November 1, 2023

TO: The Honorable Jay Inslee, Governor of the State of Washington
    Members of the Washington State Legislature
    Stakeholders of the Office of the Corrections Ombuds
    Cheryl Strange, Secretary of the Department of Corrections

We are pleased to submit the Fiscal Year 2023 Annual Report of the Office of the Corrections Ombuds, which provides an account of the agency’s activities from July 1, 2022, through June 30, 2023.

During this reporting period, the Office of the Corrections Ombuds (OCO) opened 3,657 cases representing complaints from, or about, 1,779 incarcerated individuals. We resolved 3,854 complaints. The most frequently received complaints concerned healthcare, disciplinary cases, and DOC staff conduct.

Bringing about positive change in Washington’s corrections system is our collective responsibility. The OCO is committed to clearly and effectively communicating to the Washington Department of Corrections (DOC) problems that need to be fixed and asking for change and solutions. In return, we deliver objective, honest, transparent, and responsive communications and negotiations to positively impact the community we serve.

In May, I had the extreme honor to travel to Norway with correctional leaders from California, Oregon, and Washington, on a sponsored delegation of the University of California San Francisco’s Amend project. Being able to see for myself the “Norway Model” and the positive ripple effects of using advanced decarcerating strategies and better systems of accountability, I brought home a deeper awareness of our responsibility to provide analysis of where Washington DOC is falling short of its goal to be a more humane corrections system. The OCO staff remains committed to supporting policy change aimed at achieving measurable improvements in public health and human rights in our state’s corrections system.

It is an honor to serve as the Director of the OCO and work alongside courageous public employees who are bold and persistent problem solvers. We thank you for supporting the Office of the Corrections Ombuds and our work to increase positive outcomes for the community we serve. As always, we remain optimistic that this annual report and our work empowers and makes a difference.

Sincerely,

Caitlin T. Robertson, Ph.D.
Director, Office of the Corrections Ombuds

INTEGRITY • RESPECT • COLLABORATION • EQUITY • COURAGE
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**Annual Report prepared by:**

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**Office of the Corrections Ombuds**

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**INTEGRITY · RESPECT · COLLABORATION · EQUITY · COURAGE**

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Executive Summary

In Fiscal Year 2023 (July 1, 2022, through June 30, 2023), the Office of the Corrections Ombuds opened 3,657 cases representing complaints from, or about, 1,779 incarcerated individuals. The office resolved 3,854 complaints during this time period.¹ The Office of the Corrections Ombuds (OCO) received over 5,000 calls, or an average of 456 calls for assistance each month through our hotline. The OCO is a small office, currently consisting of 13 dedicated public employees.

Complaints related to health care (medical, mental health, and dental) were the most frequently received type of concern in FY 2023.

Disciplinary cases and DOC staff conduct were the second and third most common types of complaint received in FY 2023.

The OCO successfully negotiated hundreds of positive outcomes (provided assistance) during FY 2023, ranging from individual concerns to systems changes. During this same time period, the OCO released 12 monthly outcome reports, provided comments on 14 proposed DOC Policy updates, and published 5 public reports.

The OCO doubled the number of public meetings to 8 by holding a quarterly meeting inside of a prison facility and a secondary meeting in the community to allow external stakeholders to participate.

The OCO values continuous improvement and the trust of the people incarcerated in the Washington Department of Corrections facilities and all our stakeholders. Please reach out if we can be of assistance.

To submit an online complaint, click HERE or go to: https://oco.wa.gov/submit-complaint

To subscribe to our OCO notification listserv and news bulletins click HERE or go to: https://public.govdelivery.com/accounts/WAGOV/subscriber/new?topic_id=WAGOV_158

Questions and/or comments about this report can be sent to:
Office of the Corrections Ombuds
P.O. BOX 40009
Olympia, Washington 98505
OCOCorrespondence@gov.wa.gov

¹ Closed case figures include cases that were closed as duplicates as well as those reopened for quality assurance purposes and closed at the conclusion of that review.
Core Duties

The Office of the Corrections Ombuds is an independent and impartial public office within the Governor's Office. The Office of the Corrections Ombuds (OCO) serves the state of Washington by helping to resolve issues involving people incarcerated in the Department of Corrections facilities. Through our casework and published reports, we work to promote a positive change in corrections.

The following duties and responsibilities of the Ombuds are set forth in state law:\(^2\):

- Maintain a statewide toll-free confidential hotline.
- Provide information and technical assistance to incarcerated individuals and stakeholders.
- Receive, investigate, and resolve complaints.
- Monitor and provide system oversight related to the health, safety, welfare, and rehabilitation of incarcerated individuals.
- Monitor and provide legislative and policy developments affecting correctional facilities.
- Submit an annual report by November 1\(^{st}\) of each year.
- Submit an annual report to the legislature on the status of the implementation of unexpected fatality review recommendations.

Budget and Expenditures

The Office of the Corrections Ombuds Fiscal Year 2023 budget and expenditures:

<table>
<thead>
<tr>
<th>Category</th>
<th>Allotment</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESSB 5119: Individuals in Custody - FY23</td>
<td>118,000</td>
<td>72,338</td>
</tr>
<tr>
<td>001-General Fund: Salaries and Expenses - FY23</td>
<td>1,437,390</td>
<td>1,535,890</td>
</tr>
<tr>
<td>A/ Employee Salaries and Wages</td>
<td></td>
<td>835,956</td>
</tr>
<tr>
<td>B/ Employee Benefits</td>
<td></td>
<td>330,216</td>
</tr>
<tr>
<td>C/ Professional Service Contracts</td>
<td></td>
<td>23,185</td>
</tr>
<tr>
<td>E/ Goods and Services</td>
<td></td>
<td>249,621</td>
</tr>
<tr>
<td>G/ Travel</td>
<td></td>
<td>24,521</td>
</tr>
<tr>
<td>J/ Capital Outlays</td>
<td></td>
<td>53</td>
</tr>
<tr>
<td>Total</td>
<td>$1,555,390</td>
<td>$1,535,890</td>
</tr>
</tbody>
</table>

