schedule.	DOC staff resolved this complaint prior to OCO action. The OCO reviewed the person's records and found that since reporting the issue the patient had received health status reports (HSRs) to accommodate his specific needs. The OCO provided information to the person regarding the process to request medical snacks if the current plan is not effective.	DOC Resolved
19.	Incarcerated individual reports they do not feel safe at the camp they were moved too.	DOC staff resolved this complaint prior to OCO action. The OCO reviewed this concern and verified the individual was moved.	DOC Resolved
20.	Incarcerated individual reported concerns regarding DOC not placing them in programming and that jeopardizing their earned release date (ERD).	The OCO provided information regarding why they were not initially placed in the programming. After reviewing DOC records and speaking with DOC staff, this office was able to confirm that the programming was not necessary for them early on. However, the programming was determined to be needed after new information was provided to DOC and the assessment programs.	Information Provided
21.	External person reports concerns about their incarcerated loved one's medical care.	The OCO elevated the concerns to DOC health services leadership and confirmed additional testing was ordered and the patient received follow up appointments for the reported medical concerns. Since the patient did not file a grievance or contact the OCO directly with permission to move forward, this office sent them information about the next steps if they are experiencing ongoing concerns.	Information Provided
22.	Incarcerated individual reported concerns regarding safety issues that may arise at a proposed placement.	The OCO provided information about the person’s situation. The OCO reviewed the individual's record and spoke to DOC about this concern. The OCO confirmed that the transfer has been deferred. The OCO verified this person will not be transferred until they are interviewed by the intelligence and investigations unit (IIU) to validate their safety concerns.	Information Provided
23.	This was a request for OCO records and was not a complaint related to DOC.	The OCO provided information to the requestor about their previous public records request.	Information Provided
24.	Incarcerated person reports they should be able to access the Medication Assisted Treatment (MAT) program but is receiving conflicting information about his eligibility.	The OCO provided information about the expansion of the DOC Medication Assisted Treatment (MAT) program. The OCO contacted DOC Health Services and confirmed that the expansion project was paused at different stages throughout facilities. Some facilities are set up to provide expanded access, while others are not able to provide that level of access. The OCO is in ongoing discussion with DOC Health Services related to the MAT expansion project.	Information Provided
25.	Incarcerated individual shared concerns regarding not having access to specific programming.	The OCO provided information regarding the specific programming this individual is wanting to take. After reviewing DOC records, this office was able to confirm that this individual is not currently eligible for the programming per current DOC program guidelines.	Information Provided
26.	An incarcerated person reported concerns about a veteran’s group not having regular meetings.	The OCO provided information about how to propose a program at a facility. The OCO spoke with DOC staff about this concern who shared that veteran’s services are available by request. Incarcerated veterans at AHCC can kiosk message	Information Provided

		'AHCC Veterans' to receive assistance accessing multiple services and to propose meetings or events. DOC staff do not currently hold regular meetings for veterans. The OCO shared information about how to request organizing fundraising events, and other events including regular meetings for veterans.	
27.	Incarcerated person reports they were not given access to the Medication Assisted Treatment (MAT) program after being approved for transfer to a Reentry Center. The person reports that he was not given any information about receiving treatment in the community before leaving DOC. The person states he feels like he is being targeted because he had completed a level 3 resolution about this issue and resolutions staff were rude to him.	The OCO provided information to the person regarding the completed OCO investigation, and the current DOC Medication Assisted Treatment (MAT) protocols. The OCO reviewed the person's records, and the current Medication Assisted Treatment (MAT) protocol. The OCO found the person did not meet the criteria to start MAT medications prior to Reentry Center transfer. This criterion is based on Earned Release Date (ERD) which remains the same when someone is moved to a Reentry Center. The OCO found there was insufficient evidence to substantiate that staff delayed treatment as a result of the person using the resolution program. Resolution program staff are not included in clinical decisions.	Information Provided
28.	Incarcerated individual reported concerns regarding DOC staff photocopying mail and only providing them with black and white copies of the original mail.	The OCO provided information regarding why their mail has been provided to them in a black and white copy and not colored. This office spoke with DOC, who shared that colored printing both poses a security risk and is too costly.	Information Provided
29.	Incarcerated individual reported concerns regarding DOC placing a separatee between them and another individual for no reason.	The OCO provided information as to why there is a separatee between them and the other individual. This office also shared information related to how this individual can attempt to request a keep separate be moved. After reviewing DOC records, this office was able to confirm that the separatee was placed in pursuance with DOC 320.180.	Information Provided
30.	Incarcerated individual reported concerns regarding access to the opportunity to program to become eligible for a RC (reentry center, formerly work release).	The OCO provided information regarding why this individual was denied transfer to a Reentry Center. After reviewing DOC records, this office was able to verify that this individual was denied by the HCSC (Headquarters Classification Screening Committee) due to a lack of necessary programming. This office was also able to confirm that DOC staff are actively working with this individual to provide them with support for a successful release.	Information Provided
31.	An incarcerated person requested information about the infraction process.	The OCO provided information about the infraction process, how to appeal and when the OCO can review the concern. The person was provided with information directly from the OCO Confidential Hotline.	Information Provided
32.	Incarcerated person reports that the facility he is housed in is not allowing people to access the Medication Assisted Treatment (MAT) program. The person requests	The OCO provided information to the person regarding the current Medication Assisted Treatment (MAT) program protocol and status of the expansion. Currently the expansion of the MAT program is on hold. Many facilities were in different phases of expansion when the project was placed on	Information Provided

	the facility to expand access to the MAT program to more people.	hold. OCO confirmed the facility the person is housed at is offering MAT within current protocol timelines.	
33.	Incarcerated individual reported concern regarding DOC medical staff not providing them with adequate medical care.	The OCO provided information regarding this individual's current care plan. After speaking with DOC staff, this office was able to confirm that this individual is actively working with their provider to mitigate their concerns.	Information Provided
34.	An incarcerated person reported that a shared identity group he participates in is not being allowed to form an organizing board.	The OCO provided information about the steps to take to propose formally forming a group with a board.	Information Provided
35.	Incarcerated individual reported concerns about needing a facility keep separate from another individual.	The OCO reviewed the keep separate on file and spoke to DOC about this. The OCO confirmed that a unit separation was approved but not a facility separation. The OCO informed the individual that if they have more information about threats the other individual is still making to their safety, they will need to submit them to the Correctional Program Manager (CPM). DOC can then consider a facility, rather than unit, separation.	Information Provided
36.	Incarcerated individual shared concerns about DOC medical staff not providing them with physical therapy following surgery.	The OCO provided information regarding findings related to the alleged delay in requested care. After review of DOC records, this office was able to substantiate the delay and that this individual was provided with their requested care.	Information Provided
37.	The individual reports that he needs an SUD assessment, but DOC staff are not helping him.	The OCO contacted DOC about this concern and verified that graduated reentry partial confinement does require an SUD assessment. This office confirmed that the incarcerated individual has been referred for an assessment, but it is uncertain when he will be scheduled. This office encouraged him to utilize the resolution process for his concern.	Information Provided
38.	Incarcerated person reports concerns about the way he was transported by DOC staff. The person is requesting monetary compensation and the removal of the DOC officers involved.	The OCO provided information to the person regarding RCW 43.06C that details the authority of the OCO. The OCO does not have the authority to dictate staff disciplinary actions by the DOC. The OCO reviewed relevant documentation and confirmed that the DOC substantiated the incident but did not consider it a violation of policy. The OCO also provided tort claim information to the person.	Information Provided
39.	Incarcerated individual reported concerns regarding filing a resolution request (RR) about a DOC policy and not being given the opportunity to properly appeal the responses to his RR due to transfer to another facility.	The OCO was unable to substantiate the concern due to insufficient evidence. After reviewing DOC records, this office was able to confirm that this individual received a response to their resolution request and their appeal was provided outside of the appeal timeframe. Individuals still have the opportunity to appeal a resolution request after a transfer.	Insufficient Evidence to Substantiate
40.	Incarcerated individual reported concerns about resolution requests they filed not being handled appropriately.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the resolution requests and found they contained too many issues. The person met with a resolution program peer support person and chose not to submit a rewrite.	Insufficient Evidence to Substantiate

41.	An incarcerated person reported concern about his job and said that staff were retaliating against him by not moving him to a new job.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed DOC records and found that he was given a new job. After reviewing DOC records, including DOC Resolutions investigations, the OCO could not substantiate retaliation. The OCO also found that this individual is no longer housed at this facility.	Insufficient Evidence to Substantiate
42.	Incarcerated individual reported concerns about DOC staff targeting them after filing a resolution request about staff misconduct, which was related to searching their room and making them take a UA (urinalysis).	The OCO was unable to substantiate the concern due to insufficient evidence. After reviewing DOC records, this office was unable to substantiate misconduct by DOC staff due to the records indicating sufficient evidence for DOC to take action. The OCO verified this incident occurred prior to the person filing a resolution request.	Insufficient Evidence to Substantiate
43.	Incarcerated individual reported concern about feeling targeted for dating a former DOC staff member.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed DOC records and confirmed the person was referred to the DOC headquarters community screening committee (HCSC). DOC determined the person required maximum custody particularly due to controlled substance violations. The OCO was unable to find evidence substantiating that DOC is or was targeting the individual based on their relationships.	Insufficient Evidence to Substantiate
44.	Incarcerated individual reported concerns regarding an infraction.	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 via DOC form 14-021 to utilizing drugs and their UA tested positive for drugs.	No Violation of Policy
45.	Incarcerated person reports receiving an infraction while having a mental health crisis. The person believes that they should not be punished for things said while in a crisis.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the person's disciplinary records. The OCO found concerns about this infraction due to a mental health crisis and elevated these concerns to DOC, but DOC was unwilling to dismiss or lower the infractions.	No Violation of Policy
46.	Incarcerated individual reported concerns regarding staff taking their property after a search.	The OCO was unable to substantiate a violation of policy by DOC. The OCO confirmed the individual received a response from DOC after investigating the officer's conduct related to the search and found no violation of policy as the items that were disposed of were identified as nuisance contraband. The hobby items were sent to DOC staff before deciding they need to be shipped out of the facility as completed projects.	No Violation of Policy
47.	Incarcerated individual reported concerns regarding an infraction.	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 was directed to return to their cell and refused.	No Violation of Policy
48.	Incarcerated individual reported concerns regarding not being allowed to release to a certain city.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the documentation related to this concern and spoke with DOC and confirmed that due to victim concerns the individual cannot be released to that city.	No Violation of Policy
49.	Incarcerated individual shared concerns regarding losing their housing assignment and	The OCO was unable to substantiate a violation of policy by DOC. After reviewing DOC records, this office was able to confirm that DOC following DOC 460.050 by imposing sanctions and loss of privileges after the incident as DOC had reason to	No Violation of Policy

	job over an infraction that was later dismissed.	validate the infraction behavior occurred. This individual was initially found guilty of the infraction and after an extended period, the infraction was overturned due to administrative error. The OCO verified this individual is currently employed within a new work program.	
50.	Incarcerated person requested to go to a funeral, and DOC approved it at every level. The person said he was told DOC denied his request to attend the funeral because law enforcement was conducting an ongoing criminal investigation related to his family members death, an alleged murder. The person wants information about the DOC funeral visit policy. He reports he had no chance to appeal the approval process and was given the option to attend via Zoom as an alternative.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed DOC 420.115 and the funeral packet denial. Due the circumstances surrounding the death, the DOC did a risk assessment and determined that it could be dangerous for staff and the individual to attend the funeral. This office cannot identify any misconduct by staff. The packet was created per policy and denied per policy.	No Violation of Policy
51.	Incarcerated individual reported concerns about DOC wrongfully terminating them from their job.	The OCO was unable to substantiate a violation of policy by DOC. After reviewing DOC records, this office was able to confirm that DOC followed DOC 710.400 and terminated the individual from employment. Records indicate that this individual refused to complete assigned job task.	No Violation of Policy
52.	Incarcerated individual reported concerns about an infraction.	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. The OCO verified the individual admitted to the infraction.	No Violation of Policy
Cedar Creek Corrections Center			
53.	Incarcerated individual reported concerns regarding DOC medical staff not removing a cast despite having a cast on for an extended period.	The OCO provided assistance. After this office's outreach, DOC staff shared they have set up an appointment with the individual to discuss potential removal of the cast.	Assistance Provided
54.	Incarcerated individual reported concerns regarding DOC staff sharing sensitive information from a private group setting that resulted in them being infracted.	The OCO provided information regarding the type of information that can be shared from group settings.	Information Provided
55.	Incarcerated individual relayed concerns regarding an extended family visit (EFV) denial.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the EFV appeal decision and found no violation of DOC 590.100 attachment 1. There is a 3-year period after a category B level 1 infraction until an individual can apply for EFVs.	No Violation of Policy

Clallam Bay Corrections Center			
56.	Incarcerated individual has been on a maximum custody program for over a year. The individual has completed four programs and has maintained infraction free behavior; however, he was still retained maximum custody at his recent review. The individual is requesting DOC allow him access to level 3 privileges if DOC is unwilling to promote him.	The OCO provided assistance. The OCO contacted DOC Headquarters to request a review of his level 3 request. This individual has maintained good behavior and if he cannot be promoted out of max, he should at least be allowed promotion to level 3. DOC agreed to review his level.	Assistance Provided
57.	Incarcerated individual reported concerns about access to participate in specific programming but being provided with conflicting information regarding the criteria for eligibility.	DOC staff resolved this concern prior to the OCO taking action on this complaint. After reviewing DOC records and speaking with DOC staff, this office was able to confirm that this individual has been accepted into the requested programming.	DOC Resolved
58.	Incarcerated individual reported concerns regarding not getting access to their property.	The OCO provided information about property access in solitary confinement. The OCO contacted DOC regarding this concern and confirmed that because the individual refused housing and is being housed in solitary confinement, they do not have full property access while in restricted housing.	Information Provided
59.	Incarcerated individual reported concerns regarding the usage of GVRS (group violence reduction strategy).	The OCO reviewed this concern and spoke to DOC about GVRS. The OCO informed the individual that the OCO is in ongoing conversation with DOC about the usage of GVRS at this time and continues to escalate concerns related to how GVRS is utilized.	Information Provided
60.	Incarcerated individual reported concerns regarding DOC not providing them with meals that adequately fulfill their nutritional needs and DOC staff purposefully withholding their special diet.	The OCO provided information regarding the current diets and limitations currently in place. After reviewing DOC records, this office was able to substantiate that this individual had received the incorrect food portions. However, the OCO was unable to confirm any purposeful wrongdoing by DOC staff.	Information Provided
61.	Incarcerated individual reported concerns regarding the usage of GVRS (group violence reduction strategy).	The OCO reviewed this concern and spoke to DOC about GVRS. The OCO informed the individual that the OCO is in ongoing conversation with DOC about the usage of GVRS at this time and continues to escalate concerns related to how GVRS is utilized.	Information Provided
62.	An anonymous concern was filed with the Department of Health regarding cleanliness of kitchen and housing facilities at Clallam Bay Corrections Center, along with other concerns.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO visited the facility in question and was unable to verify the shared concerns.	Insufficient Evidence to Substantiate

63.	Incarcerated person reports a DOC staff that does not usually work in the unit shared the person's medication to the dayroom. The person reported it to DOC as a HIPPA issue, but her level 2 resolution request response said they didn't have to follow HIPPA. The person wants to move to a medium custody unit.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the level 3 Resolution Request, and the claim was unsubstantiated. There was no audio proof, and the staff all agreed that they did not hear anything. DOC is not subject to HIPPA requirements when sharing protected health information. Per DOC Classifications policy, this individual will remain in close custody for 2 years. They are targeted for medium in June.	Insufficient Evidence to Substantiate
64.	External person reports their loved one was accused of gang activity and they were moved. The incarcerated person has not had any infractions and now is in restrictive housing.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed these concerns and found there were infractions regarding STG activity. The individual was placed under investigation and then was moved to a different custody level per DOC 300.380 and 320.200.	No Violation of Policy
65.	Incarcerated individual reported concerns regarding an infraction.	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 was observed throwing closed fist punches to another incarcerated individual and refused directives to stop, requiring the deployment of OC spray.	No Violation of Policy
66.	Incarcerated individual reported concerns regarding an infraction.	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 video evidence shows the individual running towards the riot and refusing directives to leave the fight.	No Violation of Policy
67.	Incarcerated individual reported concerns regarding two infractions.	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 for either infraction as the individual was confirmed to be in possession of drugs and attempting to introduce more drugs.	No Violation of Policy
Coyote Ridge Corrections Center			
68.	Incarcerated individual reported concerns regarding DOC wrongfully revoking their DOSA (Drug Offender Sentencing Alternative) and placing them in IMU (Intensive Management Unit) for incorrect reasons.	The OCO provided assistance by getting DOC staff to review this individual's placement again after our outreach. After speaking with DOC staff and reviewing DOC records, this office was also able to confirm that DOC will not be revoking their DOSA. DOC staff also submitted a new request for a CFP upon further review of this individual's situation.	Assistance Provided
69.	Incarcerated individual reported concerns regarding DOC staff not providing them with their requested accommodation.	The OCO provided assistance by speaking with DOC staff and getting them to agree to speak to the individual regarding their concerns. After speaking with DOC staff, staff shared they are actively working to provide them with the requested accommodation.	Assistance Provided
70.	Incarcerated individual reported concerns regarding	The OCO provided assistance. The OCO spoke to DOC about the infraction appeal, DOC confirmed that they received the infraction appeal and responded, but due to an administrative	Assistance Provided

