OFFICE OF THE
CORRECTIONS
OMBUDS

Monthly Outcome Report
March 2024

Unexpected Fatality Reviews: 2

Case Investigations: 226

Assistance Provided: 30
Information Provided: 90
DOC Resolved: 36
Insufficient Evidence to Substantiate: 16
No Violation of Policy: 54
Substantiated: 0

Intake Investigations: 50

Administrative Remedies Not Pursued: 29
Declined: 7
Lacked Jurisdiction: 6
Person Declined OCO Involvement: 4
Person Released from DOC Prior to OCO Action: 4

Resolved Investigations:
278
Assistance or Information Provided in
53%
of Case Investigations

OCO Casework Highlights

March 2024

Assistance Provided

Reported Concern: Person reported being held on segregation status for an extended amount of time and stated that DOC has not given them a notice for hearing and are past timelines for that.
OCO Actions: The OCO reviewed this concern and found that the DOC was past timelines for the hearing. The individual was infracted in July and did not have their hearing until September. After the hearing, the individual appealed the decision and did not receive the appeal response until December.
Negotiated Outcomes: This office contacted the facility to discuss the delays in the timeline and to request a review of the individual's custody facility plan so they could transfer from MAX custody to close custody. The DOC agreed and the individual is now scheduled for transfer.

Assistance Provided

Reported Concerns: External person reports that her loved one's life is in danger at the current facility they are housed, and that the person is currently being held in restrictive housing.
OCO Actions: The OCO reviewed this individual's custody facility plan and saw the plan indicated the individual was medium custody and should have been transferred. This office contacted DOC headquarters and asked for a transfer to the appropriate facility. The individual had a medical hold that was hindering the transfer, however the individual was refusing transport to the appointment.
Negotiated Outcomes: The medical hold was removed, the individual was transferred, and will continue care at the new facility.

Assistance Provided

Reported Concerns: Incarcerated individual relayed concerns regarding placement on MAX custody.
OCO Actions: The OCO went to the facility to speak with the individual several times to discuss this concern, reviewed the individual's infraction records as well as recent custody facility plans and spoke with DOC staff at the facility leadership level as well as at headquarters regarding this.
Negotiated Outcomes: DOC decided not to place the individual on MAX custody and this office was able to inform the individual of this decision along with DOC facility leadership in person.

Unexpected Fatality Reviews

RCW 72.09.770 requires the Department of Corrections 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 the DOC and the legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for incarcerated individuals in the DOC's custody.

UFR-23-012: The Unexpected Fatality Review Committee reviewed the unexpected death of a 64-year-old person in August 2023. The Unexpected Fatality Review Committee Report dated March 3, 2024, and the Unexpected Fatality Review Correction Action Plan (CAP) dated March 13, 2024, are publicly available documents.

UFR-23-021: The Unexpected Fatality Review Committee reviewed the unexpected death of a 64-year-old person in November 2023. The Unexpected Fatality Review Committee Report dated March 19, 2024 is a publicly available document, and the Unexpected Fatality Review Correction Action Plan (CAP) dated March 29, 2024, are publicly available documents.

The Office of the Corrections Ombuds has included these UFR reports and UFR CAPs at the end of this Monthly Outcome Report.

MONTHLY OUTCOME REPORT: MARCH 2024

	COMPLAINT SUMMARY	OUTCOME SUMMARY	CASE CLOSURE REASON
UNEXPECTED FATALITY REVIEWS			
Monroe Correctional Complex			
1.	External person reported secondhand information about an incarcerated person passing away at the facility.	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-23-012 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The committee recommended the following corrective actions: 1. DOC Health Services should update the performance metrics to monitor the effectiveness of blood pressure treatment. 2. DOC Health Services should adopt a statewide standard system to support the effective management of high blood pressure. Additional recommendations not directly linked to the cause of death included: 1. DOC should continue to pursue funding for an electronic health record (EHR) to replace paper health records and to support interface with community health systems. 2. DOC should ensure required tasks are completed and documented in accordance with policy and unit post orders. 3. DOC should review the process to improve paper record processes while awaiting an EHR. 4. DOC should review the process for documenting alert button activation including when an incarcerated individual declines services after activating the alert button. 5. The OCO requests DOC consider changing the name of "tier-checks" to "wellness-checks" to reinforce the purpose of the checks to ensure appropriate behavior and wellbeing of the incarcerated individual.	Unexpected Fatality Review

2.	Family reported concerns about their loved one passing 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-23-021 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The following recommendations accompanied the UFR Report: 1. DOC should conduct a multi-disciplinary Healthcare Failure Mode and Effect Analysis (H-FMEA) to look at this case in addition to two other cases previously identified with care delays. 2. DOC should explore the development of a tracking tool for external provider consult reports and test results. 3. DOC should look for opportunities to continue partnering with DOH on nutrition and unintended weight loss support resources. 4. DOC should continue to implement the Patient Centered Medical Home model of care to offer multidisciplinary team support and care planning for individuals with nutritional and weight related challenges. 5. DOC should explore removing the word "offender" from the DOC electronic death report.	Unexpected Fatality Review

CASE INVESTIGATIONS

Airway Heights Corrections Center

3.	Person reported that he accepted enrollment into a treatment program, but expressed concerns about the unit he would have to transfer to complete that program. Person said that he has completed this program in the past, but DOC is not considering that. Person said there is a lack of alternative treatment programs, and he has been denied attempts to get into behavioral programs.	The OCO provided assistance. The OCO reviewed this individual's custody facility plan and program referrals and found that he was not yet enrolled in the behavioral and treatment programs. The OCO reached out to DOC staff, who said that he has not been transferred into the unit for the treatment program due to space availability in the unit. DOC staff also said that he did not meet the minimum requirements for the behavioral program, and that they would note that it was no fault of his own that he did not do the program, so it would not be held against him in the future. After the OCO's outreach, this individual was transferred to the unit for the treatment program.	Assistance Provided
4.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found that the individual's behaviors did not meet the entirety	Assistance Provided

		of the WAC elements. After OCO discussed this with DOC, DOC agreed to lower the infraction to a general infraction.	
5.	Person has been held on segregation status for an extended amount of time. They have not given him a notice for hearing and are past timelines for that.	The OCO reviewed this concern and confirmed that the DOC was past timelines for the hearing. He was infracted in July and did not have his hearing until September. After the hearing, he appealed the decision and did not receive the appeal response until December. This office contacted the facility to discuss the delays in the timeline and to request a review of his custody facility plan so he could transfer from MAX custody to close custody. The DOC agreed and he is now scheduled for transfer.	Assistance Provided
6.	An incarcerated individual wrote into the OCO requesting assistance being moved out of segregation.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO verified that the person was placed back into general population prior to the OCO receiving the letter requesting assistance.	DOC Resolved
7.	Incarcerated individual relayed concerns regarding DOC not providing tools to make gifts for a cultural event.	The OCO reviewed the corresponding grievance and confirmed that DOC resolved this concern prior to OCO involvement as DOC provided the tools that are now located in the tool crib in the cultural event room.	DOC Resolved
8.	Incarcerated individual relayed concerns regarding DOC not providing tools to make gifts for a cultural event.	The OCO reviewed the corresponding grievance and confirmed that DOC resolved this concern prior to OCO involvement as DOC provided the tools that are now located in the tool crib in the cultural event room.	DOC Resolved
9.	Incarcerated individual expressed concerns about being classified as minimum custody but being housed in a medium custody unit.	The OCO confirmed that DOC resolved this concern prior to OCO involvement as the individual now resides in a minimum custody unit.	DOC Resolved
10.	External person reports concerns about their incarcerated loved one's access to mental health medication.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO requested a release of information (ROI) signature from the patient in order to access mental health information and the patient reported the issue had been resolved.	DOC Resolved
11.	Incarcerated individual relayed concerns regarding an infraction related to a PREA investigation.	The OCO confirmed that DOC resolved this concern prior to OCO involvement. The infraction is no longer visible on the individual's record as DOC dismissed the infraction on appeal.	DOC Resolved
12.	Person reported that his eyes developed a sensitivity to light after an infection, and that he has been trying to get sunglasses. Person said that it is DOC's responsibility to provide them, because he is indigent and cannot get them at commissary.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reached out to DOC staff who confirmed that this individual received sunglasses from medical and was given disposable clip-on sunglasses in the interim while they waited for the sunglasses to arrive.	DOC Resolved

13.	Incarcerated individual reports concerns regarding a staff member's actions.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed the department's investigation of the incident and found they resolved the staff issue with action per DOC internal protocols.	DOC Resolved
14.	Incarcerated individual relayed concerns regarding DOC not providing tools to make gifts for a cultural event.	The OCO reviewed the corresponding grievance and confirmed that DOC resolved this concern prior to OCO involvement as DOC provided the tools that are now located in the tool crib in the cultural event room.	DOC Resolved
15.	Person reports DOC is not complying with the Disability Rights Washington (DRW) settlement that allows transgender individuals to have a health status report (HSR) for sweatpants. Individual reports custody staff are no longer allowing trans people to wear their HSR sweatpants out of cell.	The OCO elevated this concern to the DOC transgender settlement administration and provided the individual with the following updated information related to HSR sweatpants: HSRs for sweatpants are intended for post-op patients and an error in the health services protocol was found. DOC is moving forward with identifying women's pants options for transgender women at men's prisons. DOC will prioritize people with current HSRs for the new pants once they are available, but they will eventually be added to property and issued as state clothing. Sweatpants can still be worn in cell.	Information Provided
16.	Incarcerated individual relayed concerns regarding the denial of a tort claim.	The OCO informed the individual that this office does not have jurisdiction over a tort claim, and are unable to assist with the tort claim denial.	Information Provided
17.	An incarcerated person reports they need updated prescription glasses and DOC is not scheduling them for an appointment.	The OCO provided information regarding self-advocacy steps the person can take and verified that the resolution program did provide an appropriate response to their grievance.	Information Provided
18.	Incarcerated individual relayed concerns regarding their sentence being incorrectly calculated.	The OCO reviewed the individual's grievance related to this concern and see that the records department reviewed the sentence structure and verified that the conditions were still valid on their current conviction and the sentence was properly calculated.	Information Provided
19.	Incarcerated individual relayed concerns regarding having to quit their job due to medical reasons that resulted in an infraction that was dismissed and not being able to get another job.	The OCO reviewed the individual's infractions and job referrals and verified the infraction was dismissed and the job referrals were open before the termination and were reopened with the same priority level. Per the individual's risk level classification (RLC) employment needs are moderate, meaning the individual will not be at the top of the job list.	Information Provided
20.	An individual was the victim of a substantiated prison rape elimination act (PREA) violation. This person requested the PREA investigation from DOC records and was told by DOC staff that	The OCO provided information about how to appeal an exemption denial for this person's DOC public records request.	Information Provided