\(^2\)RCW 43.06C and RCW 72.09.770
Top Ten Investigative Case Factors

The top ten most frequently reported topics of investigative cases in FY 2023 were:

1. Healthcare
2. Discipline/Behavior Observation Entries
3. Supervision/Staff Conduct
4. Classification
5. Property
6. Release
7. Safety
8. Resolution Program/Procedure
9. Programs
10. Visitation

![Bar chart showing the top ten investigative case factors with Healthcare at 855, Discipline/BOEs at 550, Staff Conduct at 544, Classification at 499, Property at 255, Release at 231, Safety at 223, Resolution Prog. at 199, Programs at 191, and Visitation at 150.]
Top Ten DOC Institutions of Incident Complaints

The OCO received the most complaints from the following ten DOC Institutions in FY 2023:

<table>
<thead>
<tr>
<th>DOC Institution of Incident</th>
<th>Cases Opened</th>
<th>Cases Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monroe Correctional Complex</td>
<td>661</td>
<td>634</td>
</tr>
<tr>
<td>Washington State Penitentiary</td>
<td>579</td>
<td>620</td>
</tr>
<tr>
<td>Stafford Creek Corrections Center</td>
<td>544</td>
<td>594</td>
</tr>
<tr>
<td>Airway Heights Corrections Center</td>
<td>496</td>
<td>556</td>
</tr>
<tr>
<td>Washington Corrections Center</td>
<td>392</td>
<td>384</td>
</tr>
<tr>
<td>Coyote Ridge Corrections Center</td>
<td>367</td>
<td>403</td>
</tr>
<tr>
<td>Washington Corrections Center for Women</td>
<td>231</td>
<td>243</td>
</tr>
<tr>
<td>Clallam Bay Corrections Center</td>
<td>106</td>
<td>111</td>
</tr>
<tr>
<td>Cedar Creek Corrections Center</td>
<td>59</td>
<td>64</td>
</tr>
<tr>
<td>Larch Corrections Center</td>
<td>36</td>
<td>41</td>
</tr>
</tbody>
</table>

Washington Public Records Act

Since its inception, the number and complexity of public disclosure requests received by the OCO has grown tremendously; in fact, between 2020-2023 we have witnessed an increase of 100+. In response to this surge, during FY2023 the OCO expanded our public records team and dedicated

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3 The closed case figures in this table include: 1) cases opened in the prior fiscal year; 2) cases that were closed as duplicates; and 3) cases that were reopened for review and then closed again.
resources to strengthening our internal processes related to records production and records management.

Additionally, in FY2023 we invested in a robust records request management system to ensure that we could continue to properly track and provide timely services to requestors. As of February 2023, requestors now have access to the OCO’s public records portal 24 hours a day and can communicate with the OCO public records team using their GovQA account.

The OCO continues to work to inform the public of the agency’s confidentiality rules and obligations, codified in RCW 43.06C.040 and 43.06C.060, as well as Chapters 138-10 and 138-12 WAC.

**OCO Action**

**Assistance Provided – Case Investigations**
The following are examples of investigative cases in which the OCO staff provided assistance or information to incarcerated individuals in prisons throughout the state of Washington.

**Individual Concerns**

**Access to Health Care**
- Patient reported pain and delayed access care; patient was later diagnosed with cancer.
- The OCO alerted facility and headquarters health services leadership; provided updates and self-advocacy information to patient; monitored and confirmed cancer testing, treatment, and follow-ups; and requested an appointment with a re-entry nurse to discuss access planning upon release.

**Termination from CI Job**
- Incarcerated individual reported termination from Correctional Industries (CI) employment for not having or pursuing a GED. However, GED classes for people requiring English as a Second Language (ESL) were not offered at AHCC at the time.
- The OCO identified AHCC lacked a facilitator for GED classes for ESL learners, communicated the concern to facility staff, CI staff and education staff, and recommended that the individual be allowed to work in CI without pursuing their GED until a facilitator is hired. DOC agreed to reinstate the individual’s CI employment.

**Safety Concerns**
- External person reported to the OCO that their loved one had concerns for his safety if his scheduled transfer was to take place.
- The OCO identified the individual was currently housed in a safe harbor facility, communicated the concern to DOC classification at headquarters, and asked for a full review of safety concerns and for the transfer to be halted pending the review.
The DOC agreed to cancel the transfer and allow the individual to stay at the safe harbor facility.

Improper Behavior Observation Entry

- An incarcerated individual reported receiving a negative Behavior Observation Entry (BOE) for asking for the OCO phone number.
- The OCO reviewed the negative BOE and verified the concern, communicated the concern to the Associate Superintendent, and recommended the negative BOE be removed immediately. DOC agreed and removed the BOE.

Mailroom Delay

- An incarcerated individual reported that letters sent to him in a language other than English sat in the mailroom for several months awaiting translation for review by mailroom staff despite DOC policy stating mail requiring translation will be issued to the individual within five business days.
- The OCO spoke to DOC leadership and requested the issue be addressed to ensure the individual received the mail as soon as possible. DOC agreed to issue the individual their mail and re-train the mailroom staff of the proper protocol for handling mail in another language.

Loss of Dental Partial

- An incarcerated individual reported their dental partial (denture) was not returned to them after placement in segregation. The individual reported staff packed his items and did not include the denture partial.
- OCO staff made immediate outreach to the facility to intervene prior to the partial being lost or thrown out. DOC was able to provide the partial denture directly to the individual.

Access to Gender-Affirming Care

- A transgender patient reported requesting access to Hormone Replacement Therapy (HRT) at multiple facilities for several years but not receiving it.
- The OCO alerted facility and headquarters health services staff and found the Care Review Committee (CRC) denial did not specify which criteria the patient did not initially meet or what actions were needed to meet the criteria. The patient was then assessed and approved for and began HRT treatment.