	an infraction appeal that DOC never responded to	error, the individual was not given a copy of the decision. DOC will now be sending them a new copy.	
71.	Incarcerated individual reported concerns regarding DOC staff not hearing anything about a medical test they took.	DOC staff resolved this concern prior to the OCO taking action on this complaint. After speaking with DOC staff, this office was informed that this individual got their test results back and will meet with their provider soon to discuss the results.	DOC Resolved
72.	External person reported concerns about an incarcerated person's access to a tablet.	The OCO provided information about how to get a tablet replacement after one if broken. The OCO spoke with DOC staff and verified the person had received a tablet prior to our outreach. The OCO found that SecurUs investigated the tablet to determine how it was broken, leaving this person without a tablet for an extended period. The OCO also verified that no negative action towards the person came from the investigation conducted. DOC has agreed with SecurUs that broken tablets will be replaced unless an infraction is adjudicated that the damage was intentional.	Information Provided
73.	An external person reported concerns about this person not being processed for transfer to a Reentry Center or the Graduated Reentry Program (GRE) without explanation from DOC.	The OCO reviewed this individual's records and verified that this person was screened for a Reentry Center and for the Graduated Reentry Program (GRE). The OCO provided information that this person was not transferred to a Reentry Center and was not eligible to participate in GRE because they did not have more than three months left on their sentence at the time of the eligible transfer date and due to a lack of completed or available substance use treatment options at a current or prior assessed 3.3 level of care.	Information Provided
74.	Incarcerated person reported that he needs specialist evaluation of an injury.	The OCO provided information to the person. OCO staff reviewed the patient's consultations and noted that he was already scheduled for specialist consultation. OCO staff provided information about the consultation and specialist recommendation process to the person.	Information Provided
75.	Incarcerated individual reported concerns regarding DOC not providing them with adequate medical care for their mouth.	The OCO provided information regarding why DOC deemed their requested treatment option as not clinically appropriate for them. After reviewing DOC records and speaking with DOC staff, this office was able to confirm that DOC is actively working to provide this individual with medical care to take care of the concerns shared by this individual.	Information Provided
76.	An incarcerated individual reports that he received items from Union Supply that were not what he ordered, and he did not get a refund after sending the items back.	The OCO provided Union Supply's customer service number and informed the individual that DOC staff would need to arrange this phone call.	Information Provided
77.	Incarcerated individual reported concerns regarding the ISRB requiring them to do additional programming and having difficulty getting into the programs.	The OCO provided information. The OCO spoke with DOC regarding this concern and confirmed that the individual has open referrals for the programs at this time.	Information Provided
78.	Incarcerated Individual reports that during clothing exchange, staff yelled at him	The OCO provided information about the resolution program. The OCO reviewed the DOC investigation and found that appropriate action was taken. This office encouraged the	Information Provided

	and forced him to wear clothes that were too small.	individual to continue utilizing the resolution program to document issues they have with DOC staff.	
79.	Incarcerated individual reported concerns regarding DOC not providing them with colored copies of their mail.	The OCO provided information regarding why their mail has been provided to them in a black and white copy and not colored. This office spoke with DOC staff who shared that colored printing poses a security risk and has become too costly.	Information Provided
80.	Incarcerated individual reported concerns regarding DOC withholding greeting cards sent from their loved one and providing them with black and white photocopies.	The OCO provided information regarding why their mail has been provided to them in a black and white copy and not colored. This office spoke with DOC staff who shared that colored printing poses a security risk and has become too costly.	Information Provided
81.	Incarcerated person reported concern about his job termination. Person wanted to get his job and lost good conduct time back.	The OCO provided information about DOC's new review of his job termination. The OCO reviewed this person's job termination and related resolution requests. The OCO spoke with facility leadership, who reviewed his termination in detail after OCO outreach, and declined to reverse the termination or return the good conduct time. The OCO brought this individual's staff conduct concern to facility leadership. This office also found that this individual is now at a different facility.	Information Provided
82.	Incarcerated individual reported concerns regarding follow up to a previous OCO case regarding 3 BOEs (behavior observation entries) as they believe 1 was removed when all 3 should have been.	The OCO spoke to DOC about this concern and confirmed that DOC still has not received the BOE appeals, thus, none would have been removed on appeal. The OCO informed the individual of who they need to submit the appeals to.	Information Provided
83.	Incarcerated individual reported concerns regarding inaccuracies in their record and wanting a release exam for the ISRB.	The OCO reviewed the records related to this concern and found no resolution requests have gone beyond level 0 as they were not accepted with the reason being that no one can file resolution requests about the ISRB. The OCO does not have jurisdiction over the ISRB and is unable to assist with this further. The OCO provided the individual with additional policy and DOC records information.	Information Provided
84.	Incarcerated individual reported concerns regarding mail rejections for too many images which violate the individual's first amendment rights.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the individual's record but was unable to further investigate this concern as the individual did not provide any mail rejection numbers or appeals and did not provide a rewrite for the grievance to clarify the issue.	Insufficient Evidence to Substantiate
85.	An anonymous incarcerated individual reported concern with a staff member being unprofessional.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO was unable to review documentation regarding this staff member's behavior due to a lack of evidence.	Insufficient Evidence to Substantiate
86.	Incarcerated individual reported concerns regarding staff conduct when an officer took their ID and they	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the related resolution request and was unable to substantiate this concern. The concern was reviewed, and nothing was found to show	Insufficient Evidence to Substantiate

	received it back with a racist drawing on it.	someone defaced the ID, as there was no evidence to confirm or deny the allegations.	
87.	Incarcerated individual relayed concerns regarding difficulties getting responses to their grievances related to the conduct of the law librarian.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the level 0, 1, 2 and 3 resolution responses and found that the paper tore during the scan which resulted in the address not being complete on the document, which was unintentional, the law librarian will not be disciplined or reassigned for a mistake.	Insufficient Evidence to Substantiate
88.	Incarcerated person reports that DOC staff are retaliating against him by filing PREA reports on him. This person requested that OCO verify the PREA investigation was completed correctly.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the PREA investigation and found it was completed within policy. OCO staff also reviewed the person's records and could not substantiate that the PREA was filed after any protected action was taken against the reporting officer. OCO staff verified that the person has not received any infractions related to the reported event.	Insufficient Evidence to Substantiate
89.	Incarcerated individual reported concerns regarding staff harassing them by giving them infractions.	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 did not provide a UA within the allotted one-hour time frame and did not have an HSR (health status report) for any accommodations.	No Violation of Policy
90.	Incarcerated individual reported concerns regarding an infraction.	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 falsely told staff they did not get all the infraction paperwork which was properly reduced from a serious to a general infraction.	No Violation of Policy
91.	Incarcerated individual relayed concerns regarding an infraction, particularly that the presumptive positive said the test results were positive for K3 while the lab said it was K2.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the infraction materials including the lab results and confirmed that both tests resulted in a positive result for synthetic cannabinoids. Thus, there is no violation of DOC policy 460.000 as the infraction elements are met to serve the person a WAC 603.	No Violation of Policy
92.	Incarcerated individual reported concerns regarding an infraction.	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 there is evidence to show that the individual directed their gang that if there was to be a fight they all had to fight, which did occur leading to a riot and an individual needing hospitalization.	No Violation of Policy
93.	Incarcerated individual reported concerns regarding a visitation denial.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the visitation denial and appeal and found no violation of DOC policy 450.300 attachment 1 that states "persons identified as being a safety/security concern, or who have facilitated/allowed an individual to violate Department or court-ordered conditions while in the community, may be denied all facility visit privileges."	No Violation of Policy
94.	Incarcerated individual relayed concerns regarding a BOE (behavior observation entry).	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the BOE and found no violation of DOC policy 300.010 as instead of getting a 210 out of bounds infraction, the individual was given a negative BOE for scanning breakfast too early.	No Violation of Policy

95.	Incarcerated individual reported concerns regarding an infraction.	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 falsely told staff they did not get all the infraction paperwork which was properly reduced from a serious to a general infraction.	No Violation of Policy
96.	Incarcerated individual reported concerns regarding transferring facilities.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the documentation related to this concern and found no violation of DOC policy 300.380 based on the investigation done in a previous OCO case as the transfer is appropriate.	No Violation of Policy
97.	Incarcerated individual reported concerns regarding an infraction.	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 was seen throwing a closed fist strike to the back of another incarcerated individual's head.	No Violation of Policy
98.	Incarcerated individual reported concerns regarding an infraction.	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 was seen spitting in the UA cup by officers, was then given a new cup to continue the UA but was unable to provide in the one full hour given.	No Violation of Policy
99.	Incarcerated individual reported concerns regarding an infraction.	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 drugs were found in the cell and the individual admitted to possession of it.	No Violation of Policy
100.	Incarcerated individual reports he was issued a negative behavior observation entry (BOE) multiple days after the incident, violating DOC policy.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the BOE and confirmed that the individual was provided access to appeal the BOE and the appeal was given to DOC staff. DOC 300.010 states, "Individuals may challenge the content in a BOE by submitting a written request identifying the information the individual believes to be inaccurate/incomplete.... The CPM/CCS will make the final determination concerning content in a BOE and whether it will be updated, deleted, or remain the same." DOC staff chose to uphold the BOE, and that decision is within policy.	No Violation of Policy
101.	An external person reported concern about an incarcerated person being assaulted by other incarcerated people as the result of DOC staff actions.	The OCO substantiated the incident occurred as there was reason to believe that staff action could have prevented this assault. The OCO reviewed DOCs investigation of the incident and verified that the investigation was properly conducted, and appropriate action was taken.	Substantiated
102.	Incarcerated person reported that his specialist prescribed a nutritional supplement while he recovered from radiation treatment, but DOC Health Services did not allow him to have the nutritional supplement.	The OCO was able to substantiate this concern but was unable to achieve a resolution. The OCO reviewed this individual's resolution request and appointment records and substantiated that the supplement was denied by his DOC provider and that it was not reviewed by the Care Review Committee (CRC). The OCO elevated this concern within Health Services, who said that the provider was following the DOC protocol. The OCO is conducting a systemic review of the Health Status Reports protocol and will continue to discuss concerns with this protocol with DOC Health Services Leadership.	Substantiated

Mission Creek Corrections Center for Women			
103.	Incarcerated individual shared concerns regarding DOC not transferring them to a more suitable facility to participate in more programming.	DOC staff resolved this concern prior to the OCO taking action on this complaint. After reviewing DOC records, this office was able to confirm that this individual has been transferred to their desired facility.	DOC Resolved
104.	Incarcerated person reports concerns regarding her release timing and needed programing for acceptance to a reentry center.	The OCO provided information to the person regarding her release and programing request. The OCO spoke with DOC and was informed the person's current programming would not negatively impact her release date.	Information Provided
Monroe Correctional Complex			
105.	An external person shared their incarcerated loved one tried to reach out to the OCO about a previously reported concern. The incarcerated person received correspondence from the OCO and wanted to verify their concerns were being investigated.	The OCO provided assistance. The OCO spoke with this individual about his concerns and conducted a full review in another investigation. The OCO visited this individual in person in his unit and talked with him about the concerns and the OCO's work on his case.	Assistance Provided
106.	A loved one reported concern about an incarcerated individual's facility placement and said that he no longer has access to as much programming and services. The OCO spoke with this individual, who expressed concern about his placement and said that he wants an access assistant and to be transferred to a facility with more services.	The OCO provided assistance. The OCO convened DOC Health Services and custody staff and his medical providers, who reviewed his placement and the care he currently needs. They determined that the specialist care he needs currently prevents him from being transferred to a different facility, due to proximity to his specialists. His provider team will continue to review his needs and his placement as his care needs change. After OCO outreach, a new Custody Facility Plan was written laying out his current needs and placement, and names the limitations of his current placement. The OCO spoke with DOC staff about concerns about his placement and the limitations of the unit he is in. Upon OCO request, DOC staff assigned him an access assistant. The OCO visited the unit and verified that it meets policy requirements and spoke with this individual about his concerns. The individual named concerns with DOC policy, which the OCO flagged for review.	Assistance Provided
107.	Incarcerated person reported concerns about DOC staff acting outside of their qualifications in the medical unit. The person stated that they were refused care by a DOC medical staff who is not qualified to make clinical decisions.	The OCO provided assistance. OCO monitored the DOC resolution process and noted concerns with the final resolution. OCO discussed concerns with DOC Health Services leadership who agreed to review the final resolution response. After this review, the OCO was notified that the resolution was substantiated at level 3.	Assistance Provided
108.	Incarcerated individual reported concerns regarding an infraction where their cellmate took responsibility,	The OCO provided assistance. The OCO reviewed the infraction materials and spoke to DOC about this concern. The OCO requested DOC dismiss one of the WACs from the infraction as the individual's cellmate did admit responsibility, as a result, DOC agreed to dismiss the WAC.	Assistance Provided

	but they were still found guilty.		
109.	Incarcerated person reports DOC has not issued Durable Medical Equipment (DME) that was ordered for them. The person reports that they have had the Health Status Report (HSR) for several months, but nothing has been issued to them.	The OCO provided assistance. OCO verified the patient's Health Status Reports had been issued to the person for a significant amount of time. OCO verified the person's eligibility for the equipment and contacted DOC Health Services to request that it be issued. One item was on order to be delivered, and no rationale was provided for why the other item had not been given to the person. OCO confirmed the patient has access to all ordered Health Status Report items.	Assistance Provided
110.	Incarcerated individual reported concerns regarding an infraction.	The OCO provided assistance. The OCO reviewed the infraction materials and spoke to DOC about this concern. The OCO requested that DOC dismiss 4 of the WACs as one WAC encompassed all the behaviors the other 4 WACs addressed and were excessive in nature, to which DOC agreed.	Assistance Provided
111.	Incarcerated individual reported concerns regarding an infraction.	The OCO provided assistance. The OCO reviewed the infraction materials and contacted DOC and requested DOC dismiss the infraction due to the contradictory witness statement to which they agreed.	Assistance Provided
112.	Incarcerated individual reported concerns regarding an infraction.	The OCO provided assistance. The OCO reviewed the infraction materials and spoke to DOC about this concern. The OCO requested DOC dismiss one of the WACs as it was duplicative in nature and the other WAC sufficiently addressed the behavior, to which DOC agreed.	Assistance Provided
113.	Incarcerated person reports concerns about DOC staff conduct, infractions, and housing placement.	The OCO provided assistance by elevating the concerns through DOC facility and headquarters leadership. After OCO outreach, the person was approved and moved from solitary confinement. The person was provided with a single cell for post-op recovery. The OCO also investigated the staff conduct concerns and elevated them to facility leadership, and confirmed after OCO outreach facility leadership addressed the misconduct.	Assistance Provided
114.	Incarcerated individual reported concerns regarding DOC staff not processing their request for the patient-paid healthcare plan and delaying their care.	The OCO provided assistance. After OCO's outreach, DOC staff stated they were able to confirm the request had not been processed and directed staff to submit the request for care.	Assistance Provided
115.	Anonymous incarcerated individual relayed concerns regarding a leak in the kitchen that has resulted in water dripping on the clean drying trays and heard that there are dead rats in the area where the leak is coming from.	The OCO provided assistance. Upon receiving this complaint, the OCO visited the facility, toured the kitchen and spoke with both DOC staff and incarcerated individuals. The OCO confirmed that there was an active leak as described but was unable to substantiate the concerns regarding the rats. On the day of the OCO facility visit, the kitchen closed early as the leak was being repaired. The OCO informed the individuals working in the kitchen to contact the OCO if the leak was not repaired as mentioned.	Assistance Provided
116.	Incarcerated person reported that he lost his job after receiving an infraction. The person said the infraction was	DOC staff resolved this concern prior to the OCO taking action on this complaint by employing this individual. The OCO reviewed DOC records and found that this individual is	DOC Resolved

	later dismissed, but he has not gotten his job back.	currently employed with a new job and is engaging in programming.	
117.	Incarcerated person reports concerns about delayed access to medication refills.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO confirmed medications were refilled and provided prior to OCO outreach.	DOC Resolved
118.	An external person reported that their loved one was transferred to a different facility, but his tablet was not transferred with him. He has been without his tablet for over two months.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO verified through DOC staff that this person now has a working tablet.	DOC Resolved
119.	Incarcerated person reported that he has not been assigned a job and other individuals who moved into the unit after him are being assigned jobs sooner than him.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed this person's programming records and verified that he was assigned to a job.	DOC Resolved
120.	External person reports concerns regarding the healthcare being received by their loved one. They also expressed frustration with not knowing much about their loved one's condition.	The OCO provided information to the incarcerated patient regarding information found in the investigation. The OCO contacted DOC Health Services staff and discussed the patient's current care. OCO could not substantiate the concerns shared with this office. OCO staff provided the patient with contact information for their loved one to be able to access information about his care in the future.	Information Provided
121.	External person reported their incarcerated loved one is in restrictive housing and needs medical attention. The incarcerated person was found not guilty for all infractions, but DOC still issued him a maximum custody program.	The OCO provided information to the person about their situation. The OCO reviewed the persons custody facility plan, max placement, infraction history and reached out to the facility to ensure the individual is receiving appropriate medical treatment. This office could not find any complaints on record regarding medical concerns, however the facility agreed to speak with him about signing up for sick call if he needed them. The OCO could not find a violation of DOC 320.250. The person was found not guilty of some of his infractions; however, his recent infraction history caused him to be recommended for a maximum custody placement.	Information Provided
122.	A loved one reported a concern on behalf of an incarcerated individual regarding their classification being changed without notice.	The OCO provided information regarding why their classification was changed. After reviewing DOC records, this office was able to confirm that the ESRC (End of Sentence Review Committee) investigated this individual's conviction and other factors that ultimately led the ESRC to change this individual's classification.	Information Provided
123.	Incarcerated person reported that he mailed a form to DOC Headquarters regarding recognition of a religious group and has not received a response.	The OCO provided information. The OCO reached out to multiple DOC Headquarters staff and confirmed that DOC Headquarters never received this form. The OCO encouraged this individual to send the form again.	Information Provided
124.	Incarcerated individual reported concerns regarding DOC opening OCO mail before	The OCO provided information. The OCO spoke to DOC about this concern. Per DOC policy 450.100(VII)(B)(2) incoming mail will be opened in an individual's presence, inspected and issued, thus it is protocol for DOC to open the mail before	Information Provided

	giving it to them and logging it into the legal mail logbook.	giving it to individuals. The OCO confirmed with DOC that no OCO mail is being logged.	
125.	Incarcerated person reports concerns about DOC not providing privacy screens for transgender women living in men's prisons.	The OCO elevated privacy concerns to the DOC women's prison division and gender responsive specialists. The OCO provided information about DOC's current project to assess and modify showers and bathrooms across the state. Privacy screens for cells are only provided in situations where a patient needs privacy for post-op care and is not housed in a single cell. The OCO continues to monitor this concern along with other topics in the Disability Rights Washington Transgender Settlement Agreement.	Information Provided
126.	Incarcerated person reports concerns about access to work boots that properly fit.	The OCO elevated the concerns to facility staff and provided the individual with information about his next steps. This office confirmed the shoe size was on backorder and are now available, in the meantime a comparable shoe size was provided. The person can contact clothing staff if he would like to request the specific shoe size that was not previously available.	Information Provided
127.	Incarcerated person reports concerns about DOC not following their ADA accommodation.	The OCO elevated the concerns through DOC ADA leadership and provided information directly to the person. The OCO could not substantiate an active and approved Accommodation Status Report (ASR) for the accommodation the person requested; the ASR was reviewed and not authorized as of 2024.	Information Provided
128.	Incarcerated trans woman reports concerns about being housed at a men's prison.	The OCO elevated the concerns to DOC women's prison division leadership and gender responsive specialists. The OCO confirmed the person is scheduled for an upcoming housing review where she is being considered for placement at WCCW. The OCO provided information about the next steps and pathway for potential transfer.	Information Provided
129.	Incarcerated person requested information about resentencing and asked that DOC provide more information about how to be resentenced on the SecurUs FYI application on people tablets.	The OCO provided information about resentencing. DOC has shared tools explaining recent resenting legislation and court decisions to assist people that may be affected by these changes. Determining individual eligibility for resentencing requires review of the conviction. People can work with an attorney to petition the courts to re-review their sentence.	Information Provided
130.	Incarcerated person reports that he has tried the medications that were recommended by the Care Review Committee (CRC) and wants to get the medication he was requesting. He reports concerns about his current prescription.	The OCO provided information to the person regarding the completed investigation. OCO staff reviewed the person's medical records and the DOC formulary. OCO staff noted that the requested medication is not within the DOC formulary. OCO staff also noted that the person does not currently meet the diagnostic criteria for that medication. OCO staff confirmed the person is receiving treatment through DOC Health Services as outlined in the DOC Health Plan.	Information Provided
131.	Incarcerated individual reported concerns regarding DOC not providing them with a proper diet that meets their dietary and health needs.	The OCO provided information regarding DOC special diets. The special diets currently provided by DOC are limited and, although meeting dietary requirements, may not properly fit all individual's health needs. This office was also able to confirm that this individual has been released from DOC custody.	Information Provided