	some information would be redacted.		
21.	Incarcerated individual relayed concerns regarding being eligible for camp but not wanting to go there because of mental health concerns.	The OCO spoke to DOC headquarters regarding the placement decision and confirmed that the camp placement decision was a collaboration between custody and mental health.	Information Provided
22.	Incarcerated individual expressed desires to change DOC policy to protect and restore those who suffered any loss due to an infraction that is later found not guilty or reversed dismissed on appeal.	The OCO noted the individual's desired policy changes and informed the individual that when DOC policy 460.000 is up for review, the OCO will consider these policy comments in making policy change recommendations to DOC. The OCO also informed the individual that they can submit policy comments directly to DOC headquarters when the policy is up for review.	Information Provided
23.	Incarcerated individual relayed concerns regarding staff conduct related to a delayed PREA investigation.	The OCO reviewed the individual's staff conduct grievances but was unable to locate one related to specific staff conduct regarding a PREA investigation. However, the OCO reviewed the corresponding infraction as well as the PREA investigation and noted that the infraction was the result of an unfounded PREA report that was addressed within proper timeframes.	Insufficient Evidence to Substantiate
24.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials but were unable to identify evidence to substantiate the individual's account of the events. As a result, there was insufficient evidence to substantiate the concern.	Insufficient Evidence to Substantiate
25.	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 behaviors met the infraction elements.	No Violation of Policy
26.	Incarcerated individual relayed concerns regarding an infraction they received.	The OCO reviewed the infraction materials related to the concern and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
27.	Incarcerated individual relayed concerns regarding an infraction they were given for breaking a cell confinement sanction that stemmed from an infraction that was later dismissed.	The OCO reviewed the infraction and find there is no violation of policy even though the infraction that resulted in the cell confinement sanction was dismissed on appeal as sanctions are not stayed while an infraction is under appeal.	No Violation of Policy
28.	Person reports that he is being forced to take programming that is not ordered by the courts. The person states his HIPAA rights were violated because other people could see his writing assignments.	The OCO was unable to substantiate a violation of policy by DOC. Per RCW 72.09.460 all incarcerated individuals will be required to participate in department-approved education programs, work programs, or both, unless exempted as specifically provided in this section. Eligible incarcerated individuals who refuse to participate in available education or work programs available at no	No Violation of Policy

		charge to the incarcerated individuals shall lose privileges according to the system established under RCW 72.09.130. OCO staff also provided the person with information on how to report a potential HIPAA violation to the U.S. Department of Health and Human Services.	
29.	Person reported wanting to get a surgery and wanted a mental health committee to review his case.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed DOC records and found that this individual's case was reviewed by the Care Review Committee (CRC) and was considered by DOC to be level 3: not medically necessary care and not authorized to be provided. Services associated with the diagnoses listed in level 3, even if appropriate, cannot be authorized by an individual provider or CRC. Incarcerated individuals may receive level 3 care under DOC policy 600.020 at their own expense if certain conditions are met.	No Violation of Policy
	Cedar Creek Corrections Center		
30.	An incarcerated person contacted the OCO requesting help with two boxes of property that did not transfer with them at their latest facility transfer.	DOC staff resolved this concern prior to the OCO taking action on this complaint. Per DOC the two missing boxes were shipped separately by chain bus and they verified that it still had not been sent but was scheduled to be sent.	DOC Resolved
31.	Person reports they are about to be transferred and have concerns about how their medical needs will be met during the long drive. They are requesting to go to a facility that is closer to minimize the risk.	DOC staff resolved this issue prior to OCO action. OCO staff contacted the patient's facility to request the plan for moving this person with their medical needs addressed. DOC medical staff provided the patient with pain management and the person was moved by a special transport to allow for stops. OCO verified the person was transferred without incident.	DOC Resolved
32.	An incarcerated person reported that their good conduct time was not being awarded properly.	The OCO confirmed that DOC resolved this concern prior to OCO action as DOC has been awarding the individual their good conduct time in accordance with policy.	DOC Resolved
33.	Incarcerated individual reports concerns regarding an assessment he received and requested the OCO review the assessment as he does not feel it is accurate.	The OCO provided information regarding requesting a re-assessment. The OCO reviewed the assessment and found that it was completed per DOC policy. The individual is not currently in the programming prompted by this assessment, and there are no referrals on file at this time. The OCO shared how to request a re-assessment through his classification counselor.	Information Provided
34.	Incarcerated individual requests the OCO review a confidential investigation involving himself.	The OCO provided the individual with information regarding the investigation process. The OCO found the DOC is actively investigating and DOC has not made a final determination. The OCO spoke with	Information Provided

		DOC staff about the investigation and compared the status to the DOC investigation protocol. The OCO found DOC is currently completing the investigation per policy. The OCO shared with the individual how the investigation process works and how he will receive a response from DOC.	
35.	Incarcerated individual relayed concerns regarding being demoted due to refusing chemical dependency treatment which they state they had already completed, resulting in an infraction.	The OCO was unable to identify a violation of DOC policy. The OCO verified that the individual completed an alcohol treatment program during a previous incarceration and was then convicted for a new alcohol related crime, meaning that DOC will require the individual to complete a new treatment program.	No Violation of Policy
	Clallam Bay Corrections Center		
36.	External person reports that her loved one's life is in danger at the current facility he is housed at. He is currently being held in restrictive housing.	The OCO reviewed this individual's custody facility plan and saw the plan indicated he was medium custody and should have been transferred. This office contacted DOC headquarters and asked for a transfer to the appropriate facility. He had a medical hold that was hindering the transfer, however the individual was refusing transport to the appointment. The medical hold was removed and he will continue care at the new facility.	Assistance Provided
37.	Person reported he is unable to access the medication assisted treatment (MAT) program in the timeframe set by the MAT protocol. The person is requesting to start the MAT induction process.	The OCO provided assistance by contacting DOC staff and requesting the MAT protocol be initiated for this patient. DOC reported limitations to the number of patients in that facility who could be on the MAT program. OCO staff contacted DOC leadership to notify them of the limitations being faced by the facility to assist in resourcing expanded access to the program. The OCO is engaged in ongoing discussions with the DOC on expanding access to the MAT program in all facilities.	Assistance Provided
38.	Incarcerated individual relayed concerns regarding an infraction.	The OCO spoke to DOC regarding the infraction as the infraction narrative did not meet the required WAC elements. As a result of this outreach, DOC agreed to dismiss the infraction.	Assistance Provided
39.	Incarcerated individual relayed concerns regarding extended placement in segregation.	The OCO confirmed this concern was resolved by DOC prior to OCO involvement as the individual is no longer housed in segregation.	DOC Resolved
40.	Person reports he is concerned about his placement at DOC.	The DOC resolved this concern prior to OCO taking action on this complaint. The OCO reviewed this person's custody facility plan and determined he has been transferred to the facility he requested.	DOC Resolved

41.	External individual reports concerns regarding DOC staff throwing away incarcerated individual's property when they are preparing to promote to medium custody. The external individual requests the OCO talk with their incarcerated loved one for more information regarding the concern.	The OCO provided information to the incarcerated individual regarding DOC staff throwing away individual's property. The OCO spoke with facility leadership regarding this concern and they shared due to compliance checks that had not been performed in quite a while, some extra hygiene items were disposed of per DOC 400.000. DOC confirmed they allowed individuals to condense the items to keep as much of the product as possible. DOC also shared with this office that very little was thrown out. The OCO shared this information with the individual.	Information Provided
42.	Person reports he broke his foot and was in a walking boot when he got to the IMU. The person stated that IMU staff took his boot away when he was moved there.	The OCO provided information regarding how to file a tort claim. Individuals who have been harmed or who have suffered a loss as a result of negligent actions by a state employee or agency can submit a tort claim to the Office of Risk Management (ORM). ORM is required by law (RCW Chapter 4.92) to receive these claims. The DOC resolution process substantiated the person's concern and staff were educated on the protocol to process patient medical equipment in restrictive housing settings.	Information Provided
43.	Incarcerated individual expressed concerns about their placement in segregation.	The OCO reviewed the individual's custody facility plan and found no violation of DOC policy 300.380 as the individual was placed in segregation due to ongoing infraction behavior and participation in security threat group activity.	No Violation of Policy
44.	An incarcerated person requested assistance with their custody facility plan stating they were wanting help getting moved to a different facility.	The OCO was unable to identify a violation of DOC policy 300.380 as the individual's placement is in accordance with policy.	No Violation of Policy
45.	Person reported concerns about his classification and custody level, and said he has safety concerns at this facility.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed DOC records and found that he was sent to safe harbor because of having no other general population options, and then found that upon arrival he was sent to administrative segregation. The OCO spoke with DOC staff who said that he was initially sent to segregation because of protection concerns and has since received multiple infractions. The counselor stated that they would be working on a new custody facility plan (CFP) to determine the best placement for him, and the OCO verified that work on a new CFP has begun. The OCO could not find a violation of DOC policy 300.380.	No Violation of Policy

46.	Loved one relayed concerns regarding placement on group violence reduction strategy (GVRS) sanctions.	The OCO spoke to DOC regarding the individual's placement on GVRS and confirmed that they were listed as an association for a GVRS incident that occurred due to the individual's frequent interactions and visiting with the individual who committed the assault that resulted in the GVRS protocol being implemented. These are sufficient connections to place the individual on GVRS according to DOC policy 470.450.	No Violation of Policy
47.	Incarcerated individual relayed concerns regarding placement on group violence reduction strategy sanctions (GVRS).	The OCO spoke with DOC regarding this concern and confirmed that the individual was identified as a close associate of the individual who committed the infraction due to regular interactions. As a result, there is no violation of DOC policy 470.540.	No Violation of Policy
48.	The individual reports that his fiancée was removed from his visitation list and the DOC will not allow them to get married.	The OCO was unable to identify evidence to substantiate there was a violation of policy. DOC 450.300(VIII)(B) states persons identified as being involved in attempting/conspiring to introduce, or aiding and abetting another to introduce contraband, in any way, will have their visiting privileges suspended or terminated. This person's fiancée has been denied visitation and a marriage packet due to an investigation by the DOC. The information provided in the report upholds DOC's visitation suspension/termination decision.	No Violation of Policy
	Coyote Ridge Corrections Center		
49.	Person states that his communications with health services are not being responded to. The patient is experiencing multiple health issues for which he is requesting treatment by specialists. The person is also requesting that the OCO investigate his resolutions and kite responses because he is not being provided the community standard of care by medical or mental health staff.	The OCO provided assistance. OCO staff contacted DOC staff and requested a review of the health services kites tracking and substantiated that some of the patient's kites were not responded to. OCO staff requested that DOC staff ensure those kites are responded to by the person they were addressed to. DOC staff reviewed and updated the kite response protocol. OCO staff substantiated a significant delay in resolution responses due to a vacancy in that position. The DOC has filled the vacancy and is working with DOC headquarters to resolve the backlog of resolutions. OCO staff reviewed the patient's specialist consults and did not find evidence of a delay created by DOC. DOC can only schedule specialist appointments by the outside clinic's availability.	Assistance Provided
50.	Person reported that a loved one sent money designated for his commissary subaccount but was told by Securus that he does not	The OCO provided information about how loved ones can deposit money into commissary subaccounts without being subject to deductions. The OCO reviewed DOC records and found that this	Information Provided

	have a commissary account and the money was put in his spendable account and was subject to deductions.	individual was provided with a three-month statement of his accounts. The OCO reached out to the banking department at the facility, who said that his family did not follow the DOC guidelines for depositing money into an incarcerated individual's commissary account, because the deposit was not clearly labeled "commissary." They also shared that Securus does not put money into commissary subaccounts, and that this is done through cashier's checks or money orders. The banking department shared that the facility business office reached out to DOC headquarters about the deductions, and they said that the deductions could not be reversed.	
51.	Person reported multiple medical concerns, including not receiving blood pressure checks or healthcare for several conditions.	The OCO provided information. The OCO reached out to DOC staff who confirmed that this person gets blood pressure checks at least weekly, has had multiple appointments this month, and received health care after his injury from falling. The OCO encouraged this individual to kite health services and speak with his provider about the health conditions that he said are not being addressed.	Information Provided
52.	Loved one relayed concerns regarding an incarcerated individual's denial of camp placement.	The OCO reviewed the individual's most recent custody facility plan and see that the camp decision was not concurred with at the headquarters level due to the need for the individual to complete programming. The OCO informed the individual that they can appeal this decision to headquarters.	Information Provided
53.	Person said that the mailroom rejected his college course materials, even though it was preapproved from the education department.	The OCO provided information about filing an appeal. The OCO reviewed his mail rejection and reached out to DOC headquarters, who said that that individual had not filed an appeal with the facility or headquarters. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Information Provided
54.	Incarcerated individual relayed concerns regarding frustrations with the decision of the Indeterminate Sentence Review Board (ISRB), specifically regarding required programming.	The OCO reached out to DOC about the program required by the ISRB. The OCO confirmed that the program has not yet resumed but that DOC hopes to restart it this year, at which point the individual can go through the screening process.	Information Provided
55.	An incarcerated person reported that their counselor is not pushing them forward to be screened for graduated reentry (GRE).	The OCO provided information regarding DOC's process for GRE screening.	Information Provided