Failure to Update Custody Facility Plan Impacting Release Date

- An incarcerated individual reported DOC had not updated their Custody Facility Plan (CFP) for more than two years, preventing him from having a good conduct time (GCT) restoration plan finalized.
• The OCO substantiated that his CFP had not been updated for more than two years and requested DOC finalize the plan. DOC agreed to update the plan. The OCO confirmed DOC restored the individual’s GCT and nearly three years were taken off the individual’s release date.

Inaccessible Housing
• An incarcerated individual reported they were moved to a cell that was not compatible with their mobility needs.
• The OCO verified the move and requested DOC move them to a more appropriate cell. DOC agreed to immediately move the person and documented the person’s ongoing accessibility needs in the individual’s central file to prevent this from reoccurring in the future.

Lack of Mental Health Assessment
• An external person reported their loved one had developmental and mental health concerns that DOC had not reviewed and were worried for their loved one’s safety.
• The OCO contacted mental health and requested a mental health assessment and a housing review. DOC agreed to the assessment, assigned a mental health provider, and moved the individual to a different housing unit.

Sunlight is said to be the best of disinfectants.
- Justice Louise Brandeis (1914)
Systemic Concerns

**Mail:** The OCO convened a Mail Workgroup inviting internal and external stakeholders, including DOC staff responsible for the oversight of the mail program, to negotiate updates to the mail policies and practices. As a result of the Workgroup, over 20 negotiated outcomes were established including DOC agreement to review security standards for outgoing and incoming mail, revision to policies and practices, the removal of mail in a foreign language as a rejection reason for digital messages, creation of a DOC workgroup to review the definition of sexually explicit materials as well as provide updates to policy.

**COVID-19 Deaths:** The OCO reviewed the COVID-19 related deaths of 20 people under DOC care and made several recommendations to DOC including the continued utilization of a patient-centered care model that focuses on whole-person care, quarterly connections with local community hospitals by DOC medical providers, the establishment of an end-of-life decision support system, the development of hospice and palliative care models, and removal of barriers to alternative housing placements. DOC agreed with the report in substance and intent.

**Unfair Disciplinary Actions:** The OCO received multiple concerns from incarcerated individuals at Stafford Creek alleging unfair treatment and retaliation in the veteran’s pod which indicated the nine out of twelve Black men in the veteran’s pod received infractions. The OCO communicated directly with facility leadership about the matter which resulted in DOC opening an audit of the veteran’s pod infractions. Ultimately, the facility dismissed 56 infractions that impacted 13 individuals as a result of substantiating the infraction concerns.

**Withheld Payments for DNR Fire Crew:** The OCO received several complaints about withheld gratuity payments being terminated from the Department of Natural Resources Fire Crew. The OCO investigated this concern and identified inconsistencies in withheld payments and requested DOC amend the interagency agreement language to support paying workers for completed hours worked. While not funded to incur these costs, the Airway Heights Superintendent agreed to pay five AHCC fire crew workers out of the facility’s budget and the DOC leadership agreed to pay three Larch Corrections workers out of the department’s budget. DOC and DNR then worked to finalize a new interagency agreement to ensure gratuities are not withheld again.
Confidential Hotline
In Fiscal Year 2023, the OCO answered 5,476 total hotline calls with an average of 456 calls per month.

Facility Visits
In Fiscal Year 2023, the OCO staff completed 93 facility visits. This means that on average, OCO conducted in-person visits to incarcerated people and facility staff nearly twice per week.
Publications

The OCO continues to improve our investigation process with the goal of increasing positive outcomes for the incarcerated people we serve. During the fiscal year 2023 reporting period, the OCO issued the following publications⁴:

- Person-Centered Prevention and Management of Infectious Diseases Recommendations
- Two Special Reports:
  - 56 Dismissed Infractions Impacting 13 People - Stafford Creek Corrections Center
  - Earned Gratuity (Wages) Withheld After Termination - DNR/DOC Fire Crew
- Two Negotiated Outcome Reports:
  - Retaliation
  - Mail
- 12 Monthly Outcome Reports
- Policy Comments for revisions to the following policies:
  - DOC Policy 380.540 Vehicle Use in Partial Confinement
  - DOC Policy 420.310 Searches of Incarcerated Individuals
  - DOC Policy 440.000 Personal Property in Prisons
  - DOC Policy 440.020 Transport of Property
  - DOC Policy 450.100 Mail for Individuals in Prison
  - DOC Policy 460.000 Disciplinary Process for Prisons
  - DOC Policy 490.700 Transgender, Intersex, and/or Non-Binary Housing and Supervision
  - DOC Policy 500.000 Education and Vocational Programs in Prisons
  - DOC Policy 540.105 Recreation Programs in Prison
  - DOC Policy 590.100 Extending Family Visiting
  - DOC Policy 600.000 Health Services Management
  - DOC Policy 610.650 Outpatient Services
  - DOC Policy 620.020 Patient-Paid Healthcare
  - DOC Policy 700.000 Work Programs in Prisons

Monthly Outcome Reports: A Self-Advocacy Tool

The OCO investigates complaints regarding any actions or inactions of the DOC 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 of 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 a case for every complaint received by this office. We publish Monthly Outcomes Reports⁵ every month with all public decisions of the cases closed in that month. Additionally, we worked with the DOC to make sure that all our reports are

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⁴ All publications are available at the OCO website [HERE](https://oco.wa.gov/reports-publications) and at: https://oco.wa.gov/reports-publications/reports/monthly-outcome-reports

⁵ All Monthly Outcomes Reports (MORs) are available on the OCO website [HERE](https://oco.wa.gov/reports-publications/reports/monthly-outcome-reports) and at: https://oco.wa.gov/reports-publications/reports/monthly-outcome-reports
immediately available on the Securus tablets in the FYI application, and in all DOC-operated law libraries.