132.	The incarcerated individual reports that his ERD was extended due to a Mental Health Sentencing Alternative (MHA) Revocation.	The OCO reviewed this person's records and determined that this decision was made by the Court of Appeals, not DOC. He will need to work with his attorney and contact the court to provide DOC with an amended order that changes the terms to run concurrently rather than consecutively. The OCO provided the contact information for the Clark County Superior Court.	Information Provided
133.	An incarcerated person reported an inquiry into Washington Way timelines.	The OCO provided information regarding how the OCO is following Washington Way, and process changes to how the OCO may use their reported concern in future reporting.	Information Provided
134.	Incarcerated individual reported concerns regarding being held in IMU (Intensive Management Unit) for an infraction that was dismissed.	The OCO provided information regarding this person's IMU placement. After review of DOC records, this office was able to confirm that DOC IIU (Internal Investigations Unit) completed an investigation which tied this individual to a known STG (Security Threat Group). Due to those ties, this individual received a completed CFP (Custody Facility Plan) which determined his custody level as maximum custody. That means he will be housed in IMU until his next review.	Information Provided
135.	Incarcerated individual reported concerns regarding getting an infraction for protecting someone that was getting attacked.	The OCO provided the person with information about the OCO investigation. The OCO reviewed the infraction materials and spoke to DOC about this concern. The OCO requested that DOC dismiss the infraction as the individual protecting another individual from an attack. DOC was unwilling to dismiss the infraction because DOC staff were in the process of responding to the fight and DOC was unable to determine the individual's intentions prior to stopping the fight.	Information Provided
136.	Incarcerated person reported concerns regarding the DOC's implementation of the Disability Rights Washington (DRW) transgender settlement agreement and access to privacy screens. The person states that trans women are not being protected by the DOC.	The OCO provided information about current process and limitations for privacy screens as well as DOC's active project to assess and refit showers statewide. Currently, privacy screens are only provided in situations where the individual has a medical need and is not housed in a single cell. The OCO encourages individuals experiencing issues with access to shower privacy and/or privacy screens for post-op care to report the concerns to DOC via kite and resolution request, then contact the OCO to open an individual investigation. In the meantime, the OCO will be tracking this systemic concern as it relates to DOC policies, protocols, and the DRW settlement agreement.	Information Provided
137.	Incarcerated person reports he was informally told of his Care Review Committee (CRC) decision but was not given the official decision to be able to appeal. The person requested to be given the opportunity to appeal the CRC decision.	The OCO provided information to the person regarding his Care Review Committee (CRC) decision-making documentation. OCO verified the document existed and was communicated with the patient. OCO contacted Health Services leadership at headquarters and requested that the person be able to appeal the CRC decision past typical timelines. DOC staff agreed to accept an appeal for consideration. OCO confirmed that Health Services leadership communicated this with this person.	Information Provided
138.	Incarcerated person reported that the mailroom rejected books he ordered, and that staff are ignoring the policy requirements.	The OCO provided information about his mail rejection and encouraged him to file an appeal. The OCO reached out to DOC Headquarters staff, who confirmed that they never received the mail rejection appeal at Headquarters.	Information Provided
139.	Incarcerated person reports concerns about a transgender	The OCO elevated the concerns through DOC transgender services leadership. The OCO provided information about DOC	Information Provided

	housing protocol. The person requested the housing protocol to be redone and information about how to access services.	490.700, the DOC Transgender Toolkit, and process for requesting and accessing services. Transgender housing protocols are re-reviewed every 6 months and the OCO confirmed the person was provided with a new housing protocol.	
140.	An incarcerated person expressed concerns related to the quality of food being served and submitted information for the intent of providing information to use in future reporting.	The OCO provided information regarding the OCO's information gathering processes for reporting.	Information Provided
141.	Incarcerated person reports that DOC did not appropriately respond to a medical emergency. The person also reported that he has not received the necessary specialist follow-up appointments. The person is requesting to see a specific specialist in the community.	The OCO provided information to the person. OCO reviewed the persons records and incident reports. OCO confirmed that a critical incident review was completed regarding the medical emergency and corrective action was taken. The OCO reviewed the person's specialist consultations and noted that an appointment was already scheduled. OCO monitored the appointment to confirm completion and verified that further follow-up is scheduled.	Information Provided
142.	Incarcerated person reports concerns about shower safety and privacy for transgender individuals living in men's prisons.	The OCO provided information about DOC's active assessment and remodeling project focused on shower safety and privacy. The concerns were noted for future systemic opportunities for resolution, as they related to the active Disability Rights Washington (DRW) settlement agreement. The OCO provided information about current process and limitations for privacy screens as well as DOC's active project to assess and refit showers statewide. Currently, privacy screens are only provided in situations where the individual has a medical need and is not housed in a single cell. The OCO encourages individuals experiencing issues with access to shower privacy and/or privacy screens for post-op care to report the concerns to DOC via kite and resolution request, then contact the OCO to open an individual case. In the meantime, the OCO will be tracking this systemic concern as it relates to DOC policies, protocols, and the DRW settlement agreement.	Information Provided
143.	Incarcerated person reports his keyboard and headphones that were purchased by a family member were taken because DOC could not locate his receipts. DOC found the receipts and said he is not allowed to have the items because they were not purchased through an approved vendor.	The OCO reviewed the property matrix and identified he does have an approved keyboard; however, the headphones are not listed. This office provided the person with information about how to file a tort claim.	Information Provided
144.	Incarcerated person reported that he received a negative Behavior Observation Entry (BOE) for disrobing, but he	The OCO viewed DOC records and this specific negative Behavior Observation Entry (BOE). The OCO could not verify that the appeal he submitted for this BOE was processed. The OCO provided information regarding submitting a new appeal	Information Provided

	was wiping his mouth with his shirt. He submitted an appeal to the Correctional Program Manager who watched the video of the incident and stated to him that they did not see him doing anything wrong.	and encouraged this person to contact our office when they have received the outcome.	
145.	Incarcerated person is requesting a specific housing assignment to accommodate his mobility needs.	The OCO provided information to the person regarding their custody facility plan review. DOC must complete the review process before it can be reviewed by OCO. OCO verified that DOC is targeting a facility that can meet the accommodation needs of the person. OCO encouraged the person to report any safety concerns with the facility after a decision has been made.	Information Provided
146.	Incarcerated individual reported concerns regarding a prohibited contact that is making their preparation for release difficult.	The OCO spoke to DOC about this concern and provided the individual with the relevant information for this situation.	Information Provided
147.	Incarcerated person reports concerns about access to care related to a mental health emergency.	The OCO elevated the concerns through DOC health services leadership. The OCO confirmed the patient has been able to meet with mental health since the emergency and provided the patient with additional information.	Information Provided
148.	Incarcerated individual reported concerns regarding an investigation, particularly the way in which a pat search was conducted.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the related resolution request and documentation and confirmed that after the investigation, it was determined that the concern did not meet the investigation threshold, and the pat search was done per DOC procedure.	Insufficient Evidence to Substantiate
149.	Incarcerated individual reported concerns regarding a negative behavior observation entry (BOE).	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the BOE and requested all video records related to this incident. DOC did not retain the video evidence related to this concern and as a result the video was no longer available per the 30-day retention policy. As a result, there was insufficient evidence to substantiate the concern.	Insufficient Evidence to Substantiate
150.	Incarcerated individual reported concerns regarding a potential transfer and wanting to stay at Monroe Correctional Complex (MCC).	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the individual's record and confirmed that their last custody facility plan (CFP) was several months ago and did not discuss a transfer.	Insufficient Evidence to Substantiate
151.	Incarcerated individual reports he is filing resolution requests and not getting any responses back. The individual claims DOC is allowing artists to obstruct justice in his reporting because he's trying to report to the courts and the artists are obstructing judges in the courtroom.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed this concern and checked the DOC system for resolution responses. The facility is responding to his resolutions, however the information he is reporting is not substantiated.	Insufficient Evidence to Substantiate

152.	Incarcerated person reported a DOC staff conduct concern and said that a DOC staff prevented him from accessing his medication.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed two resolution requests from this individual about the DOC staff and found that they were reviewed and unsubstantiated at the facility and headquarters level. The OCO found that this individual was able to access his medication, and that DOC provided this person with information about how to inform staff of medical concerns or emergencies.	Insufficient Evidence to Substantiate
153.	Incarcerated individual reported concerns regarding an infraction.	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 was seen entering another individual's cell and starting a fight.	No Violation of Policy
154.	Incarcerated individual reported concerns regarding an infraction.	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 was seen entering another individual's cell and starting a fight.	No Violation of Policy
155.	External person reports concerns about their incarcerated loved one's housing placement.	The OCO was unable to substantiate a violation of policy by DOC. DOC assigned the facility placement per DOC 300.380 Classification and Custody Facility Plan Review.	No Violation of Policy
156.	Incarcerated individual reported concerns regarding an infraction.	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 was found in possession of another incarcerated individual's marked clothing.	No Violation of Policy
157.	Incarcerated individual reported concerns regarding an infraction.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the infraction materials and requested DOC review the infraction further as there were concerns about the evidence indicating the drugs were the individuals. DOC declined to take any action on the infraction as the individual did not deny the drugs were theirs, rather, they only raised procedural concerns about the way the evidence was handled. As a result, there is sufficient evidence to uphold the infraction under DOC policy 460.000 "some evidence" standard as the drugs were found in the individual's property.	No Violation of Policy
158.	Incarcerated person reports that his disability is not being considered when DOC staff write behavior observations or infractions.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the person's most recent infractions and noted that one infraction was dismissed, the second infraction was not a violation of policy. There is no health status report or accommodation status that would preclude a person from the infraction that was given. The OCO provided information to the person regarding the right to request witness statements from staff for infraction hearings.	No Violation of Policy
159.	Incarcerated individual reported concerns regarding difficulties with their job.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the related resolution request and confirmed that the individual was moved shift times due to possessing personal information about officers but were allowed to keep their job.	No Violation of Policy
160.	Incarcerated person reported concern about being discharged from a treatment program and expressed	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed DOC records and reached out to DOC staff, who confirmed that this individual is still eligible for this program at this facility and is going to be rescreened for the	No Violation of Policy

	concern about the appeal process.	program. DOC staff described the appeals process, which includes counterparts from a different facility to ensure impartiality. This office could not substantiate a violation of DOC 570.000.	
161.	Incarcerated individual reported concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual received multiple notices that they were to stop communication with another incarcerated individual's parent yet continued and then received a package from that person who they were not authorized to communicate with or receive items from.	No Violation of Policy
162.	Incarcerated individual reported concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual refused to return to their cell and required deployment of the quick response strike team (QRST).	No Violation of Policy
163.	Incarcerated individual reported concerns regarding a behavior observation entry (BOE).	The OCO reviewed the negative BOE and found no violation of DOC policy 300.010 as the OCO could not locate other evidence to dispute the BOE.	No Violation of Policy
164.	Incarcerated individual reported concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual refused to go back to their unit and did not provide any information that could be verified.	No Violation of Policy
165.	Incarcerated individual reported concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's outgoing messages were intercepted due to being sexually explicit and violated imposed conditions.	No Violation of Policy
166.	Incarcerated person reports concerns about mental health appointments being conducted in a room that has a window and requested access to appointments in a confidential space one on one with their provider with no windows.	The OCO was unable to substantiate a violation of policy or protocol by DOC. Per DOC 610.650 Outpatient Services, "Except for services provided in an infirmary or Extended Observation Unit, all health services provided within a Department facility are considered outpatient services and will be provided in a manner that maintains the safe, secure, and orderly operations of the facility and conducted in settings that respect patient privacy." The provider has the authority to determine if a space meets safety, security, and privacy needs and is not required to provide a windowless room for sessions in accordance with facility security practices.	No Violation of Policy
167.	Incarcerated individual reported concerns regarding an infraction and states that too many DOC staff were administering the urinary analysis (UA).	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000. The individual was seen altering the UA sample. The OCO found no indication that there were too many DOC staff administering the UA.	No Violation of Policy
Olympic Corrections Center			
168.	Incarcerated person reported concerns about mold/mildew on their bed and mattress.	The OCO provided assistance. The OCO spoke with facility leadership and DOC headquarters staff about the concern of mold/mildew on people’s mattresses and beds. After speaking with facility leadership and DOC headquarters about the concern, OCC created a new mattress maintenance protocol to keep people’s mattresses and beds clean of mold/mildew. Incarcerated people at OCC are instructed to frequently flip their mattresses and clean them often using warm soapy	Assistance Provided

		water. If mold/mildew is not able to be cleaned off, people are encouraged to kite the OCC Superintendent about the issue and a new mattress will be provided. The OCO asked about testing the mold/mildew, and it is not clear if the mold will be tested. All reports of mold/mildew in other areas will be addressed as it is reported to OCC staff.	
169.	Incarcerated person reported that DOC rejected a publication under old guidelines and was told that he could not appeal under the new guidelines, because he had appealed in the past.	The OCO provided assistance by reaching out to DOC Headquarters staff, who confirmed that this was rejected under old guidelines. DOC Headquarters then reached out to the facility, who still had the publication at the facility, and gave the publication to the individual.	Assistance Provided
170.	Incarcerated person reported concerns about mold/mildew on their bed and mattress.	The OCO provided assistance. The OCO spoke with facility leadership and DOC headquarters staff about the concern of mold/mildew on people's mattresses and beds. After speaking with facility leadership and DOC headquarters about the concern, OCC created a new mattress maintenance protocol to keep people's mattresses and beds clean of mold/mildew. Incarcerated people at OCC are instructed to frequently flip their mattresses and clean them often using warm soapy water. If mold/mildew is not able to be cleaned off, people are encouraged to kite the OCC Superintendent about the issue and a new mattress will be provided. The OCO asked about testing the mold/mildew, and it is not clear if the mold will be tested. All reports of mold/mildew in other areas will be addressed as it is reported to OCC staff.	Assistance Provided
171.	Incarcerated person reported concerns about mold/mildew on their bed and mattress. The person also reported a concern about their resolution request appeal.	The OCO provided assistance. The OCO spoke with facility leadership and DOC headquarters staff about the concern of mold/mildew on people's mattresses and beds. After speaking with facility leadership and DOC headquarters about the concern, OCC created a new mattress maintenance protocol to keep people's mattresses and beds clean of mold/mildew. Incarcerated people at OCC are instructed to frequently flip their mattresses and clean them often using warm soapy water. If mold/mildew is not able to be cleaned off, people are encouraged to kite the OCC Superintendent about the issue and a new mattress will be provided. The OCO asked about testing the mold/mildew, and it is not clear if the mold will be tested. All reports of mold/mildew in other areas will be addressed as it is reported to OCC staff. The OCO also verified the person resolution request appeal was accepted at all levels.	Assistance Provided
172.	Incarcerated person reported concerns about mold/mildew on their bed and mattress.	The OCO provided assistance. The OCO spoke with facility leadership and DOC headquarters staff about the concern of mold/mildew on people's mattresses and beds. After speaking with facility leadership and DOC headquarters about the concern, OCC created a new mattress maintenance protocol to keep people's mattresses and beds clean of mold/mildew. Incarcerated people at OCC are instructed to frequently flip their mattresses and clean them often using warm soapy water. If mold/mildew is not able to be cleaned off, people are encouraged to kite the OCC Superintendent about the issue and a new mattress will be provided. The OCO asked about testing the mold/mildew, and it is not clear if the mold will be	Assistance Provided

		tested. All reports of mold/mildew in other areas will be addressed as it is reported to OCC staff.	
173.	Incarcerated person reported concerns about mold/mildew on their bed and mattress.	The OCO provided assistance. The OCO spoke with facility leadership and DOC headquarters staff about the concern of mold/mildew on people's mattresses and beds. After speaking with facility leadership and DOC headquarters about the concern, OCC created a new mattress maintenance protocol to keep people's mattresses and beds clean of mold/mildew. Incarcerated people at OCC are instructed to frequently flip their mattresses and clean them often using warm soapy water. If mold/mildew is not able to be cleaned off, people are encouraged to kite the OCC Superintendent about the issue and a new mattress will be provided. The OCO asked about testing the mold/mildew, and it is not clear if the mold will be tested. All reports of mold/mildew in other areas will be addressed as it is reported to OCC staff.	Assistance Provided
174.	Incarcerated person reported concerns about mold/mildew on their bed and mattress.	The OCO provided assistance. The OCO spoke with facility leadership and DOC headquarters staff about the concern of mold/mildew on people's mattresses and beds. After speaking with facility leadership and DOC headquarters about the concern, OCC created a new mattress maintenance protocol to keep people's mattresses and beds clean of mold/mildew. Incarcerated people at OCC are instructed to frequently flip their mattresses and clean them often using warm soapy water. If mold/mildew is not able to be cleaned off, people are encouraged to kite the OCC Superintendent about the issue and a new mattress will be provided. The OCO asked about testing the mold/mildew, and it is not clear if the mold will be tested. All reports of mold/mildew in other areas will be addressed as it is reported to OCC staff.	Assistance Provided
175.	Incarcerated person reported concerns about mold/mildew on their bed and mattress.	The OCO provided assistance. The OCO spoke with facility leadership and DOC headquarters staff about the concern of mold/mildew on people's mattresses and beds. After speaking with facility leadership and DOC headquarters about the concern, OCC created a new mattress maintenance protocol to keep people's mattresses and beds clean of mold/mildew. Incarcerated people at OCC are instructed to frequently flip their mattresses and clean them often using warm soapy water. If mold/mildew is not able to be cleaned off, people are encouraged to kite the OCC Superintendent about the issue and a new mattress will be provided. The OCO asked about testing the mold/mildew, and it is not clear if the mold will be tested. All reports of mold/mildew in other areas will be addressed as it is reported to OCC staff.	Assistance Provided
176.	Incarcerated person reports that he was denied access to the Graduated Reentry (GRE) Program. The person is requesting to be approved so that he can access treatment before release. The person also requested information about the program.	The OCO provided information to the person. OCO staff reviewed the person's record and found he had been offered a conditional approval for graduated reentry. OCO staff contacted DOC staff to request the information that was requested by the individual.	Information Provided