56.	Person reported concerns with mistreatment by staff, including sexual harassment from a corrections officer, and being placed in solitary confinement. Person stated that while being placed in solitary confinement, some of his property went missing. Person also reported a disability which requires a health status report (HSR), but he is not being accommodated.	The OCO provided information. The OCO reviewed DOC records and found that this individual was placed in solitary confinement after several infractions, and that he was moved to general population after being reclassified to a different custody level. The OCO reviewed the Prison Rape Elimination Act (PREA) investigation regarding the incident of him being sexually harassed by staff and found that it was unsubstantiated. This office reviewed resolution requests regarding his missing property, and found that they were either withdrawn, or informally resolved because he received his property upon leaving solitary confinement. The OCO reached out to his current facility about the HSR, and they said that he has not contacted medical about his concern. The OCO reviewed medical records regarding his disability and reached out to his previous facility and found that he kited health services, and they said the HSR he is requesting is not allowed except for specific pathologies, and DOC staff stated that he will need to see a specialist. The OCO encouraged this individual to kite health services about reviewing his HSR and asking to see a specialist.	Information Provided
57.	Incarcerated individual relayed concerns regarding pleading guilty to an infraction because of the presumptive positive memo.	The OCO informed the individual that the September 6th DOC presumptive positive memo only pertains to 603 introduction/possession of contraband infractions and not general infractions like the one the individual received.	Information Provided
58.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
59.	Incarcerated individual relayed concerns regarding a negative behavior observation entry (BOE).	The OCO was unable to identify a violation of DOC policy as the individual received warnings prior to the issuance of the BOE.	No Violation of Policy
60.	The OCO opened a case on the individual's behalf regarding an infraction they received after reviewing the related incident report.	The OCO reviewed the infraction packet and video related to the infraction and confirmed that DOC reduced the infraction from a serious to a general. While the initial serious infraction did not appear appropriate for the circumstances surrounding the infraction narrative, the general infraction is not a violation of DOC policy 460.000.	No Violation of Policy
61.	Person reports issues with how his medication is being administered. The person states that the way it is being given is	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed the patient's medication orders and recent provider notes. OCO staff verified the medication was ordered within	No Violation of Policy

	causing negative side effects and is requesting to have it changed.	pharmaceutical management and formulary manual guidelines.	
62.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements required by the WAC.	No Violation of Policy
63.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
	Monroe Correctional Complex		
64.	External person reports their loved one is not able to access the medication assisted treatment (MAT) program despite having a qualifying diagnosis.	The OCO provided assistance by contacting DOC staff and requesting the MAT protocol be initiated for this patient. DOC reported limitations to the number of patients in that facility who could be on the MAT program. OCO staff contacted DOC leadership to notify them of the limitations faced by the facility to assist in resourcing expanded access to the program. The OCO is engaged in ongoing discussions with the DOC on expanding access to the MAT program in all facilities.	Assistance Provided
65.	Incarcerated individual relayed concerns regarding placement on MAX custody.	The OCO went to the facility to speak with the individual several times to discuss this concern, reviewed the individual's infraction records as well as recent custody facility plans and spoke with DOC staff at the facility leadership level as well as at headquarters regarding this. DOC agreed to not place the individual on MAX custody and this office was able to inform the individual of this decision along with DOC facility leadership at cell-front.	Assistance Provided
66.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and did not find that the required elements of one of the two WAC violations were met and asked if DOC would be willing to dismiss the infraction. DOC agreed to review the infraction and in reviewing decided to overturn the entire infraction as the investigation was minimal and there was not enough evidence to prove the elements of either of the charged violations.	Assistance Provided
67.	Incarcerated individual expressed concerns about their sentence being incorrectly calculated.	The OCO provided assistance with getting the individual's sentencing records . The OCO requested that DOC staff review the individual's records for any errors. DOC staff agreed to review the individual's sentencing records and were unable to find errors in his sentencing records. The individual will need to reach out to the court of conviction for	Assistance Provided

		more information about their sentencing if they still have concerns about its accuracy.	
68.	Patient reports concerns about access to gender affirming care and delayed appointments.	The OCO provided assistance by contacting DOC staff, reviewing appointments, and confirming scheduling. This office reviewed appointments for voice therapy, pre-surgical consults, and electrolysis. The OCO discussed updated concerns with the patient and added appointments to the office appointment tracker. A new case was opened regarding care concerns after transferring facilities.	Assistance Provided
69.	The incarcerated individual reports that he was suspended from his job and never had a facility risk management team (FRMT) regarding his suspension. He also reports that DOC chooses who gets their job back based on race.	The OCO provided assistance. This office contacted DOC and inquired about the status of this person's FRMT. DOC provided documentation of the investigation surrounding the individual's job suspension and resulting termination. However, DOC did not produce a copy of form 05-794 Classification Hearing Notice/Appearance Waiver signed by the individual. There was no paperwork that showed the individual attended or declined to attend the FRMT. The OCO spoke with DOC again, and DOC staff agreed to give this person a new FRMT for his previous job termination.	Assistance Provided
70.	A loved one expressed safety concerns about an incarcerated individual possibly transferring to a different facility.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and found that DOC headquarters decided to not transfer this individual to a different facility.	DOC Resolved
71.	Person reported having multiple health status reports (HSR) that have expired and said that he has filed a resolution request and sent kites to health services asking for the HSRs to be renewed but has not gotten a response.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and verified that this individual's HSRs were renewed.	DOC Resolved
72.	Person reports still experiencing pain following a surgery last year. The patient states that he has not had follow up with the specialist since the surgery.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff contacted DOC staff and were informed the patient had recent follow up with his provider where his concerns were addressed and a plan was created with the patient for the next follow up.	DOC Resolved
73.	Person reports having chronic pain and not agreeing with the plan of treatment. The person was told he had to go through a chain of medications to be approved for the medication he requested.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff contacted DOC staff to request the patient be supplied with education regarding the ordering protocol for the requested medication. OCO staff were informed the patient had already been moved through the	DOC Resolved

		protocol and was receiving the requested medication.	
74.	Incarcerated individual reports concerns regarding staff conduct upon arriving at a segregation unit. The individual reports he did not receive a meal and staff treated him unkindly. The individual requests DOC staff apologize to him.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed the individual's resolution request and found DOC apologized for not providing him with a meal after arriving to the unit. The DOC reviewed video and could not confirm staff treated him unkindly.	DOC Resolved
75.	Incarcerated individual relayed concerns regarding a mail rejection.	The incarcerated individual informed this office that DOC overturned the mail rejection and they were able to receive the mail, as DOC has resolved this concern prior to OCO involvement.	DOC Resolved
76.	Incarcerated individual reports concerns regarding their segregation placement.	DOC staff resolved this concern prior to the OCO taking action on this complaint. DOC staff spoke with the individual to get more information and plan to transfer him out of segregation based on new information provided to them.	DOC Resolved
77.	Person reported that he is in solitary confinement and does not currently have access to a TV, though is allowed one per his level of confinement.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reached out to DOC staff who confirmed that he now has a TV in his cell.	DOC Resolved
78.	An incarcerated person reached out to the OCO and reported they are planning for release but are currently on the west side of the state but their supports are all on the east side of the state.	DOC staff resolved this concern prior to the OCO taking action on this complaint. DOC had already documented that the plan was for the incarcerated person to be transferred to a DOC facility on the east side of the state prior to release so that release could happen in the appropriate county; DOC had not shared this information with the incarcerated person.	DOC Resolved
79.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found that DOC had dismissed the infraction prior to OCO involvement.	DOC Resolved
80.	External person reports their loved one needs to see a specialist for a definitive diagnosis. The person reports the emergency room did not do any testing but sent him back with a diagnosis.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff reviewed the patient's records and noted that the person did receive the appropriate testing in the emergency room for the reported symptoms. OCO staff also confirmed that the patient has been receiving treatment for the diagnosis he received.	DOC Resolved
81.	Incarcerated individual relayed concerns regarding an infraction.	The OCO confirmed that the infraction the individual expressed concerns about is no longer visible on the individual's record as DOC resolved this concern prior to OCO involvement.	DOC Resolved

82.	Person reports he was threatened with an infraction for where he placed his durable medical equipment (DME). The person said the item does not work if it is not situated correctly. This person also voiced concerns regarding changes to his unit being carried out by DOC.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff contacted DOC staff to request a work order to address the need for updates to the person's cell. OCO staff were informed that the unit was being moved sooner than a work order could be completed. OCO staff followed up with DOC staff and verified that the patient's new cell met the support need.	DOC Resolved
83.	An incarcerated individual reports that when someone is quarantined for COVID, medical staff are not contacting custody staff to release them from quarantine lockdown.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO contacted DOC staff who reported that medical staff will send custody staff the individual's upcoming testing dates and release dates based on the results of their positive COVID test. This individual had already been moved out of quarantine when this office contacted the DOC.	DOC Resolved
84.	A loved one reports that the incarcerated individual will be moving to another part of the unit which he describes as solitary confinement.	The OCO provided information about this person's concern. The OCO toured the space and found it to be more accommodating for individuals in wheelchairs and the space has multiple ADA cells. This office also noted that it is located closer to transport for medical visits. The OCO informed the individual they may submit a courtesy cell change using DOC form 21-595 Cell/Bed Change Request indicating why they need to move.	Information Provided
85.	Person reports being moved to the IMU after becoming ill. The person states that he should not be punished for being sick. The person also reported that his living unit was going to be moved to another location within the facility and is requesting that OCO stop DOC from making that move.	The OCO provided information to the person regarding how to file a tort claim. Individuals who have been harmed or who have suffered a loss as a result of negligent actions by a state employee or agency can submit a tort claim to the Office of Risk Management (ORM). ORM is required by law (RCW Chapter 4.92) to receive these claims. The OCO is not able to prevent the DOC from making changes to the facility.	Information Provided
86.	Incarcerated individual relayed concerns regarding their medical care.	The OCO verified that the individual's medical concerns are being properly addressed and provided the individual with information regarding the extraordinary medical placement protocol.	Information Provided
87.	An individual reports a complaint regarding staff removing legal work from his religious items box, food, and over the counter medications during a cell search.	Individuals who have been harmed or who have suffered a loss as a result of negligent actions by a state employee or agency can submit a tort claim to the Office of Risk Management (ORM). ORM is required by law (RCW Chapter 4.92) to receive these claims. This office provided this person with instructions on how to file a tort claim and where to send the form.	Information Provided