Based on feedback we received from incarcerated individuals, we updated our case closure reasons to better show data that reflects the outcomes reached and to provide greater transparency into the work of the office. The updated case closure reasons are as follows:

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

The following are key recommendations made by the OCO that remain outstanding as of October 2023:

<table>
<thead>
<tr>
<th>OCO Recommendations to the DOC</th>
<th>Issued</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOC should ensure that an individual’s mental health status is considered throughout the disciplinary process.</td>
<td>2021</td>
<td>Unresolved</td>
</tr>
<tr>
<td>DOC should reduce the frequency of placement and length of stay in any segregated housing for individuals with serious mental health conditions.</td>
<td>2021</td>
<td>Unresolved</td>
</tr>
<tr>
<td>DOC should explore best practices for successfully housing and treating individuals with behavioral challenges.</td>
<td>2021</td>
<td>Unresolved</td>
</tr>
<tr>
<td>DOC should equip DOC correctional officers and other staff with knowledge and skills needed to support individuals with mental health conditions.</td>
<td>2021</td>
<td>Unresolved</td>
</tr>
<tr>
<td>DOC staff should train all custody staff on using de-escalation tactics instead of force.</td>
<td>2021 &amp; 2023</td>
<td>Unresolved &amp; Re-issued</td>
</tr>
<tr>
<td>DOC should develop a comprehensive RTU [Residential Treatment Unit] policy that addresses:</td>
<td>2021 &amp; 2023</td>
<td>Unresolved &amp; Re-issued</td>
</tr>
<tr>
<td>a) objective criteria for admission;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) modified disciplinary system;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) modified classification system;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) pathway out of RTU, including objective criteria for discharge;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) mandatory specialized mental health training for RTU custody staff;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) programming availability in RTU (to include programming support).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOC should develop a comprehensive IBMP [Individual Behavior Management Plan] policy which may include:</td>
<td>2021 &amp; 2023</td>
<td>Unresolved &amp; Re-issued</td>
</tr>
<tr>
<td>a) objective criteria for who should or must have an IBMP;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) guidelines for incentives that may be used;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) guidelines for safety responses that may be used, including whether/when use of restraints may be part of an IBMP;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) mandatory training for all mental health providers that addresses how to write an IBMP;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) mandatory training for any DOC custody staff who routinely work with individuals who have IBMPs; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) routine audits of IBMPs by qualified headquarters staff.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DOC should **improve suicide prevention practices.** The OCO is aware that the DOC received one assessment (2015) and one reassessment (2023) from Lindsay Hayes, a nationally recognized expert in the field of suicide prevention within jails, prisons, and juvenile facilities.

The DOC **should publicly share its corrective action plan for each category of Mr. Hayes’ recommendations.**

DOC should **rename the Special Offender Unit (SOU).** The OCO encourages the DOC to remove the terminology “Special Offender Unit” and rename the unit to better align with its role as a mental health residential treatment unit.

<table>
<thead>
<tr>
<th>Ongoing Concerns with the Residential Treatment Units</th>
</tr>
</thead>
</table>

On March 13, 2023, the OCO received information, including the photographs below, from an anonymous complainant regarding the physical conditions of cells and allegations of mistreatment of two patients housed in the Residential Treatment Unit (RTU) at Monroe Correctional Complex, referred to as the “Special Offender Unit” (SOU). The photos depicted hazardous living conditions in two different cells and suggested a failure of custody, healthcare, and physical plant coordination and leadership. After reviewing the information, the OCO initiated an investigation into the conditions of confinement and medical treatment of two patients in the Residential Treatment Unit at Monroe.

On March 14, 2023, the OCO made an unannounced visit to MCC-SOU to ascertain the current conditions of these cells and speak with the two patients. While touring the living units, the OCO observed multiple unoccupied RTU cells in various stages of repair. The OCO discussed concerns with facility staff, who provided information about the steps taken to protect against a similar situation occurring again.

On March 15, 2023, the OCO urged the DOC to investigate the system failures that had allowed conditions in these RTU cells to deteriorate so significantly. The DOC agreed to initiate an internal...
systemic review. On June 6, 2023, the OCO received a copy of the Secretary Special Inquiry Review of the MCC-SOU.

On June 20, 2023, the OCO communicated recommendations to the DOC related to strengthening and enriching mental health care access and services throughout the DOC’s Residential Treatment Units. Some of these recommendations had been originally issued by the OCO in 2021 but remained unresolved (see table above) and were therefore re-issued.

On June 30, 2023, the DOC posted on its website a news spotlight including a “before” photo of a cell in MCC-SOU and an “after” photo of a different MCC-SOU cell. The news spotlight, “Humanity in Corrections – Treating Complex Mental Health Disorders in Prisons”⁶, included a link to a portion of a Secretary Special Inquiry Review which stated that the Secretary had launched the review to determine what improvements could be made to support individuals in the SOU.

While work continues to improve the RTUs statewide, many of the OCO’s recommendations remain unresolved. We are publishing these recommendations and related photos here in our annual report to ensure that Washington state policymakers are aware of this history and these incidents.

Simultaneous to this investigation and review, there was an alarming increase in deaths by suicide in the Department of Corrections’ Residential Treatment Units. Deaths by suicide occurred:

- February 20, 2023, in the Close Observation Area located in the MCC-SOU⁷
- May 17, 2023, in the RTU at the Monroe Correctional Complex⁸
- June 11, 2023, in the RTU at the Washington State Penitentiary⁹
- June 12, 2023, in the RTU at the Washington State Penitentiary¹⁰ and
- June 16, 2023, in the RTU at the Washington State Penitentiary¹¹.

All five suicides were independently investigated by the Department through its Critical Incident Review (CIR) process, and the deaths underwent an unexpected fatality review (UFR) by representatives of the Department of Health, the Health Care Authority, the Office of the Corrections Ombuds, and the Department of Corrections.