177.	A loved one expressed concern about an incarcerated individual being retaliated against by being given an undesirable job.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed DOC records and found that he was given a new job. After reviewing DOC records, including DOC Resolutions investigations, the OCO could not substantiate retaliation. The OCO also found that this individual is no longer at this facility.	Insufficient Evidence to Substantiate
178.	Incarcerated individual reported concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000. DOC had multiple levels of evidence to verify the infraction was appropriate.	No Violation of Policy
179.	Incarcerated individual reported concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the "some evidence" standard is met as DOC staff observed the individual in a headlock trying to wrestle the other incarcerated individual to the ground which meets the infraction elements.	No Violation of Policy
Other			
180.	Incarcerated person reported concerns about DOC staff while working in a juvenile rehabilitation facility.	The OCO verified we cannot review concerns about juvenile rehabilitation facilities. The OCO provided information about the OCO's jurisdiction and the passing of Senate Bill 5032 that if signed into law will expand oversight of the Office of the Family and Children's Ombuds (OFCO), allowing them to review concerns at juvenile rehabilitation facilities. The OCO encouraged the person to monitor the senate bill as it still requires the Governor's signature. If signed, OFCO will implement a process for people living in juvenile rehabilitation facilities to report concerns to them.	Information Provided
Reentry Center - Ahtanum View - Yakima			
181.	Incarcerated individual reported that they are not getting enough food, and breakfast items continually run out. The individual also reports that the sack lunches are days old, and the amount of food they get is not enough to feed a grown man.	The OCO provided assistance by visiting the Ahtanum View Reentry Center and completing a monitoring visit of the kitchen, yard, and living units. The DOC reported staffing issues with only two cooks employed when there should be at least three. The OCO confirmed that DOC is actively recruiting for this vacant position. During the visit, OCO staff saw fruit, cereal, oatmeal, and cake sitting out for anyone to eat. The OCO also looked in the fridge, which had two gallons of milk, fruit cups, breakfast sandwiches, and pre-made lunches in paper bags. The OCO substantiated that there are some issues around hot meals being served consistently and food running out. However, these problems are related to staffing, which the Department is actively working to resolve.	Assistance Provided
182.	An incarcerated individual reports that the sack lunch he took to work was four days old, and kitchen staff told him to take it or leave it.	The OCO provided assistance by visiting Ahtanum View Reentry Center and completing a monitoring visit of the kitchen, yard, and living units. The DOC reported staffing issues with only two cooks employed when there should be at least three. The OCO confirmed that DOC is actively recruiting for this vacant position. During the visit, OCO staff saw fruit, cereal, oatmeal, and cake sitting out for anyone to eat. The OCO also looked in the fridge, which had two gallons of milk, fruit cups, breakfast sandwiches, and pre-made lunches in paper bags. The OCO substantiated that there are some issues around hot meals being served consistently and food running out. However, these problems are related to staffing, which the Department is actively working to resolve.	Assistance Provided

183.	An external person reports that her brother is not being fed, and the facility only gives them fruit and breakfast sandwiches.	The OCO provided assistance by visiting Ahtanum View Reentry Center and completing a monitoring visit of the kitchen, yard, and living units. The DOC reported staffing issues with only two cooks employed when there should be at least three. The OCO confirmed that DOC is actively recruiting for this vacant position. During the visit, OCO staff saw fruit, cereal, oatmeal, and cake sitting out for anyone to eat. The OCO also looked in the fridge, which had two gallons of milk, fruit cups, breakfast sandwiches, and pre-made lunches in paper bags. The OCO substantiated that there are some issues around hot meals being served consistently and food running out. However, these problems are related to staffing, which the Department is actively working to resolve.	Assistance Provided
184.	Incarcerated person reports that they did not receive breakfast three days in a row.	The OCO provided assistance by visiting Ahtanum View Reentry Center and completing a monitoring visit of the kitchen, yard, and living units. The DOC reported staffing issues with only two cooks employed when there should be at least three. The OCO confirmed that DOC is actively recruiting for this vacant position. During the visit, OCO staff saw fruit, cereal, oatmeal, and cake sitting out for anyone to eat. The OCO also looked in the fridge, which had two gallons of milk, fruit cups, breakfast sandwiches, and pre-made lunches in paper bags. The OCO substantiated that there are some issues around hot meals being served consistently and food running out. However, these problems are related to staffing, which the Department is actively working to resolve.	Assistance Provided
185.	Incarcerated person reports that they are not being fed and have gone three days without any breakfast.	The OCO provided assistance by visiting Ahtanum View Reentry Center and completing a monitoring visit of the kitchen, yard, and living units. The DOC reported staffing issues with only two cooks employed when there should be at least three. The OCO confirmed that DOC is actively recruiting for this vacant position. During the visit, OCO staff saw fruit, cereal, oatmeal, and cake sitting out for anyone to eat. The OCO also looked in the fridge, which had two gallons of milk, fruit cups, breakfast sandwiches, and pre-made lunches in paper bags. The OCO substantiated that there are some issues around hot meals being served consistently and food running out. However, these problems are related to staffing, which the Department is actively working to resolve.	Assistance Provided
Reentry Center - Longview - Cowlitz			
186.	Incarcerated Individual relayed concerns regarding not being allowed to go to church by DOC reentry center staff.	The OCO provided information about the reason for the denial and options to access religious services. The OCO reviewed the related grievances and confirmed that the reason the individual was not granted a pass to attend church was due to their only mode of transportation and the distance of the church violating their health restrictions. DOC worked with the individual to find alternatives including other modes of transportation or attending the church service remotely.	Information Provided
Stafford Creek Corrections Center			
187.	Incarcerated person and their loved one reported concern about access to their tablet or a TV while in solitary	The OCO provided assistance. The OCO spoke with DOC staff and after our outreach DOC began providing reentry resources to this person. After further conversation with DOC, they are working to enroll this person in programming that will assist	Assistance Provided

	confinement. The person also expressed concerns about releasing from solitary confinement.	them in their release. Due to the incidents that led to DOC holding this person in solitary confinement, they are unwilling to allow them access to a tablet or TV.	
188.	Incarcerated individual reported concerns regarding an infraction appeal that DOC never responded to.	The OCO provided assistance. The OCO spoke to DOC about this concern and confirmed that DOC never received an appeal from the individual but at OCO request, DOC is willing to accept a resubmitted appeal.	Assistance Provided
189.	An incarcerated individual reports that a DOC staff member is handing out negative behavior observation entries (BOE) and not informing the incarcerated individual that they are receiving a negative BOE.	The OCO provided assistance. The OCO reviewed the negative BOE, DOC 300.010, and contacted DOC staff. The Department looked further into this incident and the other individuals who reported this concern and ultimately made the decision to delete the negative BOE from this person's record.	Assistance Provided
190.	Incarcerated individual reported concerns regarding an infraction.	The OCO provided assistance. The OCO reviewed the infraction materials and found no evidence to substantiate infraction. The OCO requested that DOC dismiss it from the individual's record. DOC agreed to remove the infraction from the infraction group. The OCO then requested DOC reverse the visitation termination as infraction was removed. DOC was unwilling to reinstate the individual’s visit privileges.	Assistance Provided
191.	Incarcerated person reports he needs a medical item that accommodates him for job programming. The person reports staff have been giving him conflicting information about the process to meet this need.	The OCO provided assistance. OCO staff contacted DOC Health Services staff and requested the person be referred to the specialist that could order the requested item. OCO staff monitored the consultation until the person attended the appointment. DOC staff provided contact information for the person to follow up with specific staff to help him navigate the process as it moves forward.	Assistance Provided
192.	An incarcerated individual reports that a DOC staff is handing out negative behavior observation entries (BOE) and not informing the incarcerated individual that they are receiving a negative BOE.	The OCO provided assistance. The OCO reviewed the negative BOE, DOC 300.010, and contacted DOC staff. DOC looked further into this incident and the other individuals who reported this concern and ultimately made the decision to delete the negative BOE from this person's record.	Assistance Provided
193.	An incarcerated individual reports that a DOC staff member is handing out negative behavior observation entries (BOE) and not informing the incarcerated individual that they are receiving a negative BOE.	The OCO provided assistance. The OCO reviewed the negative BOE, DOC 300.010, and contacted DOC staff. The Department looked further into this incident and the other individuals who reported this concern and ultimately made the decision to delete the negative BOE from this person's record.	Assistance Provided
194.	Incarcerated person reports he got a negative behavior observation entry (BOE) last year, and he appealed it, but	The OCO provided assistance. The OCO contacted DOC and asked if they would be willing to review a new appeal for the negative BOE from last year. DOC staff agreed to review a new appeal for the negative BOE.	Assistance Provided

	DOC told him they have no record of his appeal.		
195.	Incarcerated person requested the OCO attend a CARES group meeting and hold a listening session related to people's concerns at the facility.	The OCO provided assistance by attending the group meeting and holding a listening session. The OCO plans to attend another upcoming meeting to follow up. The OCO is also in continued conversations with health services about people's concerns.	Assistance Provided
196.	An incarcerated individual reports that a DOC staff member is handing out negative behavior observation entries (BOE) and not informing the incarcerated individual that they are receiving a negative BOE.	The OCO provided assistance. The OCO reviewed the negative BOE, DOC 300.010, and contacted DOC staff. The Department looked further into this incident and the other individuals who reported this concern and ultimately made the decision to delete the negative BOE from this person's record.	Assistance Provided
197.	Incarcerated individual reports that DOC headquarters agreed to give him a new hearing for an infraction he had appealed. This person has been waiting several months, and the new hearing has not been scheduled.	The OCO provided assistance. The OCO reviewed the individual's infraction history and contacted DOC staff about this concern. The DOC worked to resolve this issue, and ultimately, the individual was given a new hearing.	Assistance Provided
198.	External person reports concerns about a DOC memo from SCCC related to changes in visitation. They requested a meeting with DOC leadership.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO confirmed DOC agreed to meet with the community members about the visitation memo and updates.	DOC Resolved
199.	Incarcerated person reported that he has a medical concern related to his back that is causing pain and DOC is refusing to address the issue or provide pain management care.	DOC staff resolved this concern prior to the OCO taking action on this complaint. This person contacted the OCO and requested the investigation be closed. The person was able to schedule an appointment with DOC health services.	DOC Resolved
200.	External person reports concerns about a DOC memo from SCCC related to changes in visitation. They requested a meeting with DOC leadership.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO confirmed DOC agreed to meet with the community members about the visitation memo and updates.	DOC Resolved
201.	External person reports their loved one needs the Medication Assisted Treatment (MAT) program so he can stay in recovery and stop getting infracted for seeking medication on the unit.	The OCO provided information to the incarcerated person. The OCO contacted DOC Health Services to verify that the provider responsible was aware of the person's situation. OCO provided current protocol information with the person.	Information Provided

202.	Incarcerated individual reported concerns regarding not getting medically approved boots.	The OCO provided information about the person's current care plans. The OCO spoke to DOC about this concern and confirmed that the individual has been seen by the Hangar Shoe Clinic to address this concern.	Information Provided
203.	Incarcerated individual reported concerns that their mental health provider recommended they get a health status report (HSR) for a single cell, but states headquarters overrode this decision.	The OCO reviewed the related records and confirmed that during the single cell screening, DOC custody staff deferred to DOC mental health staff who determined that the individual needs to try other coping tools before switching to a single cell. The OCO provided this information to the individual.	Information Provided
204.	An incarcerated person requested information about participating in the WA Way Residential Advisory Committee and asked for the OCO to escalate a request for additional supports.	The OCO provided information regarding process changes in our office and informed the person that the OCO will strive to attend, as observers, any community meeting an incarcerated group holds if invited by that group. The OCO also shared information about how an incarcerated person can self-nominate to be included on the WA Way Residential Advisory Committee. The OCO also shared with the person that the OCO is continuing to monitor WA Way roll out across the state.	Information Provided
205.	Incarcerated individual reported concerns regarding not getting a response to an infraction appeal.	The OCO reviewed the infraction materials and confirmed that DOC responded to the appeals. The OCO informed the individual that if they did not receive a copy of the appeal decision, they will need to kite the hearings department and ask for a new copy.	Information Provided
206.	Incarcerated person reported concerns about their sentence and shared that they were unaware that their sentence was under the Indeterminate Sentence Review Board (ISRB). The person reported concerns about being held past their release date.	The OCO provided information about the ISRB. The OCO verified that the ISRB has jurisdiction over this person's conviction. Per the DOC website, the ISRB is a quasi-judicial board that retains independent decision making. The board has jurisdiction over three types of convictions which are, people who committed crimes prior to July 1, 1984, and were sentenced to prison, people who committed certain sex offenses on or after September 1, 2001, and people who committed crimes prior to their 18th birthday and were sentenced as adults. People under the ISRB jurisdiction will go before the Board prior to release, the board determines releasability.	Information Provided
207.	Incarcerated person reported that they filed a complaint, and the investigation was not substantiated. The person is requesting a facility separation from that person.	The OCO provided information to the person regarding the investigation. OCO reviewed the investigation and contacted DOC to discuss the findings. OCO reported concerns with adherence to timelines and evidence retention to the headquarters investigation coordinator. OCO provided information to the person regarding the process to request a separatee per DOC 320.180.	Information Provided
208.	The incarcerated person reports needing access to the Medication Assisted Treatment (MAT) program so he can stay in recovery and stop getting infracted for seeking medication on the unit.	The OCO provided information to the patient. OCO contacted DOC Health Services staff to verify that the provider responsible was aware of the person's situation. OCO provided current protocol information with the person.	Information Provided

209.	Incarcerated individual reports he is pending transfer to a facility that he does not feel can meet his healthcare needs. The person is wheelchair bound and has mental health concerns.	The OCO provided information about the findings of the OCO investigation. The OCO reviewed this individual's placement, transfer and Health Services Report's (HSRs). DOC Health Services maintains that this person can receive appropriate care at the facility he is scheduled to go to. The person is not currently in a wheelchair and will have access to programming, medical and mental health at the new facility. The DOC would not authorize override to a lower custody per DOC 300.380.	Information Provided
210.	Incarcerated person reported concern about job access at SCCC. The person reports that people serving long sentences do not get as much access to employment and educational programing.	The OCO provided information about employment at SCCC. The OCO reviewed employment opportunities at SCCC and found that because of inadequate fencing around the Correctional Industries jobsites at SCCC, many people cannot gain employment with CI. SCCC has limited employment inside the facility fencing. Also, per DOC protocol, people closer to their release will have priority access to employment and education opportunities. People wishing to obtain employment can work with their Classification Counselor.	Information Provided
211.	Incarcerated individual reported concerns regarding wanting to get a sunglass clip to help with light sensitivity.	The OCO provided information. The OCO reviewed the related resolution request and confirmed that DOC Health Services does not provide sunglass clips unless medically necessary. The OCO informed the individual that they will need to work with their provider for this but can order sunglasses from the Union Supply catalogue in the meantime.	Information Provided
212.	Incarcerated person reported concern about job access at SCCC. The person reports that people serving long sentences do not get as much access to employment and educational programing.	The OCO provided information about employment at SCCC. The OCO reviewed employment opportunities at SCCC and found that because of inadequate fencing around the Correctional Industries(CI) jobsites at SCCC, many people cannot gain employment with CI. SCCC has limited employment inside the facility fencing. Also per DOC protocol, people closer to their release will have priority access to employment and education opportunities. People wishing to obtain employment can work with their Classification Counselor.	Information Provided
213.	Incarcerated individual relayed concerns regarding their placement and medical holds.	The OCO reviewed the individual's custody facility plan (CFP) and found no violation of DOC policy 300.380 as it was decided the individual be demoted to close due to infractions. The OCO confirmed that the individual does have a medical hold and once the medical hold is lifted, informed the individual that they will be transferred. Regarding safety concerns, the OCO confirmed the individual does not have any documented keep separates or prohibited placements and informed the individual that if they are having safety concerns they will need to discuss those with the intelligence and investigations unit (IIU) so they can be verified.	Information Provided
214.	Incarcerated person reports concerns about the Indeterminate Sentence Review Board (ISRB) and their decision to add time to their sentence. The Person requested the OCO review the decision and recommend	The OCO provided information about the ISRB. Per the DOC website, the ISRB is a quasi-judicial board that retains independent decision making. The board has jurisdiction over three types of convictions which are, people who committed crimes prior to July 1, 1984 and were sentenced to prison, people who committed certain sex offenses on or after September 1, 2001 and, people who committed crimes prior to their 18th birthday and were sentenced as adults. . When the ISRB deems a person not releasable, they provide	Information Provided

	the ISRB deem then releasable.	recommendations for the person to complete before their next hearing. The OCO shared this information with the person and explained that requesting the programming recommended in the decision can help in their next ISRB hearing. People can contest ISRB decisions by filing a personal restraint petition. (PRP).	
215.	Incarcerated individual reported concerns regarding DOC not allowing them to move into a single cell.	The OCO provided information regarding why they are not going to be moved into a single cell. After reviewing DOC records, this office was able to confirm that this individual has been screened and denied for the single cell by facility leadership. This office also provided information related to the single cell protocol and the factors that go into being approved or denied for a single cell.	Information Provided
216.	Incarcerated person reports that the resolution from a previous OCO case was not provided to him. The person is requesting further OCO investigation as DOC did not resolve the issue.	The OCO provided information to the person. OCO reviewed the person's consultations and verified an appointment is scheduled for further care.	Information Provided
217.	An incarcerated person sent information to the OCO detailing their experiences working with the AMEND program.	The OCO provided information regarding process changes in our office and informed the person that their information has been received.	Information Provided
218.	Incarcerated person reported concern regarding jobs. The person reported that DOC is not providing him with a job due to his sentence structure. The person reports the facility they live in does not have enough jobs to employ everyone.	The OCO provided information about DOC job programs and how a person gets a job in prison. The OCO also provided details specific to the person's situation. The OCO reviewed the persons file and verified they have not had a job recently, because of multiple factors. The OCO shared how to advocate for employment by working with their classification counselor and unit staff. The OCO was not able to substantiate a lack of jobs at the facility, however we continue to follow up and ask questions about employment and programming opportunities. The OCO understands the importance of employment while incarcerated.	Information Provided
219.	Incarcerated person reported concerns regarding the lack of jobs at SCCC. The person reported concerns with the current protocol and reports that this process leaves people serving longer sentences with less access to programming and jobs.	The OCO provided information about employment at SCCC. The OCO reviewed employment opportunities at SCCC and found that because of inadequate fencing around the Correctional Industries jobsites at SCCC, many people cannot gain employment with CI. SCCC has limited employment inside the facility fencing. Also, per DOC protocol, people closer to their release will have priority access to employment and education opportunities. People wishing to obtain employment can work with their Classification Counselor.	Information Provided
220.	Incarcerated individual reported concerns regarding staff conduct, particularly that a staff member singled them out.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed a previous related OCO investigation and DOC resolution request response. The OCO found no evidence showing the staff singled the individual out as the emergency tone was activated and all movement to callouts must stop, this included the individual.	Insufficient Evidence to Substantiate