88.	An incarcerated individual relayed concerns regarding placement in administrative segregation (ad seg) including timeframes and levels.	The OCO resolved the concern regarding placement in ad seg in another OCO case. Regarding the concerns about timeframes and levels, this office is aware of this concern and will continue monitoring this issue.	Information Provided
89.	An incarcerated individual reports that his loved one added funds to his Securus media account, however the money was never made available. This individual submitted several help tickets with Securus but could not resolve the issue. This person also mentioned that his loved one has proof of the transaction in their bank records.	The OCO provided information during the hotline call. OCO staff advised the incarcerated individual to have their loved one call Securus customer service since they have proof of the transaction. The individual followed up with this office and reported that this issue had been resolved.	Information Provided
90.	An incarcerated person requested assistance with getting new shoes and asked for policy clarification.	The OCO provided information regarding DOC policy 440.050 and advised to kite the property officer if their shoes are damaged to the point of needing to be replaced.	Information Provided
91.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reached out to DOC prior to the infraction hearing as the records management system was reflecting a delay in the hearing that would violate DOC policy 460.000. After that outreach, the hearing was then held in an appropriate timeframe. This office reviewed the infraction materials but because the individual admitted to the behavior, a guilty plea was entered and the individual did not appeal the infraction, there were no further steps for this office to take at this time.	Information Provided
92.	Incarcerated individual relayed concerns regarding other incarcerated individuals not following the COVID protocol.	The OCO informed the individual that they will need to work with their unit CUS or counselor to discuss these concerns.	Information Provided
93.	Incarcerated individual reported concerns regarding staff conduct, access to programming, access to the resolution program and planning his release.	The OCO provided information regarding access to the resolutions program and improvements DOC has implemented to access this program. The OCO also shared information this office found regarding his release planning and access to programming and shared how to work with DOC staff to address these requests and concerns with DOC staff. The OCO worked with multiple DOC staff to ensure that he is able to access release planning, programming, and the resolution program. In reviewing this concern, the OCO found the DOC resolution program is starting a new program that provides	Information Provided

		assistance to individuals wanting to file resolution requests and the resolution staff at the facility agreed to reach out to the individual once the program is running to help him access the resolution program.	
94.	Incarcerated individual reports concerns regarding an electrical issue at the facility. The individual reports this issue is keeping people in their cells longer than usual, and requests DOC allow them out to use the dayroom and to go to yard more frequently than currently.	The OCO provided information regarding actions DOC took to mitigate the electrical issue. The OCO spoke with DOC facility staff who explained that after a weekend of more time in the cell than usual due to the electrical issue, individuals have been allowed time out of their cells and the electrical issue has been resolved.	Information Provided
95.	Incarcerated individual relayed concerns regarding wanting to quit their job due to mental health concerns but worry that it will result in a negative ISRB action.	The OCO informed the individual that they will need to continue working until their upcoming release but if they are having mental health symptoms they should reach out to their mental health counselor to discuss options.	Information Provided
96.	Incarcerated person states he is being denied mental health care and was terminated from the residential treatment unit.	The OCO reviewed the custody facility plan and contacted DOC staff regarding the discharge from the residential treatment unit. The DOC maintains that this individual no longer meets the criteria for the residential treatment unit and can be treated in the general population. He has now been transferred to the general population.	Information Provided
97.	Person reported that he was sexually harassed and mistreated by his supervisor at work. Person said that his supervisor reduced his hours, and he wrote a letter to his supervisor's boss about the situation, and said he was retaliated against after writing the letter.	The OCO provided information. The OCO reviewed this individual's resolution request and found that the supervisor was within policy to reduce his hours, and that this individual did not file a Prison Rape Elimination Act (PREA) complaint about the sexual harassment. The OCO encouraged this individual to file a PREA complaint about this supervisor.	Information Provided
98.	Incarcerated individual reports concerns regarding pay for community work crews. The individual reports that other jobs received a pay increase but the community work crews (CWC) did not.	The OCO provided information regarding gratuity increases. The OCO reviewed the individual's gratuity and found that he was being paid the correct amount on the CWC. Per the DOC memo issued on July 10, 2023, gratuity for CI and class III positions was increased. This office is aware that DOC ensured that everyone is paid for actual hours worked that created pay differences or some people that were being paid a flat amount, which was not allowed per policy.	Information Provided

99.	Transgender person reports their gender was listed as female in OMNI but has since been changed back to male. She would like her gender listed as female again.	The OCO elevated this concern to DOC headquarters transgender settlement administrator and provided the individual with information about this issue. The OCO substantiated the gender marker has been changed back to male in OMNI and confirmed there is an IT project in queue to update the system to exclude gender markers from the home page of any incarcerated person's page in OMNI. Currently, gender identity is kept confidential within PREA.	Information Provided
100.	A loved one reported concerns about cell temperatures in an incarcerated individual's cell and expressed concern with how his facility risk management team and custody facility plan was conducted. The loved one wanted this individual to receive an override to medium custody so he can stay at his current facility.	The OCO provided information. The OCO verified that multiple work orders are open to ensure there is adequate heat in the cells at this facility. The OCO reviewed this individual's custody facility plan and found that he is being demoted because of receiving multiple infractions, and that he has been transferred to a different facility.	Information Provided
101.	Incarcerated individual reports concerns regarding gratuity after the gratuity increases. The individual reports that people are signing agreements to work over forty hours without pay and has concerns about that.	The OCO provided information regarding DOC gratuity increases. The OCO reviewed the individual's gratuity and found that they were paid for hours worked. The OCO found that there was a directive to ensure that all incarcerated workers are paid for hours worked. The OCO recommended the individual review the July 10, 2023 memo related to gratuity and work with DOC staff as issues arise related to his gratuity. If other incarcerated individuals are signing an agreement regarding their work with DOC staff but have concerns about the agreement, we encourage them to contact us and we can review the matter.	Information Provided
102.	Person reports he is supposed to have a medical hold for surgery but was told he will be transferred to camp. He is requesting to stay where he is until the procedure is completed.	They OCO provided information to the person regarding their planned procedure. OCO staff reviewed the transfer order and found it had been deferred, pending the completion of his surgery.	Information Provided
103.	Incarcerated individual relayed concerns regarding staff conduct, infractions and being denied medical care.	The OCO reviewed the individual's records related to the three concerns. For the concern regarding staff conduct, there was insufficient evidence to substantiate the concern as the individual did not provide any evidence in the grievance investigation to substantiate these concerns. For the infraction concerns, the OCO reviewed the infraction materials and found that there was evidence to substantiate the infraction based on the individual's possession of	Information Provided

		contraband. For the medical concern, the OCO confirmed that the individual had been seen by medical and their concerns have been addressed properly.	
104.	Person reports he experiences extreme chronic pain and has been receiving pain management medications, however it has not been sufficient to make him free from pain. The person is requesting a change in medication, specialist evaluation, and information regarding contacting legal help.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed the patient's medical records and noted his pain management plan was documented with the clinical rationale. OCO staff confirmed the patient has access to pain management medications. Per DOC 600.000, clinical decisions cannot be countermanded by non-clinicians. OCO staff also verified the patient has active specialist consults. OCO staff provided other requested information to the patient.	Information Provided
105.	Incarcerated individual disputes an infraction that they received.	The OCO reviewed the infraction materials and spoke to DOC staff regarding the infraction but was unable to identify information to substantiate the individual's account of the alleged infraction.	Insufficient Evidence to Substantiate
106.	Incarcerated individual reports concerns regarding a staff member and reports he was terminated from employment as a result of retaliation from the staff member. The individual requests the OCO investigate the retaliation allegation.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed all records related to the incident and was unable to substantiate retaliation. The individual was terminated for infraction behavior and there is no evidence staff conduct was reported prior to the infraction. To substantiate retaliation, the OCO must be able to prove that a negative action from a DOC staff member is not only linked close in time to an incarcerated individual's protected action but there must be evidence of a clear relationship between the two acts.	Insufficient Evidence to Substantiate
107.	Incarcerated individual expressed concerns about several infraction they received.	The OCO reviewed the individual's infraction history but were unable to identify evidence to substantiate the individual's account of the events that led to the infraction as there was insufficient evidence.	Insufficient Evidence to Substantiate
108.	A family member reports their loved one is being written up by DOC staff unfairly and is going to be forced to change facilities due to loss of levels caused by infractions.	The OCO was unable to substantiate the concern due to insufficient evidence. The person has not been moved and has no recent infractions.	Insufficient Evidence to Substantiate
109.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
110.	Incarcerated individual expressed concerns about numerous infractions they received.	The OCO reviewed all of the infractions the individual has appealed in the past six months and	No Violation of Policy

		found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	
111.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
112.	Person reported concerns with his custody facility plan and institutional assignment and expressed concern about DOC trying to demote him to close custody.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed DOC records and found that this individual initially received an override to remain medium custody, and then received another infraction which caused a new custody facility plan to be developed, which recommends demotion to close custody. The OCO could not find a violation of DOC policy 300.380.	No Violation of Policy
113.	Loved one relayed concerns regarding the denial of a graduated reentry (GRE) and work release decision for an incarcerated individual.	The OCO was unable to identify a violation of policy as this office reviewed DOC policy 390.590 and confirmed that an individual can be denied for showing too high of a risk to the community.	No Violation of Policy
114.	Incarcerated individual relayed concerns regarding the denial of a graduated reentry (GRE) and work release decision.	The OCO was unable to identify a violation of policy as this office reviewed DOC policy 390.590 and confirmed that an individual can be denied for showing too high of a risk to the community.	No Violation of Policy
115.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and was unable to identify a violation of DOC policy 460.000 as the individual's behavior met the infraction element.	No Violation of Policy
116.	The incarcerated individual reports that he was not released on his earned release date (ERD) and would like to know why.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. DOC 350.200(I)(B) states individuals requiring an approved release address may be held in confinement up to their max date until an approved release address is secured. The OCO verified that the DOC is working on a release plan for this person. However, the incarcerated individual has significant mental health concerns and has been in prison for a long time; making his release plan complex. This office determined that DOC staff communicated with this person in advance and let him know he would not be released on his ERD.	No Violation of Policy
117.	Person reported that he is being targeted by the resolutions specialist and that they will not meet with him. Person reported that the resolutions specialist showed one of his resolution requests to other incarcerated	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed this individual's resolutions request and found that his concern about his confidentiality was adequately investigated and unsubstantiated. The investigator does not need to meet with the individual per policy until level 2, and the OCO confirmed that this resolutions specialist	No Violation of Policy