⁷UFR-23-004
⁸UFR-23-005
⁹UFR-23-007
¹⁰UFR-23-008
¹¹UFR-23-009
OCO staff continue to diligently monitor conditions in the Residential Treatment Units statewide. We will continue to examine the root causes that contributed to these inhumane living conditions with the objective that no one incarcerated by the Washington DOC will ever live in similarly deplorable conditions again.

Pro-Equity Anti-Racism (PEAR) Work

The OCO is committed to creating a culture that centers equity and belonging to sustain workplace diversity and we are collaborating to manifest a pro-equity anti-racism ecosystem in a multicultural Washington state where everyone flourishes and achieves their full potential now and for future generations. The OCO’s PEAR team was established in 2022 as directed in Executive Order 22-04 and under the direction of the Office of Equity. During Fiscal Year 2023, the OCO PEAR team undertook several projects to ensure that our small state agency works in a way that reduces disparities and improves equitable and just outcomes for everyone in Washington.

FY 2023 OCO PEAR work included:

- Identifying, developing, and launching a demographic data reconciliation project to ensure that OCO data properly reflects the data provided by incarcerated individuals to the Department of Corrections.

- Arranging showings of Race: The Power of an Illusion followed by thoughtful small group discussions about the content and connections to OCO work and office.

- Improving stakeholder engagement by holding quarterly meetings inside prison facilities in addition to quarterly hybrid meetings for non-incarcerated stakeholders. This change allowed for and resulted in increased feedback from incarcerated people on OCO work.

- Engaging in ongoing trauma responsive care training with the Center for Trauma-Responsive Practice Change. These trainings are provided to all staff and specialized coaching is provided to the supervisory team. The aim of the work is to enhance trauma-responsive practices used by staff and leadership of the OCO in order to empower disenfranchised persons and address issues of systemic oppression.
• Establishing a contract and implementing a process for having written OCO communications translated into languages spoken by OCO customers in an effort to reduce barriers to accessing OCO services for people whose primary language is a language other than English.

Additionally, throughout Fiscal Year 2023, the OCO Director was an active member of the DOC’s PEAR subgroup focusing on examining the DOC’s disciplinary and sanctioning processes. In Fiscal Year 2024, the DOC Secretary created a PEAR Advisory Board and invited the OCO Director to serve on the Advisory Board. The Board is scheduled to meet twice annually and tasked with: (1) monitoring the progress that DOC teams are making on their PEAR service line investments; (2) providing feedback and helping prioritize future service line investments; and (3) reviewing proposed updates to the DOC’s PEAR Strategic Plan.

Stakeholder Input

Historically, the OCO held public meetings in person and outside of prisons and transitioned to virtual meetings during the pandemic. The OCO public quarterly meetings for FY 2023 were all held inside a Washington DOC facility. We were excited about making this change to allow us to bring our public meetings directly to the stakeholders living inside WA DOC facilities. We are proud to include the voices of incarcerated people on our public platform. In addition to the public meetings inside of the prisons, we also held a secondary public meeting in a hybrid format that allowed stakeholders in the community to attend in person or virtually.

The 2023 Calendar Year OCO Quarterly Public Meeting Schedule

- January 6, 2023: Washington Corrections Center, Shelton
- January 26, 2023: Helen Sommers Building, Olympia
- April 26, 2023: Monroe Correctional Complex, Monroe
- April 28, 2023: Helen Sommers Building, Olympia
- July 6, 2023: Walla Walla Community College, Walla Walla
- October 6, 2023: Clallam Bay Corrections Center, Clallam Bay
- November 1, 2023: Helen Sommers Building, Olympia

In keeping with our PEAR principles, not only were OCO staff inside prisons presenting our quarterly data directly to the community we serve, we also worked with the DOC to guarantee that our

INTEGRITY • RESPECT • COLLABORATION • EQUITY • COURAGE
presentation materials were uploaded to all Securus Tablets and available to review in all DOC Law Libraries. All presentation materials are available on our public website here.

As part of the office’s 2023 strategic planning, we surveyed our community partners, including members of the Statewide Family Council as well as incarcerated individuals, asking for feedback on the work and function of the OCO. The responses were informative and played a significant role in the shaping of our new three-year strategic plan. A sample of this feedback is below:

The OCO's vision is a more humane Washington corrections system. To reach our vision, what should we work on first? Ranked Order, with 1 being the most important.

<table>
<thead>
<tr>
<th>Responses from Incarcerated Individuals</th>
<th>Responses from Community Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. DOC staff conduct</td>
<td>1. Healthcare access &amp; quality</td>
</tr>
<tr>
<td>2. Healthcare access &amp; quality</td>
<td>2. Individual investigations/negotiated outcomes</td>
</tr>
<tr>
<td>4. DOC policy recommendations</td>
<td>4. DOC staff conduct</td>
</tr>
<tr>
<td>5. DOC resolutions program</td>
<td>5. DOC policy recommendations</td>
</tr>
<tr>
<td>6. Classification</td>
<td>6. Classification</td>
</tr>
<tr>
<td>7. Legislative work (examples: Correctional Industries, building improvements)</td>
<td>7. Access to programming/education</td>
</tr>
<tr>
<td>8. Solitary confinement</td>
<td>8. DOC resolutions program</td>
</tr>
<tr>
<td>10. Other</td>
<td>10. Other</td>
</tr>
</tbody>
</table>

Looking to the Future

Throughout the summer and early fall of 2023 the OCO staff worked with our colleagues at Results Washington to develop a comprehensive three-year strategic plan. Our first task was to establish our vision, mission, and values. After a robust and collaborative process, led by our facilitators, we are pleased to share our new vision, mission, five core values, and strategic priorities.
OCO’s Vision

The Office of the Corrections Ombuds envisions a more humane and transparent Washington corrections system.