221.	An incarcerated individual reports that he is a diabetic and had his insulin shot before count started. The individual was out in the yard and felt like his blood sugar was dropping, and requested to be moved back to his cell, so he could eat. DOC staff refused to move him, and he was forced to wait about an hour before he could eat anything.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO contacted DOC, who reports they do not move individuals around the IMU during count, and this person opted to go to the yard right before count started. During the count, the person declared a medical emergency, and the nurse checked his blood sugar, which was in the normal range. This office verified that nothing emergent was documented by health services, and the person was moved back to their cell shortly after count was cleared.	Insufficient Evidence to Substantiate
222.	Incarcerated person reports he was placed on Intoxication Protocol in January and April for possibly being intoxicated. He was given a urinalysis (UA) with negative results both times. Then, he was placed on Ad-seg for 'found contraband' but he states he has been in the IMU since April.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed the medical records from January, which showed the person tested positive for a drug and DOC medical staff signed off on the test results. In April, the UA test was negative for any drug. It was then sent to a forensic drug testing lab for confirmation. The lab found the test was positive. The DOC maintains that contraband was also found in the individual's cell and tested positive for drugs. The OCO gave the person information about how to access their medical records to better understand the test results.	Insufficient Evidence to Substantiate
223.	Incarcerated person reports concerns about their medication being discontinued after transferring.	The OCO was unable to identify a violation of DOC policy as the specified medication that was discontinued is not covered by the current DOC Health Plan or Formulary. The person was also released from DOC custody.	No Violation of Policy
224.	Incarcerated individual reported concerns regarding their placement.	The OCO reviewed the individual's custody facility plan (CFP) and found no violation of DOC policy 300.380.	No Violation of Policy
225.	Incarcerated individual reported concerns regarding placement in segregation and requested to promote out of segregation.	The OCO reviewed the individual's custody facility plan (CFP) and found no violation of DOC policy 300.380. Due to continuous infraction behavior, DOC found the individual to not be appropriate for lower custody levels as they pose a safety and security risk.	No Violation of Policy
226.	Incarcerated individual reported concerns regarding DOC not processing their resolution requests.	The OCO reviewed the related resolution requests and confirmed that DOC properly responded to them. One resolution request was a duplication of a previous issue, and one was about care review committee decisions which must be appealed.	No Violation of Policy
227.	Incarcerated individual reported concerns about an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000.	No Violation of Policy
Washington Corrections Center			
228.	Incarcerated people living in the DOC receiving units called to report concerns about lack of access to showers, yard, and the dayroom due to restricted movement. Some people reported the issues in	The OCO provided assistance by speaking with facility leadership about the concerns the same day they were reported and verifying that the units received showers that evening. The OCO followed-up the next week and confirmed the units were able to access a shower, have been taken off restricted movement, and that staff actions are being reviewed by DOC.	Assistance Provided

	the unit are related to DOC staff actions.		
229.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000. The OCO confirmed that the individual had not received a copy of the infraction appeal response and at OCO request, DOC is providing the individual with a copy.	Assistance Provided
230.	Incarcerated people living in the DOC receiving units called to report concerns about lack of access to showers, yard and the dayroom due to restricted movement. Some people reported the issues in the unit are related to DOC staff actions.	The OCO provided assistance by speaking with facility leadership about the concerns the same day they were reported and verifying that the units received showers that evening. The OCO followed up the next week and confirmed the units were able to access a shower, have been taken off restricted movement, and that staff actions are being reviewed by DOC.	Assistance Provided
231.	Incarcerated people living in the DOC receiving units called to report concerns about lack of access to showers, yard and the dayroom due to restricted movement. Some people reported the issues in the unit are related to DOC staff actions.	The OCO provided assistance by speaking with facility leadership about the concerns the same day they were reported and verifying that the units received showers that evening. The OCO followed up the next week and confirmed the units were able to access a shower, have been taken off restricted movement, and that staff actions are being reviewed by DOC.	Assistance Provided
232.	Incarcerated people living in the DOC receiving units called to report concerns about lack of access to showers, yard and the dayroom due to restricted movement. Some people reported the issues in the unit are related to DOC staff actions.	The OCO provided assistance by speaking with facility leadership about the concerns the same day they were reported and verifying that the units received showers that evening. The OCO followed up the next week and confirmed the units were able to access a shower, have been taken off restricted movement, and that staff actions are being reviewed by DOC.	Assistance Provided
233.	Incarcerated individual relayed concerns regarding an infraction that they appealed.	The OCO reviewed the infraction materials and could not find an appeal on record. The OCO contacted DOC about the appeal and DOC confirmed that they received and responded to the appeal but due to an administrative error, the appeal was never entered into the individual's record and a copy was not given to them. At OCO's request, a new copy is being provided to the individual.	Assistance Provided
234.	Incarcerated people living in the DOC receiving units called to report concerns about lack of access to showers, yard and the dayroom due to restricted movement. Some people reported the issues in the unit are related to DOC staff actions.	The OCO provided assistance by speaking with facility leadership about the concerns the same day they were reported and verifying that the units received showers that evening. The OCO followed up the next week and confirmed the units were able to access a shower, have been taken off restricted movement, and that staff actions are being reviewed by DOC.	Assistance Provided
235.	Incarcerated individual reported concerns about DOC using force on him.	The OCO provided assistance. The OCO reviewed all the records related to the use of force and spoke to DOC about three main concerns that were identified. OCO verified that	Assistance Provided

	Specifically, the person reported three main concerns, which were: the usage of the restraint bed for an extended period, the lack of privacy clothing during the use of force incident, and DOC placing a spit hood on the person and leaving the hood on after the person was placed into a cell.	this person was held on the restraint bed for an extended period. DOC received the required extension documentation. The OCO verified that this person received medical attention and follow-up care after this incident. After OCO outreach, DOC purchased new upgraded privacy clothing that is currently in use and can be placed on an individual and secured with Velcro to avoid utilizing a towel. At OCO's request, a debrief was conducted with unit staff regarding spit hood usage and was discussed during the Supervising Use of Force Training. The OCO informed the individual that this office continues to have conversations regarding Use of Force concerns with DOC at the headquarters level.	
236.	Incarcerated people living in the DOC receiving units called to report concerns about lack of access to showers, yard and the dayroom due to restricted movement. Some people reported the issues in the unit are related to DOC staff actions.	The OCO provided assistance by speaking with facility leadership about the concerns the same day they were reported and verifying that the units received showers that evening. The OCO followed-up the next week and confirmed the units were able to access a shower, have been taken off restricted movement, and that staff actions are being reviewed by DOC.	Assistance Provided
237.	Patient reports concerns about changes in access to medication since transferring to Washington DOC custody.	The OCO provided assistance by elevating this concern to DOC health services leadership. After outreach, the patient was scheduled for a medication management appointment with a provider. The OCO also confirmed DOC completed the Release of Information and received records from the county jail related to the medications. This office also provided information about the patient's next steps.	Assistance Provided
238.	Incarcerated people living in the DOC receiving units called to report concerns about lack of access to showers, yard and the dayroom due to restricted movement. Some people reported the issues in the unit are related to DOC staff actions.	The OCO provided assistance by speaking with facility leadership about the concerns the same day they were reported and verifying that the units received showers that evening. The OCO followed-up the next week and confirmed the units were able to access a shower, have been taken off restricted movement, and that staff actions are being reviewed by DOC.	Assistance Provided
239.	Incarcerated people living in the DOC receiving units called to report concerns about lack of access to showers, yard and the dayroom due to restricted movement. Some people reported the issues in the unit are related to DOC staff actions.	The OCO provided assistance by speaking with facility leadership about the concerns the same day they were reported and verifying that the units received showers that evening. The OCO followed-up the next week and confirmed the units were able to access a shower, have been taken off restricted movement, and that staff actions are being reviewed by DOC.	Assistance Provided
240.	Incarcerated people living in the DOC receiving units called to report concerns about lack of access to showers, yard and the dayroom due to restricted movement. Some people reported the issues in	The OCO provided assistance by speaking with facility leadership about the concerns the same day they were reported and verifying that the units received showers that evening. The OCO followed-up the next week and confirmed the units were able to access a shower, have been taken off restricted movement, and that staff actions are being reviewed by DOC.	Assistance Provided

	the unit are related to DOC staff actions.		
241.	Incarcerated people living in the DOC receiving units called to report concerns about lack of access to showers, yard and the dayroom due to restricted movement. Some people reported the issues in the unit are related to DOC staff actions.	The OCO provided assistance by speaking with facility leadership about the concerns the same day they were reported and verifying that the units received showers that evening. The OCO followed-up the next week and confirmed the units were able to access a shower, have been taken off restricted movement, and that staff actions are being reviewed by DOC.	Assistance Provided
242.	Incarcerated people living in the DOC receiving units called to report concerns about lack of access to showers, yard and the dayroom due to restricted movement. Some people reported the issues in the unit are related to DOC staff actions.	The OCO provided assistance by speaking with facility leadership about the concerns the same day they were reported and verifying that the units received showers that evening. The OCO followed-up the next week and confirmed the units were able to access a shower, have been taken off restricted movement, and that staff actions are being reviewed by DOC.	Assistance Provided
243.	Person reports receiving an infraction for not being able to provide a urine drug screen. The person had his medical provider write a witness statement and the hearings officer refused to dismiss the infraction. The person stated he was not aware that he needed an HSR before being asked for the drug screen.	DOC staff resolved this concern prior to OCO action. OCO staff reviewed the person's record and found the infraction had been dismissed and was no longer on their record.	DOC Resolved
244.	Incarcerated individual relayed concerns regarding wanting to go to their home facility.	The OCO reviewed the individual's placement and confirmed that they have transferred to their home facility.	DOC Resolved
245.	Patient reports concerns about access to medical care following a back injury when a door was closed on him.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO elevated the concerns to DOC health services leadership and confirmed the patient received a follow up assessment the next day, including additional treatment, testing, and physical therapy recommendations.	DOC Resolved
246.	Person reported that the elevator in the gym has been broken and that individuals in wheelchairs have not been able to access the gym.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reached out to facility leadership, who confirmed that this issue was fixed and that the elevator is functioning.	DOC Resolved
247.	Incarcerated individual shared concerns regarding not being able to transfer his music from the old JPAY system to the newer Securus system and losing their music.	DOC staff resolved this concern prior to the OCO taking action on this complaint. After speaking with DOC staff, this office was able to confirm that Securus and DOC are actively working with this individual to reimburse them for their lost music.	DOC Resolved

248.	A family member reported that their loved one is classified incorrectly despite having all of his points and zero infractions. Additionally, he was also denied work release even though he signed his agreement for the graduated-reentry (GRE) program.	The OCO confirmed that this individual is close to their projected release date and has an approved release plan. The OCO also reviewed the individual's classification, including his custody level, and found it to comply with DOC 300.380 Classification and Custody Facility Plan Review. The OCO shared information with the incarcerated individual about the graduated re-entry process.	Information Provided
249.	External person reports concerns about their incarcerated loved one's access to care related to a medical emergency.	The OCO elevated the emergent medical concerns to DOC health services leadership and confirmed the patient received follow up assessment and care including hospital care and monitoring in the DOC IPU. The OCO confirmed the patient has since been discharged from IPU and this office provided information directly about next steps if the patient has ongoing concerns.	Information Provided
250.	An individual reports concerns staff misconduct, the law library, and not getting a blanket while in the closed observation area (COA).	The OCO reviewed the individual's records, and DOC confirmed that a mistake had been made and this person should have been given a blanket. This individual has several resolutions open regarding law library access and staff misconduct. The OCO encouraged this person to continue utilizing the resolution program to resolve his concerns.	Information Provided
251.	Incarcerated individual relayed concerns about infraction sanctions including no access to a tablet.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that per their CFP, they are to maintain level 2 only.	Information Provided
252.	Incarcerated individual shared concerns regarding DOC not providing them with medical care following a declared medical emergency.	The OCO provided information regarding the medical emergency process and how to properly utilize the medical emergency kites. After review of DOC records, this office was able to confirm that this individual submitted their emergency medical concern utilizing a normal medical kite, which can delay care for emergencies. Further review shows that once DOC staff became aware of the medical concern, DOC swiftly moved to provide the individual with care for their concern.	Information Provided
253.	Incarcerated individual relayed concerns regarding not being able to get their good conduct time (GCT) back.	The OCO spoke to DOC about the concern and confirmed that because the individual's earned release date (ERD) is within 12 months of receiving an infraction, they are not eligible per DOC policy 350.100 to establish a restoration of good conduct time pathway (RGCT).	Information Provided
254.	Person reports that he has been waiting for 2 months to have an MRI after a bad fall on ice. The person is requesting that the MRI happen and that he receive treatment based on the results of the MRI.	The OCO provided information to the person regarding their request. OCO staff verified the requested imaging occurred. OCO staff contacted DOC Health Services staff and were informed that the patient would be scheduled for planned follow-up with their provider. The OCO noted that the patient was evaluated and diagnosed at the time of injury using the correct DOC Health Services protocol.	Information Provided
255.	Incarcerated person reported concerns about infraction sanctions being issued consecutively.	The OCO provided information about the WAC guidelines for infraction sanctions. The OCO spoke with DOC staff regarding this and found that DOC is currently reviewing this practice and gathering more clarity about how sanctions should be served.	Information Provided

256.	The incarcerated individual reports that the FYI app is missing some OCO monthly outcome reports, and the click pathway to the annual reports is broken.	The OCO confirmed with DOC that the Annual Report and MORs are uploaded to the tablets and available in the FYI app.	Information Provided
257.	An external person reports that their loved one has not had a classification counselor for months, and their custody facility plan (CFP) is past due. Additionally, this person is receiving excessive sanctions that include a loss of phone for six months and his tablet for a year.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the person's Custody Facility Plan (CFP) and verified that it is current and complies with DOC 300.380 Classification and Custody Facility Plan Review. This office provided information about how to appeal an FRMT decision per DOC 300.380, which states that appeals must be submitted to the Superintendent on DOC Form 07-037 within 72 hours of being notified of the decision.	Information Provided
258.	Incarcerated individual relayed concerns regarding a delayed transfer.	The OCO spoke to DOC and confirmed that transfers are delayed at the moment due to capacity.	Information Provided
259.	The individual reports concerns regarding his tablet. He does not have access to communicate with anyone because all of the apps are locked.	The OCO reviewed the individual's record and confirmed that he is level two per his previous facility. This means he will not have his tablet but can use the phone when he is out of his cell. There is an appeal process when an individual disagrees with their custody facility plan (CFP), but they must file within 72 hours of their CFP being finalized.	Information Provided
260.	Incarcerated individual relayed concerns regarding not being allowed to go to graduated reentry (GRE) and an infraction that they did not get an appeal response to.	The OCO reviewed the individual's record and confirmed that they have been screened for GRE track 1 and an email was sent regarding their eligibility and willingness. The OCO informed the individual that they will need to continue through that process and appeal the decision if they are denied. Regarding the infraction, the OCO reviewed the infraction materials and found no violation of DOC policy 460.000.	Information Provided
261.	Person reports that his provider took him off a medication that he has been on for several years. The patient is requesting to be returned to his prior plan of care.	The OCO provided information to the patient. OCO staff reviewed the patient's records and noted that the changes to his care plan were reviewed by his medical provider and the Facility Medical Director. OCO staff also noted that the patient was scheduled for further evaluation to figure out a clinically appropriate intervention, as the requested medication was no longer beneficial for the issue. The OCO provided information about future community medical appointments to the patient.	Information Provided
262.	Person reports that he is being told there is a several month wait for dental cleanings at his facility. The person is requesting that the DOC hire additional staff.	The OCO provided information to the person regarding current dental wait times. OCO staff substantiated that many facilities statewide are understaffed in the dental department and that the DOC is recruiting for several dental positions statewide. The OCO contacted DOC Health Services leadership and were informed that they are working towards recruitment for the requested role, however it is pending approval before recruitment can begin.	Information Provided
263.	Person is requesting access to the Medication Assisted Therapy program.	The OCO provided information to the person regarding the current Medication Assisted Therapy (MAT) program protocols and the status of DOC expanding those protocols. The OCO also provided information about informal recovery support groups that may be available.	Information Provided