	individuals, violating his confidentiality.	was acting appropriately in assigning the investigations to the appropriate staff.	
118.	A loved one expressed safety concerns about an incarcerated individual being transferred to a different facility.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed DOC records and found that this individual received multiple infractions and DOC had safety concerns housing him at his current facility. The OCO could not find a violation of DOC policy 300.380.	No Violation of Policy
119.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
120.	Person reports he was supposed to have surgery prior to incarceration from a work injury several years ago. The person states the pain management being provided is not adequate and is requesting to be guaranteed surgery.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed the patient's consults and treatment plan and noted that surgery has not been indicated by the specialists he has seen since being incarcerated. The OCO cannot guarantee any medical intervention that is not ordered by a medical provider.	No Violation of Policy
121.	Incarcerated individual requests the OCO review an investigation completed by the DOC to ensure it was conducted per policy.	The OCO was unable to substantiate a violation of policy by DOC. The OCO verified that the confidential investigation was conducted per DOC policies and protocols.	No Violation of Policy
122.	Person reported receiving a negative behavioral observation entry (BOE) for calling a medical emergency that he thought met the criteria of an emergency. Person said he appealed the BOE, but it was upheld.	The OCO was unable to substantiate a violation of policy by DOC after reviewing the BOE and its appeal. DOC policy 300.010 states "B. Behaviors in a clinical treatment setting may be reported at the discretion of the clinical treatment professional," and "H. 2. The CPM/CCS will make the final determination concerning content in a BOE and whether it will be updated, deleted, or remain the same."	No Violation of Policy
123.	Person reports their provider refused to renew a health status report (HSR) and also refused to submit the request to the care review committee (CRC) again. He tried a medication that was not effective and would like his request to be reconsidered.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed the CRC decision and contacted the patient's medical provider. The CRC had already denied the patient's request and recommended further evaluation of the reported symptoms and alternative treatment. OCO staff verified there was a consult placed for the patient to be evaluated by a specialist. Per DOC 600.000, clinical decisions cannot be countermanded by non-clinicians. The OCO encouraged the person to work with the specialist to find the most appropriate treatment.	No Violation of Policy
124.	Incarcerated individual reports concerns regarding the DOC transport vehicle. The individual	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the DOC investigation related to the transport vehicle and	No Violation of Policy

	reports that the way the backseat is configured could harm someone, and requested the OCO investigate the matter.	found the DOC verified that the current structure of the backseat meets current safety standards and that DOC is not allowed to alter the vehicle in any way.	
	Olympic Corrections Center		
125.	The individual reports that there is another incarcerated person who is harassing him. This individual would like some kind of separation between himself and this other person.	The OCO provided information regarding how to request a keep separate between him and the other individual.	Information Provided
126.	Incarcerated individual reports concerns regarding a rodent problem and the traps DOC provides. The individual also reported concerns regarding staff actions and retaliation for reporting concerns to staff.	The OCO provided information regarding the rodent traps and how to report issues with staff. This office spoke with facility leadership about the rodents and confirmed staff are mitigating the concern as it arises. The OCO also reviewed the relevant RCW regarding the rodent trap and verified the trap used by DOC is legal. The OCO reviewed recent resolution requests, infractions and behavior observations and were unable to substantiate retaliation. To substantiate retaliation, the OCO must be able to prove that a negative action from a DOC staff member is not only linked close in time to an incarcerated individual's protected action but there must be evidence of a clear relationship between the two acts. The OCO encouraged the individual to continue to report staff concerns as they arise.	Information Provided
127.	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 behaviors met the infraction elements.	No Violation of Policy
128.	Person reported that he had to be assessed for a treatment program and thinks that DOC staff are changing people's assessment scores in order to make them take the treatment program.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed this individual's assessment records and found it was in compliance with DOC 580.000. The OCO could not substantiate that his assessment was altered.	No Violation of Policy
	Other - Community Custody		
129.	Incarcerated individual relayed concerns regarding a graduated reentry (GRE) termination.	The OCO reviewed the GRE termination and found no violation of DOC policy 390.590.	No Violation of Policy
	Stafford Creek Corrections Center		
130.	Person reports there is a DOC staff member in medical who is rude and unprofessional to	The OCO provided assistance by notifying DOC staff. OCO staff noted reoccurring complaints naming this staff member's behavior and requested DOC staff	Assistance Provided

	patients. The person's interactions with this staff member have led to issues with accessing medically necessary supplies.	review the situation. OCO staff confirmed DOC leadership reviewed and took appropriate action. OCO staff reviewed the patient's property and noted he had received the item he needed.	
131.	Person reports his provider told him he was going to be placed on an alternative medication line to manage his pain treatment plan. The patient has concerns about how that designation could impact his ability to release.	The OCO provided assistance to the person. OCO staff met with DOC staff and discussed the patient's concern with the changes. DOC staff then worked with the patient to formulate a plan that worked for the patient.	Assistance Provided
132.	Incarcerated individual relayed concerns regarding needing documents they sent to the OCO forwarded to DOC.	The OCO processed the request in GovQA as a records request and will send a copy back to the individual with the address to DOC as they will have to send the documents to DOC themselves.	Assistance Provided
133.	External person reports concerns about an incarcerated individual's access to a cancer related colonoscopy referral.	The OCO provided assistance by meeting with the patient at the facility and following up with DOC health services. DOC staff met with the patient to clarify treatment plan, next steps, and explain the error with the offsite scheduler that has now been addressed. The OCO met with a medical Multi-Disciplinary Team (MDT) to discuss the patient's concern, care, and next steps.	Assistance Provided
134.	Patient reports concerns about a mix up related to a recent cancer care appointment and wants to ensure he receives the recommended testing and follow up.	The OCO provided assistance by contacting DOC health services and requesting the issues be addressed. This office confirmed the patient is now scheduled for the recommended colonoscopy and EGD. The OCO attended a health services Multi-Disciplinary Team (MDT) meeting to discuss the patient's complex case, concerns, and next steps in care planning. This office also confirmed a provider is meeting with the patient multiple times a week now to talk through their continuity of care and release planning.	Assistance Provided
135.	Incarcerated individual reports safety concerns at the facility they are finalized to transfer to.	The OCO provided assistance. The OCO spoke with DOC staff at the facility who then contacted the individual, reviewed their safety concerns and verified them. The DOC then requested to cancel the transfer and will be looking at other placement options soon.	Assistance Provided
136.	Person reported safety concerns about being demoted custody levels and transferred to a different facility.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and found that this individual did not get demoted custody levels or transferred to the facility he had safety concerns at.	DOC Resolved

137.	A loved one reported concern about delays with an incarcerated individual's release and said that his paperwork was not being processed on time.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and found that this individual's release plan was approved and he has a planned release date.	DOC Resolved
138.	Person reported that he was removed from his job, even though he got an extension due to an ADA accommodation. Person said that he reported this to the superintendent.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed this individual's resolution request and found that this individual appealed his custody facility plan because of his concern with his job. DOC staff responded to this individual and said that this individual was moved to a different unit due to facility needs and he would contact the unit about employment. The OCO reviewed this individual's programming information and found that he was hired to the same job he used to have, but now in his new unit.	DOC Resolved
139.	Incarcerated individual reports concerns regarding the food and reports that he found bone matter in the food. The individual would like the investigation that was conducted by Correctional Industries (CI) and would like the meal with the bone matter found to be taken off the menu.	The OCO provided information about obtaining the investigation documents from CI. The OCO spoke with CI regarding the incident and reviewed the investigative reports by CI. CI found that this was an isolated incident and was not able to substantiate a larger issue with the food quality. The OCO spoke with multiple CI staff including leadership at the CI food factory. This office also reviewed labels showing the food grade and type and were unable to substantiate that bone matter in the food was a reoccurring incident. The OCO is unable to substantiate where the bone matter came from even after thoroughly reviewing how meat products are manufactured, made into meals, and distributed at DOC. The OCO provided details regarding how to request the CI investigation to the individual.	Information Provided
140.	Incarcerated individual expressed concerns about the OCO closing their previous case as administrative remedies not pursued despite them filing grievances.	The OCO reviewed the individual's grievances and spoke with DOC about them as they had been removed for an administrative review. The OCO confirmed with DOC that appropriate action was taken regarding the staff's conduct.	Information Provided
141.	Incarcerated individual reports concerns regarding access to the courts and legal access.	The OCO provided information regarding DOC policy 590.500 and how to access legal services. The OCO shared with this individual how to ensure access to the courts through the legal liaison officer and provided them with information about the policy and procedures. The OCO also confirmed the individual was able to attend a telephonic hearing related to his access concerns.	Information Provided

142.	Incarcerated individual relayed concerns regarding placement in maximum custody.	The OCO reached out to DOC headquarters and confirmed that the individual's custody facility plan (CFP) appeal was received, and their concern that they should have gotten points that will allow them to go to a different custody level was addressed as per DOC policy 350.100(III)(B)(3)(c), individuals housed in MAX are ineligible for programming points.	Information Provided
143.	Person reports concerns about delayed access to alternative clothing items outlined in policy, specifically properly fitting support bras for transgender women.	The OCO elevated this concern through DOC headquarters. The OCO provided information about DOC's current bra pilot project that is seeking to gather input from the population in order to improve the items available for ordering.	Information Provided
144.	Incarcerated individual relayed concerns regarding DOC staff damaging their property.	The OCO reviewed the individual's grievances related to the concern but found there was insufficient evidence that staff further damaged the TV during the search as the individual could not provide specific evidence during the grievance investigation showing how the damage. The OCO informed the individual that they will need to file a tort claim seeking compensation for the damage.	Information Provided
145.	Person reported that he was given an ADA accommodation for an ergonomic chair in the resource room, and he wanted to be able to use the chair in the dayroom but was told that it was a security concern.	The OCO provided information. The OCO reviewed the decision from the accommodation review committee and found that ADA and custody staff denied this individual's request for using the ergonomic chair in the dayroom because the chair cannot be secured down. The OCO reached out to the ADA Coordinator, who said they were working with the individual to ensure he has access to his ergonomic chair for studying for his classes. The OCO provided information about how he can request for accommodation for using his ergonomic chair during educational programming.	Information Provided
146.	Incarcerated individual reports concerns regarding another incarcerated individual.	The OCO provided information regarding how to report concerns with DOC staff and provided resources for self-advocacy.	Information Provided
147.	Incarcerated individual reports experiencing difficulty getting contacts ordered.	The OCO provided information to the individual regarding the department approved pathway to have contacts sent to his facility. Currently DOC allows incarcerated individuals to order contacts through one approved vendor and work with property staff directly to order the contacts. Individuals will document their contacts by kiting medical and requesting to file patient paid durable medical equipment (DME) documentation. Per DOC policy 450.100 Attachment 1: #40 property from a third	Information Provided

		party that is not an approved vendor is not authorized.	
148.	Incarcerated individual relayed concerns regarding property that was purchased from Union Supply that is not compatible with the TV.	The OCO informed the individual that they will need to file a tort claim if they are seeking compensatory relief with the Department of Enterprise Services (DES).	Information Provided
149.	Incarcerated individual reports the phones in the yard are not working. The individual reports if someone does not have a tablet they cannot make calls.	The OCO provided information regarding phone access. The OCO shared with DOC staff that phone access was down in the unit; DOC staff reported they are working with a Securus technician to restore the access. The OCO requested further information and DOC staff shared later the phone access was restored after a Securus technician visited the facility.	Information Provided
150.	Incarcerated individual reports concerns with their facility placement and requests assistance being moved to another area of the unit.	The OCO provided information regarding the individual's placement. The OCO found the individual lacks housing options at the facility where they are currently located, and DOC is working to find a viable placement option for the person. The OCO provided information regarding why the individual cannot go to the area they wish the transfer to, and what options are available for self-advocacy.	Information Provided
151.	An incarcerated person called the hotline to a report DOC staff behavior issue indicating that a fellow incarcerated person had been denied an evening meal and states DOC swing shift staff are kicking doors and when he expressed upset at his door being kicked, they documented that he was refusing his meal and did not provide him dinner today.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed relevant video footage and documents and was not able to substantiate the concerns reported.	Insufficient Evidence to Substantiate
152.	Person reported that he purchased dice for a table top roleplaying game but is not allowed to have them. Person said that Securus has a dice app on the tablets, but not everyone has the ability to buy the app.	The OCO provided information. The OCO reviewed this individual's resolution request, which was reviewed by DOC headquarters, as well as the DOC memos that allowed for role playing games to be allowed in prisons. The memos stated that the publications for these games were allowed, but additional game pieces, including dice, were not. The resolution request response said that DOC headquarters recognized the value of these games and the need for dice to play the games, which is why they contacted Securus to request they make a dice app available on the tablets. The resolution	Information Provided