OCO’s Mission

The Office of the Corrections Ombuds is on a mission to provide opportunities for people impacted by incarceration to raise issues and resolve conflicts. We work to reduce harm in the Washington corrections system by negotiating outcomes, recommending positive change, and reporting individual and systemic concerns.

OCO’s Values

Integrity: We believe in honesty, transparency, and authenticity.

Respect: We are a compassionate, kind, and consistent organization. We value our collective humanity and dignity.

Collaboration: We work together to deliver objective communications and negotiations to positively impact the community we serve.

Equity: We recognize the importance of diversity and lived experience. We aim to provide equitable services to all people impacted by incarceration.

Courage: We are bold and persistent problem solvers. We work to safeguard the health, safety, and welfare of incarcerated individuals. We remain optimistic that our work empowers and makes a difference.

OCO Strategic Priorities for 2023-2026

For the next three years, we are prioritizing work that will achieve the following three key outcomes:

Public Communications & Education: Improve outreach, education, and access.

Comprehensive Investigations: Deliver individual resolutions and publish systemic recommendations that achieve positive and persistent change.

Capacity Building: Strengthen internal systems and processes to ensure continuity of quality services.
October 30, 2023

Dr. Caitlin Robertson  
Office of the Corrections Ombuds  
PO Box 40009  
Olympia, WA 98504-0009

RE: 2023 Annual Report

Dr. Robertson,

Thank you for the opportunity to receive and respond to the Office of Corrections Ombuds (OCO) 2023 Annual Report. The partnership between the Washington Department of Corrections (DOC) and the OCO is an integral part of fulfilling the department’s vision of working together for safer communities. Over the last year there have been many shared successes between our agencies and continued opportunities for partnership. We appreciate this opportunity to highlight updates on certain concerns noted in your report, milestones we have recently achieved, as well as the agency’s progress toward our agreed upon actions.

**Milestones**

The department’s mission is to improve public safety by positively changing lives, and we are committed to advancing safe and humane systems for the incarcerated population in our care. Recent milestones include the following:

**Solitary Confinement Transformation Project**

Recently, the department committed to further reducing its use of solitary confinement by 90% over five (5) years. The agency partnered with Integrated Solutions Group (ISG) and the Falcon Group to analyze our current use of solitary confinement and develop a comprehensive plan for achieving this significant reduction. Our team engaged hundreds of stakeholders in the process, including Disability Rights Washington, ACLU of Washington, Teamsters Local 117, and the OCO. The final plan represents an innovative, industry-leading initiative and prioritizes the safety of our staff and incarcerated population. We are excited to work with the OCO in bringing it to fruition.

**Classification Model Modernization**

The department has contracted with a nationally recognized expert to build, modernize, and update our classification tool. Washington State correctional system data will more accurately predict the risk of prison misbehavior and assign appropriate resources, while also working to address ethnic disparities and improve gender responsiveness. The department hopes to complete this modernization by the end of calendar year 2024.
Reimagine Washington Corrections Center (WCC)
The goal of Reimagine WCC is to reduce the duration of our intake process to below the 30-day industry benchmark, while reducing the overflow in WCC reception. Today, initial classifications occur within 60-90 days, on average, and the project is focused on reviewing the work streams, capacity, and flow of incarcerated men entering prison. Since its inception the project has maintained a bottom-up approach, ensuring staff working closest to intake, and with the most experience, are providing long term solutions to these barriers. The Reimagine WCC team has crafted recommendations and implemented some of the suggestions for improving and streamlining the intake process. The team has also generated improvements for initial classification, health services, clerical work, record keeping, and transportation. The combined results of these improvements are leading to a more efficient intake and classification process, less congestion, and a more humane and effective reception process for our incarcerated individuals.

Washington Way (AMEND)
Washington Way represents an innovative approach to corrections and improving our prison environment by focusing on improvement in the lives of the incarcerated, staff wellness, and public safety. The department has successfully implemented trainings for staff across the state and added legislatively funded resource teams at several facilities. The department is pleased to provide the following specific example of Washington Way in operation.

A Success Story: Prior to being involved in Washington Way, an incarcerated individual lived in isolation while on maximum custody for more than ten (10) years. Refusing to live in general population, he stated “I am the real deal, a stone-cold killer.” He displayed nonverbal behaviors with staff and other incarcerated individuals while sitting in his cell for 23 hours per day, refusing recreation, and only leaving his cell to shower.

A Washington Way resource team began working with this individual, normalizing interactions, and taking time to converse and be present and engaged. The team learned he was a former veteran with past trauma and afraid to live around other incarcerated individuals. With this information, the team immediately began exploring his possible transition from Restrictive Housing to the Veterans Unit. The team facilitated a visit from the Veterans Unit Custody Unit Supervisor, an incarcerated mentor and dog handler, as well as the unit counselor. Highlighting the culture of the Veterans Unit through a normalized and informal conversion, the individual was given the opportunity to ask questions about the Veterans Unit while spending positive time with the unit’s dog. Following the meeting, the individual agreed to transition to lower custody.

After nine (9) months, this individual is thriving in general population, laughing, smiling, and leading conversations in large groups. This one example represents the incredible, transformative impact of the Washington Way program.

Below, please find our progress and status as to the systemic items the OCO noted in this report.

Mail Policy and Procedure
The department is revising its mail policy to improve clarity surrounding “rejection” words, the definition of sexually explicit mail, and the videogram (tablet) dress code. The Correctional Services team conducted a survey of all other states, regarding their definition of sexually explicit mail, and inconsistencies exist across state correctional agencies.
A multi-agency workgroup was established to review and update the agency’s definition, using the survey results. The workgroup consisted of representatives of the Attorney General’s Office, OCO, DOC Sexual Offense Treatment Program, the Office of the Secretary of State, DOC’s Security Management Unit, and DOC’s Programs and Services Unit. The workgroup reached consensus on an updated definition. Once the updated policy is approved, we anticipate this will result in fewer rejections, which will positively impact incarcerated individuals and their loved ones.