264.	Individual reports that DOC placed him on a MAX program due to his medical hold issues. He feels that he's getting a max program solely due to his medical hold.	The OCO reviewed this concern and verified he was on a medical hold and being held in restrictive housing. He was in a facility that did not house his classification. He was then released to general population.	Information Provided
265.	Person reports concerns with the administration of a medication due to the effects experienced afterwards. The person is requesting the administration be investigated.	The OCO provided information about the medication from the manufacturer about common side effects. OCO staff reviewed the person's medical records and were unable to substantiate the patient's concern. Documentation showed the person's decline was respected. OCO staff verified the person was evaluated for side effects and it was determined that they were common side effects that were detailed by the manufacturer.	Information Provided
266.	A loved one shared concerns on behalf of an incarcerated individual regarding DOC staff not allowing them to appeal an infraction they received.	The OCO was unable to substantiate the concern due to insufficient evidence. After review of DOC records, this office was able to confirm that they waived their appearance for their infraction hearing. Due to this, their appeal was not accepted.	Insufficient Evidence to Substantiate
267.	An external person reports that her loved one was not fed any lunch when he was transported across the state to Walla Walla.	The OCO contacted DOC about this concern. DOC Staff reported that individuals are given a breakfast boat before they leave, and there is usually one stop along the way. DOC confirmed on this particular day, the transport vehicle left at six in the morning, and the incarcerated individuals stepped off the bus at Washington State Penitentiary before one pm.	Insufficient Evidence to Substantiate
268.	Incarcerated individual shared concerns regarding DOC staff not allowing them to appeal an infraction they received.	The OCO was unable to substantiate the concern due to insufficient evidence. After review of DOC records, this office was able to confirm that this individual waived their appearance for their infraction hearing. Due to this, their appeal was not accepted.	Insufficient Evidence to Substantiate
269.	Person reports that DOC has prevented him from making court ordered phone calls due to infractions he received.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff could not substantiate the presence of a court order for the DOC to be required to allow this person to make calls while under disciplinary sanctions. OCO staff reviewed the person's infractions and verified the sanctions given were within DOC sanction guidelines.	Insufficient Evidence to Substantiate
270.	Incarcerated individual relayed concerns regarding a behavior observation entry (BOE).	The OCO reviewed the individual's record but were unable to find a BOE matching the description provided.	Insufficient Evidence to Substantiate
271.	Incarcerated individual shared concerns regarding DOC providing an inadequate diet despite their health concerns.	The OCO was unable to substantiate a violation of policy by DOC. After reviewing DOC records, this office was able to confirm that DOC clinical staff were unable to confirm that this individual had the health concern adequate for the diet they were requesting. This office was also able to confirm that this individual was provided with an alternative special diet.	No Violation of Policy
272.	Person reports that DOC staff wrongfully rejected video grams from his girlfriend. The person requests that the mail rejection policy be changed to not allow for the decisions to	The OCO was unable to substantiate a violation of policy by DOC. Per DOC 450.100, any image intended for sexual gratification is not permitted. OCO staff reviewed the mail rejections and noted the rejections met the policy criteria for rejection. This office notes that this policy was written to allow	No Violation of Policy

	be based on individual opinion of staff.	subjective decision making and has an appeal process in place for rejections to be rereviewed at a higher level.	
273.	Incarcerated individual relayed concerns regarding denial of an extended family visit (EFV) as the individual states they have now done parenting classes and should be eligible.	The OCO reviewed the denial decision and confirmed that despite the parenting classes, the individual still has not done SOTAP and until they do so, they will be ineligible for EFVs per DOC policy 590.100 attachment 2.	No Violation of Policy
274.	Individual reports that DOC is not validating his safety concerns and gave him a max program based on an event that happened last year.	The OCO reviewed the individual's placement and spoke to DOC staff about this concern. The OCO found no violation of DOC 320.250 regarding the individual's max custody placement. The OCO encouraged this person to continue programming and work with classifications during his next max custody review. If the individual disagrees with the outcome of his next review, he can appeal the max custody committee decision using DOC 07-037and submit it to the Assistant Secretary of Prisons.	No Violation of Policy
275.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the infraction content met the "some evidence" standard utilized by DOC.	No Violation of Policy
276.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's intoxication led to a for cause search.	No Violation of Policy
277.	Incarcerated individual relayed concerns regarding their custody points being incorrectly calculated.	The OCO spoke with DOC regarding the concern. Per DOC policy 310.150, individuals either receive 6 points or 0. If you have a qualifying crime, you will not receive any points, if you do not, you will receive 6 points. Because the individual has a qualifying crime, they did not get the 6 points.	No Violation of Policy
278.	Incarcerated person reported concerns about their placement into solitary confinement. The person states they would like to be placed in a general population setting before their upcoming release.	The OCO substantiated the incarcerated person was held in solitary confinement due to concerns about placement options and delays in infraction adjudication. The OCO spoke with DOC staff at the facility about the persons placement and asked that these reviews be completed so the person could release from segregation. The person obtained another infraction while in segregation, which further delayed their transfer to general population. The OCO found the person was released from segregation one day prior to their release from prison.	Substantiated
279.	Incarcerated individual shared concerns regarding DOC staff confiscating their property and destroying it in the attempt to find drugs.	The OCO was able to substantiate this concern but was unable to achieve a resolution. After review of DOC records, this office was able to confirm that this individual's property was destroyed during DOC's investigation but staff failed to find any evidence supporting the cause for investigation. The OCO provided this individual with information regarding how to file tort claims.	Substantiated
Washington Corrections Center for Women			
280.	An incarcerated person called the OCO and reported that another incarcerated individual was being mistreated by DOC staff.	The OCO contacted DOC about this concern and visited the facility to check on this person's well-being. The incarcerated individual does not speak English, and this office confirmed that DOC provided an interpreter during the reported incident. DOC staff reported that the facility was working on a new custody facility plan (CFP) for this person, and when OCO staff	Assistance Provided

		visited the individual in the IMU, the individual confirmed that interpretation services are being provided and wants to go home. The OCO followed the case and made sure the individual was given a new CFP and moved to the mental health unit.	
281.	Person reports concerns with housing placement after post-op and requested single cell HSR or work release.	The OCO elevated the concerns through DOC women's prison division. After OCO outreach, this office confirmed the individual was approved and transferred to work release.	Assistance Provided
282.	An individual was given an infraction because DOC believed they were trying to divert their Suboxone when they took the medication.	The OCO provided assistance by speaking with the individual's family member and the DOC about this concern. Ultimately, the facility dropped the infraction.	Assistance Provided
283.	An individual reported that DOC staff are retaliating against them by not following the mail policy, rejecting mail for incorrect reasons, and returning mail to the sender when they should be using the mail rejection policy.	The OCO contacted DOC about this concern and substantiated that the policy was not followed when the incarcerated person's mail was returned to the sender. DOC staff were instructed to follow policy 450.100 when rejecting mail so that the incarcerated individual can appeal the mailroom's decision. The OCO encouraged this person to have their loved one resend the letter so that the mail policy can be applied, and the individual can choose to appeal the facility's decision.	Assistance Provided
284.	Person reported that she was assaulted by another individual and although she reported the incident to DOC staff, her concern was not addressed and a Keep Separate was not put in place between the two individuals.	The OCO reviewed the information and confirmed that this person has a current keep separate between herself and the individual who assaulted her.	DOC Resolved
285.	External person reports their loved one is being mistreated and targeted by staff. They are not allowed to have a roommate even though mental health has said it would be beneficial. They would like the OCO to investigate the culture of the staff at the facility.	The OCO confirmed that this individual received a roommate shortly after this concern was filed. Part of the suggested resolution request in the complaint was to investigate the culture at this facility and how individuals are treated. The OCO will continue to investigate concerns at this facility.	Information Provided
286.	An external person reports that an incarcerated individual is unable to obtain their medical records because the current DOC policies regarding the production and release of medical records prevent reasonable accessibility.	The OCO spoke with DOC about this concern and the current practice of requesting DOC medical records. Requests for health care information are subject to RCW 70.02 and are processed separately from the Public Records Act (PRA). PRA fees are charged pursuant to WAC 137-08-110, which says an agency can charge .15 cents per page for printed copies. If an individual requests copies of their medical records, the Department can charge a reasonable fee as defined in RCW 70.02.010 for searching and duplicating health care records. In accordance with RCW 70.02.010, the Department of Corrections charges .20 per page for a printed copy of medical records, and the fees are pursuant to WAC 246-08-420.	Information Provided

		Additionally, the OCO provided information to this person regarding the DOC's Policy Change and Rule-Making processes.	
287.	Person reported that people who do not need to use the ADA bathroom in the unit are using it and are not restocking the toilet paper.	The OCO provided information regarding ADA bathroom accessibility and why it must be open to all parties.	Information Provided
288.	External person reports concerns about a transgender woman being transferred from WCCW to a men's facility.	The OCO tracked the individual's placement and elevated the concerns to DOC women's division leadership. The OCO contacted the person directly to provide self-advocacy information about the pathway for reconsideration of placement at WCCW. This office also provided a complaint form in case the individual has more details or updated concerns.	Information Provided
289.	Person reports needing an MRI and this being denied by her provider. The person also reported that she needs an assistive device that was also denied. The person is requesting a new provider.	The OCO provided information to the patient regarding her specialist consultation. OCO staff reviewed the patient's records and verified that her situation has been reviewed by multiple medical providers who agree to the same conclusion about the MRI request. OCO staff confirmed the patient has an assistive device, with the requested device having been denied by the medical provider. This is a clinical decision that cannot be countermanded by non-clinicians.	Information Provided
290.	Incarcerated individual relayed concerns regarding placement in segregation.	The OCO reviewed the individual's custody facility plan (CFP) and found no violation of DOC policy 300.380 as the MAX committee decided to maintain close custody due to the threat the individual presents towards others including recent infractions. The OCO confirmed the individual has been released from segregation.	No Violation of Policy
291.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the infraction met the “some evidence” standard.	No Violation of Policy
292.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the infraction met the “some evidence” standard.	No Violation of Policy
Washington State Penitentiary			
293.	Person reported that when he arrived at the facility Intensive Management Unit (IMU), he never received the initial medical intake he was supposed to have. Person described experiencing severe symptoms from an infection. Person said he had not received care for his infection and was not allowed to have the Durable Medical Equipment (DME) he was provided with at another facility to ease the symptoms. Person expressed concern about staff conduct when he	The OCO provided assistance by ensuring that this individual received medical attention and his DME. The same day as receiving this report, the OCO reached out to unit and medical staff, who provided a wellness check and scheduled him to receive medical care for his infection. The OCO consistently followed up with staff on this issue to ensure that this individual received medical care. The OCO found that there were discrepancies between what staff said and documented regarding whether his DME was allowed in the IMU. After OCO outreach, this individual was given his DME. The OCO spoke with facility leadership about the discrepancy and miscommunication about this DME and confirmed that this DME is allowed in the IMU. Facility leadership spoke with their staff to let them know this DME is allowed and edited this individual’s BOEs on the issue to reflect that.	Assistance Provided

	filed medical and mental health emergencies. Person said that staff were dismissive and told him that his symptoms were not an emergency.		
294.	Person reports needing additional medication to treat an ongoing injury. The person reports everything else about the injury has been handled but he is still experiencing severe pain.	The OCO provided assistance. OCO staff reviewed the person consultations and contacted DOC Health Services staff and did not receive a response for a significant amount of time. OCO staff noted that DOC found a discrepancy in the specialist's orders that needed to be resolved prior to changing his treatment plan. OCO staff follow up and confirmed that the person is receiving the class of medication requested within the related medication protocol.	Assistance Provided
295.	Patient reports concerns that DOC will start force feeding him.	The OCO provided assistance by elevating these concerns through DOC health services leadership. After OCO outreach, DOC agreed to schedule the patient for an appointment with a mental health provider. The OCO confirmed the patient is not on an involuntary diet at this time, however, is being monitored by medical including Multi-Disciplinary Team reviews twice weekly. This office provided more information to the patient directly, including how to follow up since the individual transferred and DOC 620.400 Force Feeding of Incarcerated Individuals.	Assistance Provided
296.	Incarcerated individual relayed concerns regarding assistance restoring over 1000 days of good conduct time.	Over the three-year investigation of this case, the OCO contacted numerous DOC staff members, reviewed hundreds of pages of records including mental health documentation and infraction packets, and repeatedly raised concerns with DOC about the fact that despite confirmed mental health concerns, the individual continued to be infracted which resulted in them not being able to fulfil their restoration of good conduct time pathway (RGCT). Ultimately, the OCO requested that DOC implement an alternative to infracting individuals with mental health concerns and requested that DOC retroactively change the individual's RGCT from a 12 month to 10 month requirement. The OCO was able to successfully ensure that the individual transferred from IMU to the BAR units for a period of time. While DOC has yet to implement an alternative to infractions for those with mental health concerns, such as the previous SMI project at Sky River Treatment Center, the OCO is in ongoing conversations with DOC regarding the need for not only an alternative infraction program, but also a policy surrounding this. While DOC was unwilling to retroactively change the individual's RGCT from 12 to 10 months, DOC did agree to elevate this concern to headquarters leadership and continue to monitor the individual's progress for potential changes in the future.	Assistance Provided
297.	An incarcerated individual reported concerns when he was not given access to reasonable accommodations, despite being disabled.	The OCO reviewed this person's records and contacted health services. DOC reported that the facility medical director (FMD) was working with this individual to accommodate his requests. The OCO confirmed the individual has a single cell and was given his wheelchair back. DOC health services noted that the individual was offered physical therapy (PT) to improve his condition, but he declined treatment.	DOC Resolved

298.	Incarcerated individual shared concerns regarding not being provided with programming and other privileges within IMU (Intensive Management Unit).	DOC staff resolved this concern prior to the OCO taking action on this complaint. After review of DOC records, this office was able to confirm that this individual was promoted per DOC 320.250 and provided with programming opportunities.	DOC Resolved
299.	Incarcerated individual relayed concerns regarding placement in segregation.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that they have been released from segregation.	DOC Resolved
300.	Incarcerated individual relayed concerns regarding placement in segregation.	The OCO reviewed the individual's administrative segregation (ad seg) placement and confirmed that they have been released from segregation.	DOC Resolved
301.	Incarcerated individual shared concerns regarding wanting to stay at their current facility for their safety.	DOC staff resolved this concern prior to the OCO taking action on this complaint. After review of DOC records, this office was able to confirm that this individual received a completed CFP (Custody Facility Plan) and is going to be retained at their current facility.	DOC Resolved
302.	A family member reported that DOC is incorrectly calculating her loved one's early release date (ERD).	The OCO reviewed the individual's electronic file and confirmed that DOC has been responding to the incarcerated person and their loved one about this concern. The OCO encouraged the individual to file a resolution request about their ERD and provided contact information for Okanogan County Superior Court.	Information Provided
303.	Incarcerated individual relayed concerns regarding a work release denial.	The OCO reviewed the related records and confirmed that the decision was to uphold the reentry center denial due programming concerns.	Information Provided
304.	A loved one made concerns on behalf of an incarcerated individual regarding ensuring their ability to debrief to avoid out of state transfer (OST).	The OCO provided information regarding OST and steps they can take to debrief. After speaking with DOC staff and review of DOC records, this office was able to confirm that this individual is actively attempting to debrief.	Information Provided
305.	An external person reported concerns about their loved one not being released two years ago on the Graduated Reentry Program (GRE).	The OCO provided information regarding why this person was not transferred to the Graduated Reentry Program (GRE). The OCO verified that this person was screened and approved for (GRE). The approval was administratively withdrawn per policy 390.590, Graduated Reentry because this person received four serious infractions within two months.	Information Provided
306.	Incarcerated person reported concerns about how DOC uses administrative segregation and close observation units as a way to continue to segregate people. The person reports these concerns for the OCO to investigate how DOC uses these processes to continue to segregate people in solitary confinement.	The OCO provided information about the OCO's recent solitary confinement reports and continued work the OCO is doing to investigate solitary confinement practices in Washington DOC. The OCO is in conversation with DOC about their current practices with administrative segregation and uses of close observation units.	Information Provided
307.	Person reports that custody staff interfered with his	The OCO provided information to the person regarding the requested investigation. There was insufficient evidence to	Information Provided

	access to necessary medication. The person requested that custody staff be retrained on expectations for patients with medical complaints.	substantiate the reported issue. OCO staff noted that there are not logs kept of each individual time when a person uses their call light for requests from medical unless a medical emergency is declared by the patient and the patient is taken from their cell for evaluation. OCO staff found that DOC staff were retrained as a result of the patient utilizing the resolution process related to the denial of medical care.	
308.	Incarcerated individual shared concerns regarding DOC staff writing an inaccurate BOE (Behavioral Observation Entry) and telling them not to appeal it.	The OCO provided information regarding the steps the OCO took to confirm that this individual submitted their BOE appeal and that it was reviewed by DOC staff. After speaking with DOC staff and reviewing DOC records, this office was able to confirm that this individual did appeal and it was reviewed by DOC staff.	Information Provided
309.	Person reported concerns about being able to participate in substance abuse treatment classes.	The OCO provided information regarding how to file a Closed Case Review if this person has new information that was not considered in the original investigation.	Information Provided
310.	Incarcerated person reports concerns regarding food he was served.	The OCO provided information about how to report concerns with their meal for a potential replacement. The OCO spoke with multiple DOC staff at the facility and DOC headquarters regarding food quality. After DOC visited the facility, they made changes to ensure food quality standards are met. If people have issues with the meal they are provided, they can speak with a unit staff member who will work with the kitchen to get a replacement. This method for meal exchange is specific to WSP, because they do not have dining halls.	Information Provided
311.	An incarcerated person reported a concern related to requesting additional support related to difficulty writing.	The OCO provided information regarding how to request the assistance they are needing through DOC internal processes.	Information Provided
312.	Incarcerated individual shared concerns regarding not being provided with adequate programming opportunities within their unit.	The OCO provided information regarding why their programming has been restricted. After speaking with DOC leadership, this office was able to confirm that due to staffing shortages and the security risk of this unit, the programming opportunities provided for this unit are currently limited.	Information Provided
313.	Incarcerated individual relayed concerns regarding not getting a response to their infraction appeal.	The OCO spoke to DOC about this concern and confirmed that DOC did not receive an infraction appeal and requested DOC accept a resubmitted appeal, to which DOC declined.	Information Provided
314.	An incarcerated person reported a concern related to the quality of food served at the facility.	The OCO provided information regarding the use of reported concerns for future OCO reports.	Information Provided
315.	Person reports that there was a fight and he was sitting near the incident. Afterwards, he was tagged with group violence reduction strategy (GVRS) restrictions despite not knowing the individuals who were involved in the altercation.	The OCO spoke with DOC regarding the individual's placement on GVRS, and DOC confirmed the individual was listed as an associate. GVRS is an evidence-based procedure used to deter incarcerated individuals from committing violent acts by imposing privilege restrictions. The OCO is aware of concerns about the implementation of GVRS and is in ongoing discussions with DOC about this procedure.	Information Provided