		request response also stated that dice are available at the officer's booth, and that incarcerated individuals are allowed to make their own dice.	
153.	Incarcerated individual relayed concerns regarding their safety if released to general population.	The OCO spoke with DOC staff and verified that the individual refuses to give information on why they feel unsafe and confirmed that they have not expressed these concerns to IIU. The OCO informed the individual that in order to verify their safety concerns, they will need to work with their counselor or IIU to specifically name why they are feeling unsafe or who is making them feel unsafe.	Insufficient Evidence to Substantiate
154.	Loved one relayed concerns regarding an infraction an incarcerated individual received.	The OCO was unable to identify a violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
155.	Incarcerated individual relayed concerns regarding a demotion in custody.	The OCO reviewed the individual's custody facility plan and found no violation of DOC policy because the individual was given an override for the demotion as per DOC policy 300.380(IV)(A)(2) custody will only be demoted one level at a time unless an override is approved.	No Violation of Policy
156.	Person reported receiving infractions after an incident, and said it was because he had a panic attack. Person said he should get an override and not be demoted to medium.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed DOC records and could not find a violation of DOC policy 300.380. DOC is within policy to demote this individual to medium after his infractions.	No Violation of Policy
157.	Incarcerated individual reports concerns with getting married. The individual reports the marriage was approved then his partner was suspended from visiting which prevented the marriage from occurring.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the denial reason and found that the reason was in compliance with DOC policy 450.300. This office shared that the individual's partner will be eligible to apply for visitation later this year. Per DOC policy 590.200, "The intended spouse/partner must be on the individuals approved visitor list." The OCO shared with the individual that once his partner is on his approved visiting list, they can move forward with the marriage process.	No Violation of Policy
158.	Person reported concerns about photocopies of mail that he received from the mailroom and stated that the pictures were not being photocopied correctly and were reduced in size.	The OCO was unable to substantiate a violation of policy by DOC. DOC policy 450.100 "E. In lieu of the original, photocopies of the envelope and/or contents may be provided to the individual for safety and security reasons." The incarcerated population was notified of this change in a June 2022 memo. The OCO reviewed this individual's resolutions request and found that this facility does not currently have a color printer, and that is why this individual's photocopies were in black and white.	No Violation of Policy

159.	Incarcerated individual relayed concerns regarding DOC staff not responding to their courtesy cell move requests.	The OCO confirmed DOC staff are aware of the concerns and mitigating them as they can. Per DOC policy 420.140(V)(B), DOC does not have to move someone if there is not a verifiable safety threat.	No Violation of Policy
160.	Incarcerated individual relayed concerns regarding a behavior observation entry (BOE) and general infraction.	While the OCO does not routinely review general infractions per WAC 138-10-040(3)(c) due to the nature and quality of the evidence, the OCO reviewed the individual's BOE and infraction history and see that they were given a BOE and warned that an infraction would occur next if they continued the behavior. Due to the continued behavior, the general infraction resulted. Because the individual was given a BOE as a warning prior to the general infraction, there is no violation of DOC policy 300.010(I)(D)(2)(a).	No Violation of Policy
161.	The individual reported that he wants to be able to have visits with his child, but says there have been several issues with the child being allowed to visit and requests assistance to understand what is needed to allow visitation.	The OCO was unable to substantiate a violation of policy by the DOC. This office spoke with DOC headquarters staff who verified that the individual's visits were denied per DOC policy 450.300, which states that when the court authorizes visits, the Department may still deny visits on a case-by-case bases after conducting a full review of available information.	No Violation of Policy
162.	Loved one relayed concerns regarding an incarcerated individual's placement on the out of state transfer list.	The OCO reviewed the individual's most recent custody facility plan and spoke to DOC headquarters staff about this concern. Per DOC policy 330.600(I)(A)(1) individuals may be considered for a prisons compact transfer for safety/security reasons.	No Violation of Policy
	Washington Corrections Center		
163.	External person reports concerns about an incarcerated loved one's medical care, access to a tablet while in the infirmary, and potential transfer to the east side of the state.	The OCO provided assistance by meeting with the patient in person and elevating the concerns through health services leadership. This office confirmed a tablet was provided to the patient at headquarters direction. The OCO discussed the patient's care with DOC staff, confirmed ongoing monitoring and regular provider appointments with the patient Monday-Friday. This office also monitored the patient's diagnostics process and requested regular updates from DOC staff. Original testing was inconclusive and DOC worked with Department of Health and infection control to monitor and plan follow up. Additional testing provided a clear diagnosis and an updated treatment plan was created. The patient was established with a specialist in the community and will remain at WCC pending a scheduled CT scan, then will return to	Assistance Provided

		another facility to complete their treatment. There are no pending transfers to another facility due to the patient's medical care needs.	
164.	Incarcerated individual reports safety concerns at the facility DOC decided to transfer him to.	The OCO provided assistance. The OCO reached out to DOC staff in the classification unit and ensured that they were aware of the safety concerns relayed to this office. After the safety concerns were relayed, the individual's transfer was deferred and DOC is reviewing other housing options. The OCO recommended that the individual work with his classification counselor to participate in his custody facility planning.	Assistance Provided
165.	An individual reports that their earned release date (ERD) is quickly approaching, yet the DOC has not approved the release address they submitted. This person is concerned that DOC staff have not been to the house or called their proposed sponsor, and that they will not be released on their ERD.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO was unable to substantiate a violation of policy by DOC. Per DOC policy 350.200 individuals requiring an approved release address may be held in confinement up to the maximum expiration date until an approved release address is secured. The OCO reviewed this person's release plan and verified that the DOC approved his release address and made contact with his sponsor.	DOC Resolved
166.	Loved one relayed concerns regarding an individual's placement in solitary confinement.	The OCO confirmed that DOC resolved this concern prior to OCO involvement as the individual has been moved out of solitary confinement.	DOC Resolved
167.	Incarcerated individual expressed concerns regarding a delayed transfer.	The OCO confirmed that DOC resolved this concern prior to OCO involvement as the individual has since transferred to their new facility.	DOC Resolved
168.	Incarcerated individual relayed concerns regarding ADA access.	The OCO provided the individual with information regarding their concern. The OCO confirmed that the individual was seen by the ADA team and their ADA request has been submitted for review at monthly ADA meetings.	Information Provided
169.	Patient requested a single cell due to visual impairment and was denied by DOC.	The OCO elevated this concern through DOC leadership and requested single cell placement be reconsidered. DOC did not agree to single cell placement for this patient and there was no change in the outcome.	Information Provided
170.	Person reported that the teacher in his treatment class made derogatory statements about another person's race, and that he brought it to his counselor's attention, but was not allowed to talk about it further or make a formal complaint. Person later	The OCO provided information. The OCO reviewed DOC records regarding his termination from the treatment class and verified that he alerted DOC to his behavior of this teacher. The OCO confirmed that an investigation was conducted regarding this teacher and appropriate action was taken. The OCO spoke with this individual about what he wanted to see happen next and reviewed his eligibility for other	Information Provided

	stated that he was removed from his treatment class.	programming options and provided him with that information.	
171.	An individual reports that his videogram was rejected because the person in the message was not following the in-person visitation dress code. This person appealed the rejection because the visitation policy was changing and they should have been allowed to have the videogram.	The OCO provided information to this person about the mail rejection process. The OCO requested the mail rejection and spoke with DOC staff at headquarters regarding this concern. Mail rejections have two levels of appeal: the first is within the facility and the second level is at DOC headquarters. Because this person did not follow the entire appeal process, their mail rejection was not reviewed by multiple levels of DOC staff and DOC therefore did not overturn it.	Information Provided
172.	Incarcerated individual relayed concerns regarding their infraction appeal being denied.	The OCO spoke with DOC regarding the denial of the individual's infraction appeal and inquired as to if DOC would consider the appeal despite it being received outside of timeframes, but DOC declined to accept the appeal.	Information Provided
173.	Person reports racist remarks made to him and other incarcerated individuals by a DOC kitchen staff member.	This office asked the incarcerated individual to file a resolution request so it could be pulled for investigation. The OCO contacted CI and the facility to follow up on the concern and verified it is still under investigation. If the investigation substantiates this concern then it will move into staff discipline. The individual was reassigned to another work duty due to a medical HSR.	Information Provided
174.	External person reports concerns regarding a loved one who is incarcerated. The external person reported concerns regarding their loved one's lack of access to mental health services and concerns regarding their loved one's recent placement and custody facility plan (CFP).	The OCO provided information. The OCO verified that the individual received mental health care shortly after it was requested. The OCO also spoke with DOC staff to ensure that he was able to share his concerns with staff and participate in his CFP. The OCO provided information about how to access mental health services and stay an active participant in custody facility planning.	Information Provided
175.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction and contacted DOC staff regarding the concern but were unable to find evidence to corroborate the individual's account of the incident.	Insufficient Evidence to Substantiate
176.	Loved one relayed concerns regarding an individual being on a hunger strike.	The OCO reviewed the individual's related grievance and saw that staff were working with the individual about their concerns and the individual terminated their hunger strike. As a result, there was insufficient evidence to show the individual was still participating in a hunger strike.	Insufficient Evidence to Substantiate
177.	Loved one relayed concerns regarding an incarcerated	The OCO was unable to find a violation of DOC policy 300.380. The individual has been placed in	No Violation of Policy

	individual's placement in segregation.	segregation as the result of violent behavior as allowed per policy.	
178.	A loved one reported concerns about an incarcerated individual being transferred to a different facility and expressed concern for his safety.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed DOC records and found that this individual was promoted custody levels and transferred facilities to a lower level of custody. The OCO could not find a violation of DOC policy 300.380.	No Violation of Policy
179.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
180.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
181.	Incarcerated individual relayed concerns regarding being terminated from community custody due to an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.130 as the individual's behaviors met the requirements for the community custody termination.	No Violation of Policy
182.	This person reports that they were given a MAX custody program and the facility will not let them advance beyond level two. This individual has inquired about why this is happening and has not received an explanation from DOC.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. DOC policy 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. If an individual has been identified as an influential member of a security threat group this person may only be eligible for level two while assigned MAX custody.	No Violation of Policy
183.	This person reports that they were given a MAX custody program for being an influential security threat group (STG) member and the DOC will not allow them to advance beyond level two while they are in the IMU.	The OCO was unable to identify evidence to substantiate there was a violation of policy by DOC. DOC policy 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. If an individual has been identified as an influential member of a security threat group this person may only be eligible for level two while assigned MAX custody.	No Violation of Policy
	Washington Corrections Center for Women		
184.	External person reported that a staff member used inappropriate and discriminatory language towards an incarcerated individual and then infracted them. The external person emailed the facility and the OCO regarding the incident.	The OCO reviewed this concern and spoke with the facility leadership. The infraction was dismissed and removed from the record and the staff behavior was addressed through the proper channels. DOC facility leadership also shared this information with the external reporter.	Assistance Provided