The videogram dress code requirements have also been revised. Those utilizing videograms are no longer required to follow in-person visit room regulations and now have separate clothing guidelines. The department believes this separation to be an effective distinction and is expected to result in fewer videogram denials.

Lastly, the department published a news spotlight for these collaborative efforts between the DOC mail team and OCO staff, which can be viewed on the agency webpage at News Spotlight: Mail Services Workgroup Summary.

COVID-19 Deaths
During the COVID-19 pandemic the department brought its full resources and focus to secure the safety of incarcerated individuals and staff to reduce the chance of infection. We are proud of the agency’s efforts during this unprecedented emergency, as our mortality rates were low by comparison to other states. That said, the department recognizes the death of any incarcerated individual within Washington’s prison system is a tragedy, and those listed in the OCO report are no exception.

As we exit the COVID-19 pandemic the department is committed to continuously advance improvements in its Health Services (HS) Division. The DOC agrees with the OCO’s recommendation in their COVID-19 Death’s report on the importance of developing the patient-centered care model for improving the health and wellbeing of our incarcerated population. The agency’s development of the Patient Centered Medical Home (PCMH) model addresses this primary concern noted by the OCO, and the following update is provided on the progress of that program.

The department appreciates the legislature’s support by funding allocations to advance HS improvements in PCMH implementation and the development of Electronic Health Record (EHR) system requirements. This support plays a vital role in advancing the department’s health care system, and it has allowed for the addition of a quality assurance team dedicated specifically to HS.

HS continues to redesign its health care delivery to a PCMH model, which is focused on improving patient access to care. We are currently in the process of staff training, providing LEAN tools and philosophy throughout our correctional facilities. The goal of PCMH is to:

- Reduce the amount of time patients wait for service;
- Reduce staff performing duplicated efforts;
- Lessen documentation time; and
• Reduce emergency trips for patients to external care sites by providing preventative services and continuity of care on-site.

HS teams at each location are working to reduce waste through workshops, improving communication with daily huddle boards, and collocating staff to increase working together. Overall, there are 20 care design improvements currently being tested and implemented. To date, PCMH implementation and design improvements have achieved a significant reduction in the backlog associated with patient waiting times, improving both quality and access to care.

We are proud of this work and excited for staff and incarcerated individuals witnessing these improvements in real time. The department looks forward to collaboratively working with the OCO to continue improvements to critical health services and providing future PCMH updates.

**Withheld Payments for Department of Natural Resources (DNR) Fire Crew**

The department appreciated the opportunity to collaborate with the DNR, the OCO, and the Governor’s Office to amend the interagency agreement governing DOC fire crew payments, to appropriately provide compensation for incarcerated individuals. This represents effective and constructive issue resolution for the incarcerated population, and we appreciate the OCO bringing this to our attention.

**Ongoing Concerns with the Residential Treatment Units (RTU)**

When the Monroe Correctional Complex Special Offender Unit (SOU) vacant cell conditions were initially reported to DOC leadership, Secretary Strange immediately called for a systemic review, Secretary Special Inquiry Review, available here. This review of the overall RTU operations, environments, and processes, included a root cause analysis and resulted in a Corrective Action Plan (CAP) developed by the agency for continuous action.

*Immediate action to address reported SOU cell condition*

This CAP resulted in the formation of a workgroup to develop policy and protocol to guide all operational, clinical, and classification aspects of RTU care. The workgroup consists of five (5) subcommittees to address specific RTU components, including: Treatment, Unit Operations,
Discipline, Classification and Programs as follows.

- **Treatment**
  This subcommittee focuses on identifying the RTU processes, from admission through discharge from care. This will include criteria for admission and discharge, therapy services provided while in care, and treatment planning expectations.

- **Unit Operations**
  This subcommittee focuses on tailoring custody functions to meet the needs of individuals with mental illness in the RTU. This will include training expectations for the Correctional Officers, among other things.

- **Discipline**
  This subcommittee focuses on refining draft policy developed and piloted at MCC and WCCW.

- **Classification**
  This subcommittee focuses on creating a new classification system solely for incarcerated individuals while they reside in the RTU.

- **Programs**
  This subcommittee focuses on a plan for the educational, recreational, and employment needs of incarcerated individuals with mental illness in RTU. This includes how the current employment structure should be adapted to allow more individuals to gain the experience, support, and sense of productivity in having a job.

These subcommittees are not mutually exclusive. While developing their individual guidelines, there is also an intent to coordinate, providing an integrated approach to meeting the comprehensive needs of the incarcerated residing and working in these units.

Suicide prevention is a high priority across all subcommittees and has a direct connection to many within our population. It is important to note the DOC does not correlate SOU cell conditions with the suicides experienced at the Washington State Penitentiary (WSP). The suicides at WSP were reviewed in depth during their statutorily required Unexpected Fatality Review (UFR). In each of these reviews, cell conditions were not cited as a contributing factor. These reports are publicly posted on the agency’s website [here](#).
Facility improvements include these tier safety bars at WSP and MCC to prevent self-harm

As we continue to focus on meeting the specific medical needs of those with serious mental illness, the agency is also taking steps to minimize opportunities for self-harm. In recent months the DOC has implemented facility improvements to prevent extreme actions by the incarcerated population. For more information on the department’s suicide prevention work please see the following agreed upon action updates.

Agreed Upon Actions – Updates to OCO Recommendations
The department provides the following updates for the OCO’s unresolved recommendations identified in the 2023 Annual Report.

**OCO Recommendation**
DOC should ensure that an individual’s mental health status is considered throughout the disciplinary process.

**DOC Update**
The department is reviewing data from two disciplinary process pilot programs that occurred in 2021 and 2022. This work along with ongoing training, will be used to identify ways to assure mental health status is considered during the disciplinary process. Policy [460.000 Disciplinary Process for Prisons](#) was updated to incorporate processes that considers the need for additional mental health support during the disciplinary process.