316.	Incarcerated individual relayed concerns regarding the usage of GVRS (group violence reduction strategy).	The OCO reviewed this concern and spoke to DOC about GVRS. The OCO informed the individual that the OCO is in ongoing conversation with DOC about the usage of GVRS at this time and continues to escalate concerns related to how GVRS is utilized.	Information Provided
317.	Person reports having kited medical multiple times without being seen for a possible infection. The patient is requesting a follow-up appointment with his medical provider.	The OCO provided information to the patient regarding the proposed treatment options given to the patient. The OCO contacted DOC Health Services staff and were informed that the patient had been seen and offered treatment, however the patient had declined the offer.	Information Provided
318.	An incarcerated person reported a concern related wanting CI to stop being involved in the food served in WA DOC.	The OCO provided information regarding process changes to how the OCO may use their reported concern in future reporting.	Information Provided
319.	Incarcerated individual relayed concerns regarding a certain sergeant's conduct.	The OCO reviewed the related documentation and spoke to DOC facility leadership. Due to confidentiality reasons, the OCO is not able to share details of the conversations with DOC about particular staff members, but remain in ongoing conversations with DOC regarding staff conduct concerns.	Information Provided
320.	Incarcerated individual shared concerns regarding not being provided with adequate programming opportunities within their unit.	The OCO provided information regarding why the programming opportunities are restricted. After speaking with DOC leadership, this office was able to confirm that the unit was initially set up for non-long-term placement. Due to staffing shortages, this unit has become long-term placement, and that coupled with security risk of intermixing units, the programming opportunities provided for their unit are currently limited.	Information Provided
321.	Incarcerated individual relayed concerns regarding a staff member's conduct.	The OCO reviewed the related documentation and spoke to DOC facility leadership. Due to confidentiality reasons, the OCO is not able to share details of the conversations with DOC about particular staff members, but remain in ongoing conversations with DOC regarding staff conduct concerns.	Information Provided
322.	Incarcerated individual shared concerns regarding DOC providing them with the incorrect glasses.	The OCO provided information regarding the current status of their new glasses. After speaking with DOC staff and reviewing DOC records, this office was able to confirm that DOC medical staff have placed another order for the correct glasses and are accommodating this individual in the mean time.	Information Provided
323.	Incarcerated person reported concerns about their facility placement and had questions about a previous concern reported to the OCO.	The OCO provided information to the person about DOC's classification process and how to engage with it. The OCO spoke with the person about the previous concern and the outcome of the OCO investigation. The OCO shared with the person the importance of participating in classification planning and explained how to appeal custody facility plans (CFPs). People can appeal their CFP by submitting DOC 07-037 Classification Appeal. Facility assignments cannot be appealed but other aspects of the plan can be. More details about classification appeals can be found in DOC 300.380.	Information Provided

324.	The individual reports that DOC denied him graduated reentry (GRE) due to a federal detainer.	OCO staff shared multiple details over the phone regarding how to address the detainer and how to work with DOC to be reconsidered for GRE.	Information Provided
325.	Incarcerated individual relayed concerns regarding the usage of GVRS (group violence reduction strategy).	The OCO reviewed this concern and spoke to DOC about GVRS. The OCO informed the individual that the OCO is in ongoing conversation with DOC about the usage of GVRS at this time and continues to escalate concerns related to how GVRS is utilized.	Information Provided
326.	Incarcerated individual shared concerns regarding not being provided with more privileges while housed in IMU (Intensive Management Unit) despite voluntarily being housed there.	The OCO provided information as to why they are not being provided with more privileges while in IMU. After speaking with DOC staff, this office was able to confirm that this individual does have privileges but these are limited due to the reasoning of this individual's voluntary IMU placement.	Information Provided
327.	Incarcerated individual relayed concerns regarding the usage of GVRS (group violence reduction strategy).	The OCO reviewed this concern and spoke to DOC about GVRS. The OCO informed the individual that the OCO is in ongoing conversation with DOC about the usage of GVRS at this time and continues to escalate concerns related to how GVRS is utilized.	Information Provided
328.	Person reports needing a chronic pain management plan from his provider. The person states he appealed the Care Review Committee decision but they told him that they did not receive the appeal.	The OCO provided information regarding the limitations in ordering the medication requested. OCO staff reviewed the persons records and noted that he has been started on a treatment plan. Changes to that plan will need to be made with the patient's provider. The OCO cannot compel a provider to order specific pain medications.	Information Provided
329.	Incarcerated individual shared concerns regarding DOC staff targeting them through infractions, other harassment, and jeopardizing their safety by maintaining them at their certain facility.	The OCO was unable to substantiate the concern due to insufficient evidence. After review of DOC records and speaking with DOC staff, this office was able to confirm that there was substantial evidence to corroborate the infractions incurred by this individual. This office was also able to confirm that this individual has been transferred from the original facility of concern.	Insufficient Evidence to Substantiate
330.	Incarcerated person reported concerns about staff conduct. The person also reported delays in medical care.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed DOC's actions and verified the concerns about staff were investigated and there is a lack of evidence to substantiate the person’s allegations. The OCO spoke with DOC staff and verified that the person has received medical care.	Insufficient Evidence to Substantiate
331.	Anonymous Individual called and reported DOC is in violation of their UA policy. Individual did not want to write a grievance because he was fearful of targeting. He has been here two years and they have not done one UA to anyone. Individual states that people are walking around	The OCO reviewed this concern and checked the DOC system for UA's on individuals in the facility. The OCO found that people are being UA'd. Unfortunately, since this report was anonymous, the OCO cannot gather more information for a more in depth review.	Insufficient Evidence to Substantiate

	drunk or high and it is a huge risk.		
332.	Incarcerated individual shared concerns regarding DOC staff jeopardizing their safety by targeting them.	The OCO was unable to substantiate the concern due to insufficient evidence. After review of DOC records, this office was unable to find any evidence that would substantiate staff misconduct. This individual's concern was also reviewed by facility leadership and DOC HQ where it was found unsubstantiated.	Insufficient Evidence to Substantiate
333.	Incarcerated individual relayed concerns regarding ongoing issues with staff including not being served behavior observation entries (BOEs) and retaliation for using the grievance process.	The OCO reviewed the individual's grievance and BOE history and confirmed that the individual did receive copies of the most recent BOEs as there is addendum text stating they received a copy. The OCO informed the individual that if they have not received copies from previous BOEs, they can request them from the hearings department or through a public records request. The OCO confirmed that the individual has moved facilities which should alleviate some of the staff conduct concerns related to accessing the grievance process.	Insufficient Evidence to Substantiate
334.	Person reported concern about not receiving programming points while in solitary confinement, despite engaging in programming. Person said that he thinks he did not receive those points because he is Life Without Parole, but that per policy he is still eligible for those points.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed this person's Custody Facility Plan and housing and verified that this person did not receive programming points while in solitary confinement. Per DOC 300.380, incarcerated individuals do not receive programming points while in solitary confinement/restrictive housing, and that this is unrelated to this person being Life Without Parole.	No Violation of Policy
335.	Incarcerated individual relayed concerns about an infraction for inciting a riot.	The OCO reviewed the infraction materials for a 652, group demonstration and asked DOC if they would be willing to dismiss the infraction as this occurred in the COA and there were related mental health concerns. DOC was unwilling to dismiss the infraction because the individual was actively provoking/inciting the other patients in the COA.	No Violation of Policy
336.	Incarcerated individual relayed concerns regarding level restrictions while in segregation.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that they are to maintain level 1 only due to refusing custody appropriate general population housing. As explained in a previous OCO case, the individual has no verifiable safety concerns.	No Violation of Policy
337.	Incarcerated individual relayed concerns regarding not being able to appeal an infraction as they were moved without access to their property.	The OCO spoke to DOC about this concern and asked if DOC would be willing to accept a resubmitted appeal to which they declined as it is common practice for individuals to be demoted and moved following the outcome of the hearing which would not impact the individual's ability to provide an appeal.	No Violation of Policy
338.	Incarcerated individual relayed concerns regarding getting their release housing that was previously approved, withdrawn.	The OCO reviewed the individual's electronic record and confirmed that DOC denied their release address per policy. The OCO informed the individual that they will have to find a new release address.	No Violation of Policy
339.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as they met the “some evidence” standard.	No Violation of Policy

340.	An external person reports their loved one was put in segregation and wants access to a TV and tablet. Additionally, the person is requesting that the OCO review the video footage related to the incident.	The OCO reviewed the video footage, recent infractions, and spoke with DOC about this concern. This office was unable to substantiate a violation of policy because the individual did participate in behavior that would demote his custody level and result in level one only. DOC 320.250 (C) MAX committee will consider the individual's eligibility to progress through the levels based on the reason(s) the individual was demoted to MAX custody. There is an appeal process when you disagree with your CFP, but you must file the form within 72 hours of your CFP being finalized.	No Violation of Policy
341.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's outgoing mail was intercepted and the elements met the “some evidence” standard.	No Violation of Policy
342.	An external person reports that her husband was taken to segregation and she has not heard from him in several days.	The OCO reviewed the video footage, recent infractions, and spoke with DOC about this concern. This office was unable to substantiate a violation of policy because the individual did participate in behavior that would demote his custody level and result in level one only. DOC 320.250 (C) MAX committee will consider the individual's eligibility to progress through the levels based on the reason(s) the individual was demoted to MAX custody. There is an appeal process when you disagree with your CFP, but you must file the form within 72 hours of your CFP being finalized.	No Violation of Policy
343.	Incarcerated individual relayed concerns regarding being a level 2 only while in segregation.	The OCO reviewed the individual's custody facility plan (CFP) and found no violation of DOC policy 320.250 as they are to maintain level 2 only due to their behavior.	No Violation of Policy
344.	An incarcerated person reported a concern related to having publications rejected without being provided the opportunity to appeal.	The OCO was unable to substantiate a violation of policy by DOC. The OCO was able to verify that the publications in question have been appealed up to a headquarters response and are not currently eligible for re-review.	No Violation of Policy
345.	Incarcerated individual relayed concerns regarding an infraction hearing in which they wanted to attend but DOC held it without them.	The OCO spoke to DOC about this concern and requested they remand the individual for a new hearing. DOC was unwilling to remand the individual for a new hearing as they state the individual was in the dayroom at the time of the hearing, not in their assigned cell awaiting callout and did not have any conflicting call outs.	No Violation of Policy
346.	Incarcerated individual shared concerns regarding DOC medical staff not providing them with adequate rehabilitation following a medical procedure.	The OCO was able to substantiate this concern but was unable to achieve a resolution. After review of DOC records and speaking with DOC staff, this office was able to confirm that this individual did not receive an element of their clinically appropriate treatment due to staff shortages within the facility. Further review indicates that this individual is now being provided with that treatment as that position has been filled.	Substantiated
347.	Person reports concerns about access to work boots that meet his medical needs through the Durable Medical Equipment (DME) process.	The OCO elevated the concerns through DOC health services leadership, however, was unable to achieve a resolution prior to the person releasing from prison. Through this investigation, the OCO identified process improvements related to DME and is continuing to address this concern systemically.	Substantiated

Intake Investigations

Airway Heights Corrections Center

348.	Person reports that they are constantly punished for having a substance use disorder. The person requests that DOC stop infracting people who struggle with addiction issues.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
349.	An incarcerated person reported a concern related to the availability of gym equipment.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
350.	An incarcerated person reported a concern related to programming and their classification.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
351.	A friend or family member reports concerns about this person being excessively tested for drugs by the same officer.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance
352.	Someone reported concerns that this person was suddenly moved from his cell and into a four-man cell because DOC staff needed to house someone else on the lower bunk.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance
353.	Person reported that DOC staff are only allowing them to wear their medical shoes during yard.	The OCO provided technical assistance about the approval process for basic health services.	Technical Assistance Provided
354.	An incarcerated person reported a concern regarding an infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal infractions.	Technical Assistance Provided
355.	Person reported that he was infracted after changes to his medication prescriptions which resulted in a mental health breakdown.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about appealing the infraction.	Technical Assistance Provided
356.	Incarcerated person requesting information about filing complaints related to the foster care system and local law enforcement.	The OCO provided technical assistance over the phone by sharing how to contact The Office of the Children Family Ombuds via letter and by talking about ways to report concerns about law enforcement.	Technical Assistance Provided
357.	An incarcerated person reported a concern related to their custody level and facility placement and DOC custody	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 kiting	Technical Assistance Provided

	staff not being able to discuss ABHS options with him due to HIPPA.	mental health to discuss the ABHS question and put that question in context with GRE.	
358.	Person reported that they are being retaliated and harassed by DOC staff because they were filing grievances.	The OCO provided technical assistance about appealing an infraction and filing a resolution request for staff conduct concerns.	Technical Assistance Provided
359.	An incarcerated person reported a concern related to an infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about appealing infractions prior to reaching out to the OCO.	Technical Assistance Provided
Clallam Bay Corrections Center			
360.	An incarcerated person relayed a concern related to an infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal infractions.	Technical Assistance Provided
361.	Person shared concerns about not being able to receive legal paperwork mailed to him from his family because DOC policy only allows legal mail from an attorney or legal entity. His attorney uses email but he does not have a personal email address because he is in prison and his family cannot print the paperwork and mail it to him, creating a catch 22 scenario.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program to initiate a resolution at the lowest levels and then contact the OCO if DOC cannot assist him.	Technical Assistance Provided
Coyote Ridge Corrections Center			
362.	A friend or family member reported concerns about this person receiving an infraction following a visit with his wife.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance
363.	A family member reported concerns that Extended Family Visits between them and their loved were denied because DOC claims their loved one is refusing to participate in treatment first. However, it was their understanding that because the criminal case is being appealed, treatment is not required.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance
364.	A friend or family member reported concerns about the delay in transferring their loved one out of segregation and to a new facility.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance

365.	A friend or family member reported concerns about the food their loved one is being served.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance
366.	Person reports concerns regarding their medical care. They are requesting to receive care for a reoccurring medical problem.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint.	Person Declined OCO Assistance
367.	Person reported that a DOC staff person acted inappropriately and unprofessionally by telling his girlfriend that he has been talking to other girls. He was also infracted for using different phone PIN numbers to call his girlfriend.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about appealing the infraction.	Technical Assistance Provided
368.	An incarcerated person reported a concern related to the behavior 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 pursuing concerns through the resolution program.	Technical Assistance Provided
369.	The incarcerated individual reports concerns regarding the Washington Way and how correctional officers treat each other when DOC staff are positively engaging with the incarcerated population.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC resolution program. The OCO provided technical assistance about filing a resolution request for staff conduct concerns.	Technical Assistance Provided
370.	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 utilizing the resolution program and appealing concerns to a level 2 response from DOC.	Technical Assistance Provided
371.	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 appealing resolution program responses up to level 2 prior to reaching out to the OCO.	Technical Assistance Provided
372.	This person reported concerns about being infracted multiple times for the same incident and was demoted custody levels as a result. Person is on a level 2 only program and cannot access his legal property.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about appealing an infraction and contacting this office after they received the outcome.	Technical Assistance Provided
GRE/CPA			
373.	A loved one opened a concern on behalf of an incarcerated individual	This person was released prior to the OCO taking action on the complaint.	Person Released from

	regarding being wrongfully terminated from their graduated reentry (GRE) placement.		DOC Prior to OCO Action
Monroe Correctional Complex			
374.	An incarcerated person reports a concern related to not receiving assistance with a Securus concern.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
375.	An incarcerated person reported a concern related to the amount of food allowed to be kept in each person's cell.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
376.	An incarcerated person reports a concern related to items purchased from an authorized vendor not being delivered.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
377.	An incarcerated person reported a concern related to DOC issuing an infraction past allowable timeframes.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
378.	An incarcerated person reported a concern related to other incarcerated people misusing prescribed medications.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
379.	A concern related to an infraction.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
380.	An incarcerated person reported a concern related to DOC staff declining to accept information they want to report.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
381.	An incarcerated person reports concerns related to DOC failing to provide people with full information when they receive sanctions.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
382.	Incarcerated individual relayed concerns regarding the ISRB decision to give the individual more time.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
383.	Individual relayed concerns regarding the conduct of a community corrections officer.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction

384.	A friend or family member reported concerns that DOC is holding their loved one responsible for an altercation with their roommate. Their loved one is confined to a wheelchair and was placed in segregation diminishing his health and quality of life and health.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance
385.	Patient reports concerns about DOC response to a mental health emergency.	The OCO elevated the concerns to confirm the patient was seen by mental health. The patient called the OCO hotline and informed the OCO this is no longer an issue and the case was closed.	Person Declined OCO Assistance
386.	Person reports concerns regarding their classification review. They report that there are not safe in the units that DOC is planning to send them.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint.	Person Declined OCO Assistance
387.	Person reported concern about his Judgement and Sentencing, community custody, and a related resolution request.	This person was released prior to the OCO taking action on the complaint. The OCO was unable to review this concern because this person has released.	Person Released from DOC Prior to OCO Action
388.	Incarcerated individual shared concerns regarding DOC not attempting to place a keep separate between them and a DOC staff member.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
389.	A loved one of an incarcerated person reported a concern related to an infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal an infraction.	Technical Assistance Provided
390.	A loved one of an incarcerated person reported a concern related to the behavior of a DOC staff member.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to use the resolution program.	Technical Assistance Provided
391.	This person reported concerns about how DOC staff treat him and that DOC staff are not providing him the opportunity to appeal his 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 using the resolution program to address staff conduct concerns.	Technical Assistance Provided
392.	An incarcerated person reported a concern related to an infraction and denied 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 how to appeal an infraction and visitation denial.	Technical Assistance Provided
393.	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	Technical Assistance Provided

		appealing resolution program responses up to level 2 prior to reaching out to the OCO.	
394.	An incarcerated person reported a concern related to two serious infractions and 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 filing resolution requests and appealing infractions. Additionally, the OCO was able to verify that the infractions in question were downgraded to a single general infraction at the initial hearing.	Technical Assistance Provided
395.	Person reported that at their facility there is light and dark brown water coming out of their faucet.	The OCO provided technical assistance about the resolution program.	Technical Assistance Provided
396.	This person reported that he has been unsuccessful at obtaining a copy of the legal mail log in his unit so he can track his legal mail for his records.	The OCO provided technical assistance about making a public records request through the Department of Corrections.	Technical Assistance Provided
397.	Person reported concerns about DOC deducting more custody points than they should have after he received 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 appealing an infraction and contacting this office after they receive the outcome.	Technical Assistance Provided
Olympic Corrections Center			
398.	A friend or family member reported on this person's behalf that some of his food items were confiscated during a locker search. This person had receipts to prove that he had purchased the items and was within the 90-day time limit to consume the food.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about filing a tort claim to recoup the monetary loss.	Technical Assistance Provided
399.	An incarcerated person reported a concern related to a health status report (HSR).	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 an HSR.	Technical Assistance Provided
400.	Person reported that his maximum release date is wrong and an extra 23 days was added to his sentence. He stated he was sanctioned to loss of good conduct time but that should have only impacted his earned release date.	The OCO provided technical assistance about how to resolve records correction and time calculation issues.	Technical Assistance Provided
Other			
401.	Family member relayed concerns regarding the conduct of a community corrections officers.	The OCO declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction

402.	Individual relayed concerns about staff conduct while in a jail facility.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
403.	Individual relayed concerns regarding the conduct of a community corrections officer.	The OCO declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
404.	Anonymous individual relayed concerns regarding inconsistencies with how community corrections officers are deciding how aggravating factors are used/considered.	The OCO declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
Stafford Creek Corrections Center			
405.	An incarcerated individual reports that staff are targeting, retaliating, racially profiling, and religiously discriminating against him and other incarcerated individuals.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
406.	An incarcerated person reports a property related concern.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
407.	An incarcerated person reported a concern related to two infractions.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
408.	An incarcerated person reported a concern related to wanting DOC to stop using tablet access as a sanction in the disciplinary process.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
409.	A friend or family member reported concerns that this person is not receiving the appropriate medical care and has been denied the recommended medication and medical procedure that would significantly improve his quality of life.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance
410.	A friend or family member has reported concerns about the lack of appropriate mental health care and safe housing options for their loved one.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance

411.	A friend or family member reported concerns on this person's behalf that he was infracted for missing work. However, this person had an injury and an Health Status Report (HSR) allowing him to miss work before the infraction was served.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance
412.	A loved one of an incarcerated person reported a concern regarding an infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal infractions.	Technical Assistance Provided
413.	An incarcerated person reported a concern related to an infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal infractions.	Technical Assistance Provided
414.	A loved one of an incarcerated person reported a concern regarding an infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal infractions.	Technical Assistance Provided
415.	An incarcerated person reported a concern related to several infractions.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal infractions.	Technical Assistance Provided
416.	An incarcerated person reported a concern related to a denied visitor.	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 steps the visitor needs to take to appeal their denial.	Technical Assistance Provided
417.	An incarcerated person relayed a concern related to DOC's policies related to the issuance of good conduct time.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about DOC policy change process.	Technical Assistance Provided
418.	An incarcerated person reported a concern related to an infraction.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about appealing infractions prior to reaching out to the OCO.	Technical Assistance Provided
419.	This person reported that their tablet was broken and he wanted to replace it. The Securus Liaison took his tablet and was supposed to replace it, but it has been over two months and he has not yet been issued a replacement 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 contacting the Securus Liaison to follow up regarding the replacement tablet.	Technical Assistance Provided
Washington Corrections Center			
420.	An incarcerated person reported concerns related to several infractions.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined

421.	Individual reports he is having difficulty getting resolution requests accepted. He believes the resolutions staff is hindering his ability to get to level 3.	The Individual contacted the OCO and said his resolution was accepted at level 3 and we can close this complaint.	Person Declined OCO Assistance
422.	The incarcerated individual reports being held past his early release date (ERD) for a cell tag infraction.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
423.	An external person reported on their loved one's behalf that his sentence was not accurately calculated and thus his Early Release Date (ERD) is wrong.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program and contacting the records unit at DOC Headquarters to address this concern.	Technical Assistance Provided
424.	A person reported a concern on behalf of their incarcerated loved one that DOC staff violated the rights of the incarcerated individual by not following policy.	The OCO provided technical assistance about appealing an infraction.	Technical Assistance Provided
425.	Person reported on behalf of their incarcerated loved one that DOC staff are mistreating them and not providing access to proper healthcare services.	The OCO provided technical assistance about how to access health care services.	Technical Assistance Provided
426.	Person reported that a conviction out of California is on his record and he believes this is an error.	The OCO provided technical assistance about what internal steps he needs to take first and kiting the appropriate contact to request the records correction.	Technical Assistance Provided
427.	Person reported that they would like to file a complaint against a medical provider.	The OCO provided technical assistance about the process on how to file a complaint against a provider.	Technical Assistance Provided
428.	Person reports that his wife was terminated from visitation, and he was infracted in retaliation for a lawsuit against DOC that he had won. Since the conclusion of the lawsuit DOC has been watching him closely and targeting him with nonsense infractions.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to appeal visitation rejections, denials or terminations.	Technical Assistance Provided
429.	This person reported that DOC delayed serving him an infraction for an incident that occurred nearly a month earlier.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about appealing an infraction.	Technical Assistance Provided

430.	An incarcerated person reported a concern related to their time calculation not being correct.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about contacting records to get their time re-calculated and corrected if there are errors.	Technical Assistance Provided
431.	Person reported that their extended family visits were denied.	The OCO provided technical assistance about the visitation appeal process.	Technical Assistance Provided
432.	Person reported that incarcerated individuals were taken advantage of when DOC switched services from JPay to Securus and the content that was already purchased was lost or not credited to the new accounts. DOC gave individuals only 30 days to respond to the notification when the switch occurred.	The OCO provided technical assistance about Securus. The OCO does not have direct jurisdiction over Securus or JPay and is not able to mediate resolutions that fall under Securus' responsibility.	Technical Assistance Provided
433.	Person reported that their time calculations are incorrect and would like to have them recalculated.	The OCO provided technical assistance about how to access legal resources and the records correction process.	Technical Assistance Provided
Washington Corrections Center for Women			
434.	External person reports that a facility targeted her loved one whose wife was incarcerated at the facility. The person reports that staff lied about them abusing their children and the wife was sentenced due to the alleged crime and transferred to an out of state prison.	Per RCW 43.06C.040 the Ombuds will not investigate any complaint relating to the inmates underlying criminal conviction. Evidence from the facility was used to pursue criminal charges that the individual is now incarcerated for. The OCO could not find a violation of DOC 330.600 regarding the out of state transfer. Policy states the Department can transfer individuals if it is in the best interest of the state. As the individual's wife already resided at the only Washington prison for women, this individual was transferred for security purposes.	Declined
435.	A family member reported concerns that mold was found on this person's mattress.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance
436.	This person reported concerns regarding staff conduct which is effecting her mental health.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program to address staff conduct concerns and contacting Health Services for appointments and emergencies.	Technical Assistance Provided
437.	Person reports that her tablet was lost when it was confiscated by the Intelligence & Investigations Unit (IIU) over a year ago and now she will have to pay for a new one although DOC was responsible for the loss.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program.	Technical Assistance Provided

Washington State Penitentiary			
438.	An incarcerated person reported a concern related to needing special shoes.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, based on the strategic priorities of the OCO this case is being closed.	Declined
439.	An incarcerated person reports a concern regarding an issue with DOC handling of mail.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
440.	An incarcerated person reported a concern related to a medical concern.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
441.	An incarcerated person reported a concern related to the behavior of a DOC staff members.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
442.	An incarcerated person reports a concern related to an infraction.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
443.	An incarcerated person reports a concern related to legal mail.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
444.	An incarcerated person reported a concern related to the quality of food being served.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, based on the strategic priorities of the OCO this case is being closed.	Declined
445.	An incarcerated person reported a concern related to DOC incorrectly documenting information related to a problem with the facility maintenance.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
446.	An incarcerated person reported a concern related to the behavior of another incarcerated person.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
447.	An incarcerated person reported a concern related to the behavior of a DOC staff member.	Due to limited resources (RCW 43.06C.040), the OCO is only able to review one case per individual at a time, as a result the individual agreed to have this case closed until their other case investigations are complete.	Declined
448.	A friend reported safety concerns about this person being placed in general population. The only other option for them is to stay in close or protective custody where they do not have access to programming which seems like punishment.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance

449.	A friend or family member reported concerns about DOC misidentifying a rope this person uses to practice braiding during two different cell searches. After the first cell search DOC stated this person was suicidal and the rope was a noose. After the second cell search they were accused of possessing escape paraphernalia and placed in segregation.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance
450.	A friend or family member reported concerns about the lack of facility placement options for this person because of an STG status which has negatively impacted his mental health. DOC is not being responsive to his requests for mental health care.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance
451.	An external person reported that she was indefinitely terminated from visiting her fiancé without a warning first. The termination was based on behavior during a recent visit and termination from video visits with a different person in the past.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance
452.	Person reports having kited medical multiple times without being seen for a possible infection. The patient is requesting a follow-up appointment with his medical provider.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint.	Person Declined OCO Assistance
453.	A loved one of an incarcerated person reported a concern regarding a denied visitor.	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 visitor's responsibility on appealing denials	Technical Assistance Provided
454.	An incarcerated person related to the behavior of a DOC staff member and a suspended visitor.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about pursuing staff behavior concerns through the resolution program and how a visitor can appeal a visitation suspension.	Technical Assistance Provided
455.	Person reported that their points are incorrect.	The OCO provided technical assistance about the records process.	Technical Assistance Provided

456.	Person reported that Securus did not honor the contract service agreement, and he did not receive the services or items that has been paid for. This person has attempted to resolve this issue through Securus but nothing has changed.	The OCO provided technical assistance about Securus. The OCO does not have direct jurisdiction over Securus or and is not able to mediate resolutions that fall under Securus' responsibility.	Technical Assistance Provided
457.	An incarcerated person reported a concern regarding a denied visitor.	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 visitor's responsibility on appealing denials.	Technical Assistance Provided
458.	An incarcerated person reported a concern related to the behavior of a DOC staff member.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about how to utilize the resolution program.	Technical Assistance Provided
459.	Person reported that his tablet broke and Securus assured him they would replace it. It has been over a month and Securus has not replaced it yet.	The OCO provided technical assistance about contacting Securus to replace his broken tablet.	Technical Assistance Provided
460.	This person reported concerns about ongoing issues with Correctional Industries (CI) food services.	The incarcerated person has not yet sufficiently escalated the concern through an appeals process or the DOC Resolution Program. The OCO provided technical assistance about using the resolution program to address.	Technical Assistance Provided
461.	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 appealing resolution program responses up to level 2 prior to reaching out to the OCO.	Technical Assistance Provided

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

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

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

Abbreviations & Glossary

ADA: Americans with Disabilities Act

AHCC: Airway Heights Corrections Center

ASR: Accommodation Status Report

BOE: Behavioral Observation Entry

CBCC: Clallam Bay Corrections Center

CCCC: Cedar Creek Corrections Center

CI: Correctional Industries

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

CO: Correctional Officer

CRC: Care Review Committee

CRCC: Coyote Ridge Corrections Center

CUS: Correctional Unit Supervisor

DES: Department of Enterprise Services

DOSA: Drug Offender Sentencing Alternative

EFV: Extended Family Visit

ERD: Earned Release Date

GRE: Graduated Reentry

HCSC: Headquarters Community Screening Committee

HSR: Health Status Report

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

J&S: Judgment and Sentence

MCC: Monroe Correctional Complex

MCCCW: Mission Creek Corrections Center for Women

OCC: Olympic Corrections Center

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

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

SCCC: Stafford Creek Corrections Center

SOTAP: Sex Offender Treatment and Assessment Program

SVP: Sexually Violent Predator

TC: Therapeutic Community

WaONE: Washington ONE ("Offender Needs Evaluation")

WCC: Washington Corrections Center

WCCW: Washington Corrections Center for Women

WSP: Washington State Penitentiary

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-020

Report to the Legislature

As required by RCW 72.09.770

April 10, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

Table of Contents

Unexpected Fatality Review Committee Report

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

Legislative Directive and Governance

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

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

Disclosure of Protected Health Information

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

UFR Committee Members

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

DOC Health Services

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

DOC Prisons Division

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

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Heather Schultz, Associate Medical Director

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

Fatality Summary

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

Date of Incarceration: August 2023

Date of Death: December 2024

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

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

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

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

UFR Committee Discussion

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

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

   1. The committee found:

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

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

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

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

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

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

   1. Seriously Ill Notification:

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

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

   2. Extraordinary Medical Placement:

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

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

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

Committee Findings

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

Committee Recommendations

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

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-004

Report to the Legislature

As required by RCW 72.09.770

May 23, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

Table of Contents

Unexpected Fatality Review Committee Report

UFR-25-004 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

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

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on April 17, 2025:

DOC Health Services

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

DOC Men's Prisons Division

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

DOC Reentry Division

- Sarah Sytsma, Deputy Assistant Secretary

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Judy Zerzan, Medical Director

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

Fatality Summary

Year of Birth: 1958 (66-years-old)

Date of Incarceration: September 2024

Date of Death: January 2025

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

His cause of death was due to myocardial infarction, atherosclerotic and hypertensive cardiovascular disease. The manner of death was natural.

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

Days Prior to Death	Event
5 days	• The incarcerated individual was emergently seen and treated for symptoms of a chronic lung condition.
3 days	• He reported increasing shortness of breath to staff. • He was assessed by nursing staff and treatment was provided. • His condition worsened and 911 was called. • Staff continued to provide medical treatment until the incarcerated individual was transported by ambulance to a community hospital.
0 days	• He was pronounced deceased in the community hospital.

UFR Committee Discussion

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

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

   1. The committee found:

      a. The incarcerated individual had a past medical history of chronic lung disease, high blood

pressure and heart disease.

b. He was not prescribed a cholesterol lowering medication.

c. During his initial exam, he reported experiencing daily trouble breathing which worsened with activity.

d. Nursing staff did not recognize his symptoms were life-threatening, and a request for community EMS was not made until his condition deteriorated.

e. The current DOC Medical Emergency Response Form 13-440 does not include guidelines for clinical instability.

2. The committee recommended:

a. Referral to UFR Committee.

b. Nursing leadership review and update medical emergency response form, DOC 13-440 to include guidelines for clinical instability.

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

1. The CIR found:

a. There was a delay in requesting a community EMS response.

2. The CIR recommended:

a. Ensure Health Services Emergency Response training includes signs of clinical instability and reinforces when to request a community EMS response.

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

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

1. Emergency Response:

The UFR committee discussed DOC's medical emergency response process including readiness drills.

Health Services is working to incorporate visual cues into our process that include guidelines for clinical instability and red flag prompts for requesting community EMS response.

DOC has also established a collaborative workgroup between the Prisons and Health Services divisions to review and make recommendations to improve current emergency medical response processes to ensure that Department staff are equipped with information, skills and equipment needed to effectively respond to medical emergencies.

2. Care for individuals with chronic medical conditions.

   Health Services continues to expand the Patient Centered Medical Home to support individuals with chronic medical conditions utilizing a team-based care approach.

   There are quality measures in place that include heart disease.

   - The focused work has been on management of diabetes and high blood pressure.
   - The next target area is heart disease.

   The goal is development of an electronic patient dashboard for the care team to easily visualize an individual's status and care needs.

Committee Findings

The incarcerated individual died as a result of a myocardial infarction, atherosclerotic and hypertensive cardiovascular disease. The manner of death was natural.

Committee Recommendations

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

Table 1. ***UFR Committee Recommendations***
1. Nursing leadership review and update medical emergency response form, DOC 13-440 to include guidelines for clinical instability.
2. Ensure Health Services Emergency Response training includes signs of clinical instability and reinforces when to request a community EMS response.
3. Facility leaders should conduct drills and post-action emergency response debriefs to improve communication including the process of obtaining and interacting with community EMS.

Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-25-004

Report to the Legislature

As required by RCW 72.09.770

June 2, 2025

DOC Corrective Action, Publication Number 600-PL001

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

Unexpected Fatality Review
DOC Corrective Action Plan

DOC Corrective Action Publication Number 600-PL001

Legislative Directive

Engrossed Substitute Senate Bill 5119 (2021)

Unexpected Fatality Review Governance

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

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

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

Unexpected Fatality Review Committee Report

The department issued the UFR committee report 25-004 on May 23, 2025 (DOC publication 600-SR001). This document includes the required corrective action plan. The department is required to implement the corrective actions within 120 days from the corrective action plan publication.

Corrective Action Plan

CAP ID Number:	UFR-25-004 – 1a
Finding:	Nursing staff did not initially recognize the incarcerated individual's symptoms were life-threatening, resulting in delayed critical intervention.
Root Cause:	The current DOC Medical Emergency Response Form (DOC 13-440) does not provide guidance for identifying or prompt immediate request for EMS response for signs of clinical instability.
Recommendations:	Nursing leadership review and update DOC Medical Emergency Response Form (DOC 13-440) to include guidance for recognizing and managing clinical instability.
Corrective Action:	Nursing leadership will revise DOC Medical Emergency Response Form (DOC 13-440) with visual cues to better equip staff to quickly recognize and escalate care for incarcerated individuals showing signs of clinical instability.
Expected Outcome:	1. Improved emergency response as Department staff will be better equipped with information and skills needed to effectively respond to medical emergencies. 2. Timely request for EMS and improved outcomes for incarcerated individuals.

CAP ID Number:	UFR-25-004 – 1b
Finding:	There was a delay in requesting a community EMS response.
Root Cause:	Nursing staff did not initially recognize the patient's symptoms were life-threatening, resulting in a delayed EMS activation.
Recommendations:	Enhance Health Services Emergency Response training to include recognizing and responding to signs of clinical instability and reinforces timely request for community EMS.
Corrective Action:	The DOC Health Services team will implement mandatory training programs for all nursing staff focused on the updated nursing protocols and forms with emphasis on early recognition of clinical instability and prompt request for EMS response.
Expected Outcome:	1. Improved emergency response as Department staff will be better equipped with information and skills needed to effectively respond to medical emergencies. 2. Timely request for EMS and improved outcomes for incarcerated individuals.

CAP ID Number:	UFR-25-004 – 1c
Finding:	A delay occurred in requesting a community EMS response.
Root Cause:	Nursing staff did not initially recognize the severity of the patient's symptoms and the need for EMS activation and intervention.
Recommendations:	Facility leaders should implement routine emergency response drills and conduct post-action emergency response debriefs to enhance staff preparedness. These exercises should focus on improving communication, refining the process for engaging community EMS and ensuring timely medical intervention.
Corrective Action:	DOC's medical emergency response process will include readiness drills to reinforce best practices for managing medical emergencies.
Expected Outcome:	1. Department staff will be better equipped with information, skills, and equipment needed to effectively assess and respond to medical emergencies. 2. Improved quality of care for incarcerated individuals, including timely recognition, escalation, and intervention in critical situations.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-016

Report to the Legislature

As required by RCW 72.09.770

April 21, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

Table of Contents

Unexpected Fatality Review Committee Report

UFR-24-016 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

Disclosure of Protected Health Information

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

UFR Committee Members

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

DOC Health Services

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

DOC Prisons Division

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

DOC Risk Mitigation

- Michael Pettersen, Director

DOC Community Corrections Division

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

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

Health Care Authority (HCA)

- Dr. Christopher Chen, Associate Medical Director

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

Fatality Summary

Year of Birth: 1986 (38-years-old)

Date of Incarceration: October 2018

Date of Death: September 2024

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

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

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

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

UFR Committee Discussion

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

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

    1. The committee found:

        a. The incarcerated individual did not disclose he had ingested large amounts of methamphetamine.

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

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

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

    2. The committee recommended:

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

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

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

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

    1. Contraband management in DOC facilities:

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

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

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

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

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

    a. Launch of an interagency Fentanyl taskforce.

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

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

Committee Findings

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

Committee Recommendations

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

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

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

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

Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-24- 016

Report to the Legislature

As required by RCW 72.09.770

May 1, 2025

DOC Corrective Action, Publication Number 600-PL001

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

Unexpected Fatality Review
DOC Corrective Action Plan

DOC Corrective Action Publication Number 600-PL001

Legislative Directive

Engrossed Substitute Senate Bill 5119 (2021)

Unexpected Fatality Review Governance

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

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

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

Unexpected Fatality Review Committee Report

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

Corrective Action Plan

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

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

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