185.	Incarcerated individual reports concerns regarding the procedure for issuing behavior observation entries (BOEs). The individual reports concerns regarding an incident when they were threatened with a BOE and wants details about how BOE's are supposed to be issued.	The OCO provided assistance. The OCO reviewed the individuals BOE's and found no BOE was issued for the reported incident. However, the individual had an additional BOE that raised concerns. The OCO spoke with DOC staff about the BOE and the DOC removed the BOE in question. The OCO shared concerns regarding BOE trends this office is seeing and DOC staff was interested in the trends and shared that she will look out for issues like that to prevent them in the future.	Assistance Provided
186.	Person reports she has an infection that is not being treated by DOC medical. She is requesting help getting surgery to resolve the issue.	DOC staff resolved this concern prior to the OCO taking action on this complaint. OCO staff reviewed the patient's consult records and noted that surgery is already scheduled.	DOC Resolved
187.	Incarcerated individual reports concerns regarding reimbursement for paying cost of supervision for convictions vacated after the State v. Blake decision. The individual requests information about how to get reimbursement as they are not able to get clear steps on how to be reimbursed.	The OCO provided information about how to request reimbursement for cost of supervision and legal financial obligations (LFOs). The OCO reviewed memos sent out by the department and found that the department is reviewing individuals' files that paid cost of supervision for cases vacated under the State v. Blake decision and individuals will be reimbursed automatically if they qualify. To be reimbursed for LFOs, individuals will have to fill out and send the Blake Refund Instructions and Applications to the Blake Refund Bureau which was created by the Administrative Office of the Courts (AOC) to refund paid LFOs. Individuals may write to the AOC to request their cause numbers if needed to complete the application. Please direct all questions to the AOC, as this is a court program specifically created to address all Blake Refund matters.	Information Provided
188.	Person reports multiple trips to the emergency room for chest pain and states that DOC has not made a cardiology referral for the patient.	The OCO provided information to the patient regarding the planned follow up care. The OCO contacted DOC staff and confirmed the patient has a cardiology follow-up scheduled.	Information Provided
189.	An incarcerated person contacted the OCO regarding an issue they are experiencing with Securus not responding to their issue.	The OCO provided information that Securus issues have to be resolved by Securus and advised the individual to continue reaching out to Securus.	Information Provided
190.	The individual reports that the DOC is forcing her to complete chemical dependency (CD) treatment due to an assessment that contains falsified	The OCO provided information about how to get falsified information corrected. DOC policy 280.500 3. (b) states in all other cases, the individual must contact the author of the challenged document to request information be corrected in the file. If it is	Information Provided

	information. This person states she is not in prison for a drug charge and was never ordered to complete substance abuse treatment.	not possible to contact the author, the individual must contact the author's supervisor or an employee with authority to correct any information in the document. This person may send a kite or write to the author of the assessment and request they change the information that is currently in their records.	
191.	Person reports she is not being served the correct portions for the lighter fare diet. The person also states that she has not received the correct medications for a chronic condition. The patient is requesting her medications be increased and compensation from DOC for having to supplement her diet with food from commissary. She is also requesting to be released on GRE.	The OCO provided information to the person regarding the dietary guidelines for the lighter fare diet and the limitations of this office's authority to request someone be released. OCO staff contacted DOC staff and requested a review of the patient's medications. DOC staff reviewed the medications and determined the orders were up-to-date and accurate. OCO staff also requested the patient be given the DOC health services educational materials regarding special diets.	Information Provided
192.	Individual has been housed on MAX custody for the past year and has been denied a transfer back to general population.	The OCO reviewed this concern and the recent custody facility plan. The DOC has recently extended the MAX placement due to safety and security issues. This individual is currently being housed in the closed observation area and is being treated by mental health. The DOC has denied all requests for this individual to move back to general population.	Information Provided
193.	Loved one relayed concerns regarding an incarcerated individual's continued job referrals despite having an HSR that limits the ability to work.	The OCO reviewed the individual's record and see that the HSR being referenced is no longer active. The OCO spoke with DOC staff who confirmed the individual is currently working with medical to address their medical concerns. The OCO advised the individual that if they feel they need the HSR renewed, they will need to work with medical for this to occur.	Information Provided
194.	Incarcerated individual relayed concerns regarding having a broken tablet and not having the money to pay for a replacement.	The OCO informed the individual that they will need to kite the Securus liaison to see if they can get any help with the payment portion of the replacement tablet, otherwise they will have to pay for the replacement tablet as per the Securus contract.	Information Provided
195.	Person reports she was given the wrong medication at pill line and experienced adverse effects from it.	The OCO was unable to substantiate the concern due to insufficient evidence. As the patient did not report the medication side effects to medical, there was no documentation to support the concern. The OCO contacted DOC staff and verified that nursing staff were following pill line administration protocol.	Insufficient Evidence to Substantiate

196.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found that based on the low evidentiary standard utilized by DOC, "some evidence," the individual was found guilty of the infraction. Because of this standard, there was insufficient evidence to substantiate the individual's account of the incident.	Insufficient Evidence to Substantiate
197.	Incarcerated individual expressed concerns about their custody classification.	The OCO reviewed the individual's most recent custody facility plan and found no violation of DOC policy 300.380 as the individual was placed on that custody level due to continuous violent infractions.	No Violation of Policy
	Washington State Penitentiary		
198.	Person reports he has been requesting to be seen by mental health and psychiatry for a long time. The person states that his medications were changed before he was demoted custody levels and he has been trying to get back on the medications.	The OCO provided assistance. OCO staff contacted DOC staff and requested a review of his psychiatry evaluations and for him to be seen by behavioral health staff. OCO staff were informed the patient had not had a full psychiatric evaluation in a few years and agreed to initiate that process for the patient.	Assistance Provided
199.	The incarcerated individual expressed concerns about a Securus mail rejection. This person had written an article for an online publication, and when an outside person attempted to send him a copy of the article, the message was rejected.	The OCO provided assistance. This office requested a copy of the Securus message rejection and reviewed it against DOC policy 450.100 attachment 4. The OCO could not determine why the message was rejected and contacted DOC headquarters about this situation. Upon further review, DOC staff overturned the mail rejection and allowed the incarcerated individual to have the previously rejected Securus message.	Assistance Provided
200.	Incarcerated individual expressed concerns about an infraction appeal.	The OCO spoke with DOC leadership to ensure that the infraction appeal was sent to the individual's previous facility. Once the infraction arrived at the appropriate facility, this office spoke with DOC leadership regarding the dismissal of the infraction due to the confidential informant (CI) information not being provided in the infraction narrative the individual received.	Assistance Provided
201.	Person reports force was used on him to put him in the close observation area (COA). The person states he was mocked and ignored so he started hurting himself and breaking things until he was taken to the COA. The person requested that staff be held accountable for how he was	The OCO provided assistance. OCO staff reviewed available records and noted that no video evidence of the use of force was available to review. OCO leadership reported these concerns related to a restricted DOC policy to facility leadership to address with staff.	Assistance Provided

	treated during a mental health crisis.		
202.	Patient reports concerns about not being placed in residential treatment unit (RTU) for mental healthcare.	The OCO provided assistance by elevating this concern through DOC mental health leadership. The individual was approved and transferred to RTU.	Assistance Provided
203.	Incarcerated individual relayed concerns regarding filing grievances that they never received a response for.	The OCO reviewed the individual's grievances and identified that one was closed due to being reported outside of timeframes but OCO found the individual was within the timeframes when they reported the concern. The OCO then spoke with DOC about this concern who agreed to review the grievance at the headquarters level if the individual submits an appeal to the initial grievance closure.	Assistance Provided
204.	Incarcerated individual reports DOC took away his tablet due to behavior in the unit and is unwilling to return it to him. The individual reports he needs to access his tablet to plan his release with family.	The OCO provided assistance. The OCO verified that DOC took the individual's tablet away per the segregation level system that is based on behavior. The OCO spoke with reentry navigation services and requested they follow up with him to assist him with release planning. The OCO also recommended to the individual to work with their classification counselor to address release planning needs.	Assistance Provided
205.	An incarcerated person reports that they are due a refund for a CI order they never received and requested a refund in a timely manner.	The DOC resolved this concern prior to OCO involvement as DOC refunded the individual the funds to their spendable account.	DOC Resolved
206.	Person reports DOC medical is denying him several requests for durable medical equipment that would ease his pain. The person reports he has already tried the solutions offered by DOC.	The OCO provided information to the patient regarding the health status report protocol and limitations it sets on a provider's ability to order requested items. A patient's condition has to meet certain criteria to be ordered durable medical equipment (DME). OCO staff contacted DOC staff and were informed the patient's provider had reviewed the requested items and determined that the patient's condition did not meet the necessary criteria.	Information Provided
207.	Person reported that DOC staff is not following through with an agreement they made in a previous OCO case to provide him with additional toilet paper.	The OCO provided information. The OCO reviewed this individual's resolution request and found that DOC provided him with instructions as to how he can get more toilet paper from staff and stated that he is getting toilet paper when he asks for it. The OCO encourages this individual to continue working with DOC staff to get additional toilet paper or request a health status report for additional toilet paper.	Information Provided

208.	Person reported that he received an infraction and expressed concerns that he is still in solitary confinement. Person also stated that Securus has not transferred his old games and music to his new tablet.	The OCO provided information about how to request a meeting with a Securus representative. The OCO is actively monitoring the transition to Securus and is still gathering information. The OCO does not have jurisdiction over Securus but is in discussion with DOC regarding their contract with Securus and is bringing issues and concerns from incarcerated individuals to DOC's attention. The OCO reviewed DOC records and found that this individual has been transferred to a different facility, and that his concern about being in solitary confinement has been resolved.	Information Provided
209.	Incarcerated individual relayed concerns regarding appealing an out of state transfer decision but headquarters stating the appeal was never received.	The OCO reviewed the individual's related grievances and saw that the individual was provided an additional opportunity to appeal the classification (FRMT) decision as the appeal was never received despite the appeal timeframe having expired. The OCO also reviewed the individual's most recent custody facility plan (CFP) in which they were placed on an out of state transfer due to presenting a significant threat toward staff in the only custody appropriate general population housing option available to them within Washington DOC. Per DOC policy 330.600(I)(A)(1) individuals may be considered for a prisons compact transfer for safety/security reasons.	Information Provided
210.	Person reported frustrations with the outdated commissary list and said that he has been filing resolution requests for years, and that DOC said they would make changes, but it has not happened. Person expressed concern about the hygiene and food items that are available.	The OCO provided information. The OCO reviewed his level three resolution request, and DOC headquarters agreed that the commissary list, especially in restrictive housing, is outdated, and a review was being conducted about allowing additional items, including more sugar free items. The OCO reached out to DOC headquarters, who said that the commissary list was reviewed in 2023 by the statewide restrictive housing unit supervisors and Mission Housing, and no changes were approved. They said that are some proposals for further review of the commissary list, but there are no written proposals at this time.	Information Provided
211.	Individual reported he has been in MAX Custody for an extended period of time with no option to move back to general population.	The OCO reviewed the individual's custody facility plan and contacted DOC headquarters to inquire about this individual's future placement. The DOC maintains there is evidence to substantiate a threat if the individual moves back to general population. This individual was given an option to accept a safe harbor placement, however they have denied that	Information Provided