**OCO Recommendation**
DOC should reduce the frequency of placement and length of stay in any segregated housing for individuals with serious mental health conditions.

**DOC Update**
In October 2023, the DOC released a Solitary Confinement Transformation Project report outlining the department’s plan to reduce solitary confinement by 90% over the next 5 years. You
can review the plan on the department’s webpage PRESS RELEASE: DOC Takes Next Step Towards Reducing the Use of Solitary Confinement | Washington State Department of Corrections. The plan identifies many issues to overcome when reducing the frequency of placement, and length of stay in solitary confinement.

**OCO Recommendation**
DOC should explore best practices for successfully housing and treating individuals with behavioral challenges.

**DOC Update**
In the Solitary Confinement Transformation Project noted above, strategies for addressing behavioral health challenges and need for treatment resources are identified. Our partnership with AMEND and the implementation of the Washington Way will allow the department to advance these practices as part of our overall effort to house and treat individuals with behavioral challenges.

**OCO Recommendation**
DOC should equip DOC correctional officers and other staff with knowledge and skills needed to support individuals with mental health conditions.

**DOC Update**
The DOC has completed work with the AMEND Partnership to deliver two four-hour sessions of in-person annual training for DOC staff. The first session focuses on an increasing relationship building strategies and skill building for those working directly with the incarcerated population. The second session focuses Dynamic Security, or the mindset that security is more than the physical and restrictive practices our department employs.

In September 2023, the DOC was awarded a Department of Justice System Grant providing funds for development of supplemental training on working with individuals suffering from mental illness.

**OCO Recommendation**
DOC staff should train all custody staff on using de-escalation tactics instead of force.

**DOC Update**
The department has requested funding to support an additional “Training Enhancement” for correctional custody staff. The intended purpose is to provide tenured staff (i.e., 3 or more years) with refresher training on communication, de-escalation, and foundational corrections practices. DOC training staff are also working to revise the Correctional Worker CORE Academy curriculum. This collaborative, agency-wide, effort will include amend principles and is anticipated to extend the total training from 28 to 35 days due to the inclusion of additional material.

**OCO Recommendation**
DOC should develop a comprehensive RTU policy that addresses:
- a) Objective criteria for admission;
- b) Modified disciplinary system;
- c) Modified classification system;
d) Pathway out of RTU, including objective criteria for discharge;
e) Mandatory specialized mental health training for RTU custody staff; and
f) Programming availability in RTU (to include programming support).

**DOC Update**

The essential work to improve the Residential Treatment Unit (RTU) is currently under review by the department in partnership with the OCO and Disability Rights Washington (DRW). The RTU workgroup first met in October 2023, with a focus on developing a comprehensive RTU policy to address these individual recommendations. While working on identified areas of improvement, the workgroup is currently preparing RTU policy and procedural recommendations for agency leadership. We look forward to continuing this important work in collaboration with our OCO and DRW partners.

**OCO Recommendation**

DOC should develop a comprehensive IBMP policy which may include:

- a) Objective criteria for who should or must have an IBMP;
- b) Guidelines for incentives that may be used;
- c) Guidelines for safety responses that may be used, including whether/when use of restraints may be part of an IBMP;
- d) Mandatory training for all mental health providers that addresses how to write an IBMP;
- e) Mandatory training for any DOC custody staff who routinely work with individuals who have IBMPs; and
- f) Routine audits of IBMPs by qualified headquarters staff.

**DOC Update**

Health Services created a protocol for the management of challenging mental health patients to complement DOC 630.500. This was updated in September 2023 to better align with the Washington DOC Health Plan.

All mental health staff were trained in June of 2021, followed by two subsequent refresher trainings. Training is now incorporated into the employee onboarding process, and the department remains committed to training custody staff over time.

**OCO Recommendation**

DOC should improve suicide prevention practices. The OCO is aware that the DOC received one assessment (2015) and one reassessment (2023) from Lindsay Hayes, a nationally recognized expert in the field of suicide prevention within jails, prisons, and juvenile facilities.

The DOC should publicly share its corrective action plan for each category of Mr. Hayes’ recommendations.

**DOC Update**

The department is working on advancing and improving its suicide prevention practices. Taking direct action from Lindsay Hayes’ assessment of the agency’s suicide prevention practices, along with many procedural improvements, the department has achieved many advancements to support suicide prevention within Washington correctional facilities. Once this corrective action plan is finalized, the department will create a communications plan to share with our external partners.
Recent accomplishments include the following:

- Established private, confidential settings for mental health screening and evaluations in all restrictive housing units.

- Weekly mental health checks are now required in restrictive housing as well as requiring a face-to-face meeting with anyone who indicates psychiatric decompensation.

- The department is working with the Washington Association of Sheriffs and Police Chiefs to encourage jails to use a release and transfer form, ensuring important medical and mental health information is shared between county jails and the DOC.

**OCO Recommendation**

DOC should Rename the Special Offender Unit (SOU). The OCO encourages the DOC to remove the terminology “Special Offender Unit” and rename the unit to better align with its role as a mental health residential treatment unit.

**DOC Update**

The department is excited to report the SOU staff and incarcerated patients are conducting a contest to rename the unit. We expect to have this effort completed by January 2024.

The department is extremely proud of the significant progress toward operating a safe and humane corrections system and partnering with our stakeholders to transform lives for a better Washington. We recognize our work is not done, and the DOC remains fully committed to its partnership and collaboration with the Office of the Corrections Ombuds.

Thank you,

Cheryl Strange
Secretary

cc: Barbara Sorano, Policy Advisor, Office of the Governor
Sean Murphy, Deputy Secretary, DOC
Don Holbrook, Assistant Secretary, Prisons Division, DOC
MaryAnn Curl, M. D., Chief Medical Officer, DOC
Dave Flynn, Assistant Secretary, Health Services Division, DOC
Scott Edwards, Assistant Secretary, Budget, Strategy & Technology, DOC