		option. The DOC has denied the OCO's request to find this individual housing in general population.	
212.	A loved one reports that her incarcerated son has been trying to receive his medical records before he is released, but DOC has not fulfilled his request.	The OCO provided information about how to request medical records and follow-up with medical staff.	Information Provided
213.	Incarcerated individual relayed concerns regarding having the door closed on their hand resulting in concerns about medical access.	The OCO confirmed with DOC that the individual has received proper medical care after this incident and reviewed the individual's grievances related to this concern. The OCO informed the individual that if they wish to pursue the concern further they will need to file a tort claim for compensation.	Information Provided
214.	Person reported that DOC have communicated unethically and improperly in multiple ways, including showing prejudice, particularly regarding his mental health care and county of origin. Person reported that a mental health staff wrote untruthful reports about him.	The OCO provided information. The OCO spoke with this individual about this case and clarified the scope of this office and its authority. The OCO reviewed a large number of his mental health records and found that there were disagreements among the providers about his treatment. The OCO cannot make determinations about a patient's diagnosis or treatment. The OCO has addressed concerns with his county of origin in a separate case.	Information Provided
215.	Individual reported that he has been held in solitary confinement for multiple months waiting on the out of state transfer list.	The OCO reviewed his MAX custody placement and spoke with DOC headquarters multiple times regarding his status. The DOC was unwilling to return him to general population due to his alleged security threat group (STG) activity. This office also reviewed his out of state transfer packet and verified that it had been sent out to other states. He was recently approved to transfer was moved out of state.	Information Provided
216.	Incarcerated individual reports concerns regarding his property. The individual reports that DOC staff are not allowing him access to certain property while in segregation.	The OCO provided information about how to access his property from WSP and information about why he did not receive the specified property in segregation. The OCO spoke with DOC staff who shared that he was not allowed the certain items in segregation because they are not allowed per policy. The OCO confirmed that none of the individual's property was disposed of during their stay in segregation and if they would like their property, they need to work with the property staff at the new facility to coordinate with the previous facility. There currently are shipping costs for the property that will need to be paid as well, the OCO shared how to complete that process.	Information Provided
217.	An individual reports that when he was transferred to another	The OCO provided information to the person regarding the tort claim process. Individuals who have been harmed or who have suffered a loss as a	Information Provided

	facility, DOC staff lost his bag of property.	result of negligent actions by a state employee or agency can submit a tort claim to the Office of Risk Management (ORM). ORM is required by law (RCW Chapter 4.92) to receive these claims.	
218.	Incarcerated individual relayed concerns regarding difficulties contacting a loved one due to Securus stating the number is restricted.	The OCO informed the individual that they will need to contact Securus directly either by submitting a help ticket on their tablet or by kiting the Securus liaison at their facility.	Information Provided
219.	Person said he filed a grievance regarding the response to suicides in the BAR units. Person said the top tiers have been closed. Person said that only one tier is allowed out at a time to go to the dayroom, and that officers have just begun to enforce this. Person said that the mental health units are being isolated.	The OCO reviewed this concern and visited the facility shortly after the suicides occurred. This office verified that the units were restricted while the DOC conducted a critical incident review and construction started in the units shortly after to install screens on the third tier. 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-23-007 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website.	Information Provided
220.	Person reported that when he was transferred, DOC did not allow him to take his tablet or other property with him. Person also reported that other property was thrown away.	The OCO provided information about filing a tort claim. The OCO reviewed this individual's resolution request and found that DOC substantiated that transport staff did not follow 440.020 Transport of Property, which clearly outlines the process for transporting individuals with their tablet. DOC 120.500 states "All incarcerated individual tort claims alleging personal property damage/loss must be filed by the individual with the Washington State Department of Enterprise Services (DES) Risk Management Division." RCW 4.92.100 states, "(1) All claims against the state, or against the state's officers, employees, or volunteers, acting in such capacity, for damages arising out of tortious conduct, must be presented to the office of risk management."	Information Provided
221.	Individual requested to be interviewed for the solitary confinement project.	When the OCO received this request, this office had already started the interviews and had the maximum number of volunteers. The deadline to sign up was in the OCO newsletter and it was sent to the kiosk in September 2023.	Information Provided

222.	Incarcerated individual reports concerns regarding an incident that occurred at work. The individual reported that the staff member supervising them was not trained properly. The individual requests the staff be trained in safety and that he receives Labor and Industries (L&I) support.	The OCO provided information regarding how to contact L&I and the actions taken by the DOC. The OCO verified the individual received medical care and follow up to treat the injury. The OCO verified DOC investigated the incident and responded to the investigation appropriately. The OCO provided the individual with information about how to work with L&I and how to file a tort claim.	Information Provided
223.	Incarcerated individual relayed concerns regarding frustrations with the quality of the mail copies.	The OCO spoke with DOC staff about this, and informed the individual that to contest print quality, they will need to kite the mail sergeant and let him know the print quality is poor and they need to be reprinted.	Information Provided
224.	Incarcerated individual reports concerns regarding the resolution program. The individual reports they are not receiving timely responses and are sometimes not receiving responses at all. The individual requests the OCO review the resolution requests and ensure he received responses.	The OCO provided information regarding the resolution program and how to report concerns with the process. The OCO reviewed all the resolution requests the individual shared and found that many were responded to past the timeframes outlined in the resolution program manual (RPM). The OCO verified that DOC has responded to all the reported resolution requests and shared tools for working with the resolution program.	Information Provided
225.	Person reports he is suffering from medical issues related to equipment being used by staff.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO was unable to access records necessary to investigate this concern because the person declined to sign a release of information.	Insufficient Evidence to Substantiate
226.	Incarcerated individual relayed concerns regarding being targeted by staff and other incarcerated individuals.	The OCO reviewed the individual's custody facility plan and grievances and was unable to locate information to substantiate the individual's concern.	Insufficient Evidence to Substantiate
227.	Patient reports that DOC medical did not provide the brace that was agreed upon in a previous OCO case.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff contacted DOC staff and were informed that patient's provider worked with DOC custody staff to find an appropriate alternative to the requested brace. The patient had been offered multiple alternative braces that were appropriate for his living unit.	Insufficient Evidence to Substantiate
228.	Incarcerated individual relayed concerns regarding a particular DOC staff member changing the prices of items sold in the bar unit "snack shack."	The OCO reviewed the individual's grievances related to this issue which states there is a committee that decides the prices on all of the items in the shack as well as prices have risen due to inflation. Thus, there is insufficient evidence to show that a DOC staff is personally changing the prices.	Insufficient Evidence to Substantiate

INTAKE INVESTIGATIONS			
Airway Heights Corrections Center			
229.	A family member contacted the OCO regarding the quality of shower water and a related medical complaint by their family member.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. Letter sent to the incarcerated person letting them know that a family member filed a complaint on their behalf and how to access OCO services if they would like OCO assistance.	Administrative Remedies Not Pursued
230.	Incarcerated individual expressed concerns about their diet.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
231.	Incarcerated individual relayed concerns regarding a desire for assistance with a legal financial obligation (LFO) petition.	The OCO declined to investigate this concern per WAC 138-10-040(3)(e) as the requested resolution is not within the ombuds' statutory power and authority.	Declined
232.	An individual filed a tort claim after OCO closed the previous case and the tort claim was denied. This person would like to take this issue further and is looking to the OCO for next steps.	The OCO lacks jurisdiction to investigate this complaint because the complaint relates to an action taken by an agency other than the Washington State Department of Corrections. The OCO cannot impact any further change in this person's situation.	Lacked Jurisdiction
233.	Loved one relayed concerns regarding an incarcerated individual's infractions.	The OCO sent the individual an OCO review request form to ensure that they wanted this concern investigated but did not hear back from the individual. Thus, this case was closed without further investigation.	Person Declined OCO Assistance
234.	Loved one relayed concerns regarding infractions an incarcerated individual received.	The OCO sent the individual an OCO review request form to ensure this was something they wanted this office to investigate but did not hear back from them. Thus, this case was closed without further investigation.	Person Declined OCO Assistance

235.	Incarcerated individual relayed concerns regarding their job duties increasing and a simultaneous pay reduction. The individual reports that the facility combined the mailroom messenger position with two other porter jobs, and offered less pay for more work.	This person was released from DOC custody prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
	Cedar Creek Corrections Center		
236.	Incarcerated individual relayed concerns regarding improper sentence calculations.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
	Clallam Bay Corrections Center		
237.	An incarcerated person reports they are having difficulty with property purchasing processes. The person states that they attempted to purchase property but the new property sergeant is not following the same process that the previous property sergeant followed.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
238.	Incarcerated individual relayed concerns regarding an infraction.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
239.	Incarcerated individual relayed concerns regarding damaged property.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
240.	Incarcerated individual relayed concerns regarding what property is allowed in closed custody.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued

241.	A loved one reported an issue with DOC handling property disrespectfully and losing it.	This person was released from DOC custody prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
	Coyote Ridge Corrections Center		
242.	A member of the community forwarded a request from an incarcerated person regarding an infraction.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. There was no infraction appeal filed by the incarcerated person.	Administrative Remedies Not Pursued
243.	An incarcerated person reported to the OCO that they wished to appeal their classification review (FMRT), have their sentence re-calculated and be re-instated into a job.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. Person was also reinstated into a job.	Administrative Remedies Not Pursued
	Monroe Correctional Complex		
244.	Incarcerated individual expressed concerns about staff conduct.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
245.	An incarcerated person reports money sent to them was rejected and then instead of returning it to the sender it was sent to the Incarcerated Individual Benefit Fund (IIBF).	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
246.	An Incarcerated person contacted the OCO to report they are not being allowed to access gym. They have not filed any grievances or alerted the resolution program.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
247.	An incarcerated person reports DOC staff members are making inappropriate comments to each other regarding their crime of conviction.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to	Administrative Remedies Not Pursued

		resolve it through the DOC internal grievance process, administrative, or appellate process.	
248.	Formerly incarcerated individual relayed concerns regarding staff conduct that occurred several years prior during their incarceration.	The OCO declined to investigate this concern per WAC 138-10-040(3)(f) as the alleged violation is a past rather than ongoing issue as the individual has since released from prison and is no longer being impacted by this concern. The OCO provided the individual with contact information for a resource who may be able to better address their concern.	Declined
	Other - Community Custody		
249.	Individual expressed concerns about the conduct of their community custody officer.	The OCO declined to investigate this concern as it involves officer conduct on community custody and per WAC 138-10-040(3)(a) the ombuds lacks jurisdiction over the complaint. The OCO provided the individual with contact information for other resources that may be able to better address the concerns the individual raised.	Lacked Jurisdiction
	Other - Jail/County/City		
250.	Loved one expressed concerns about county jail conditions.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
251.	Loved one expressed concerns about jail conditions.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint but provided the loved one with the contact information for the King County Jail Ombuds office.	Lacked Jurisdiction
252.	Loved one expressed concerns about an individual being bothered by other individuals inside a jail facility.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
253.	Incarcerated individual relayed concerns regarding the court process of their trial.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
254.	Formerly incarcerated individual relayed concerns regarding previously being incarcerated for longer than they should have been and wanting to be paid for those additional days in prison.	The OCO declined to investigate this concern per WAC 138-10-040(3)(e) as the requested resolution is not within the ombuds' statutory power and authority.	Declined
255.	Anonymous individual reported safety concerns.	The OCO declined to investigate this concern per WAC 138-10-040(3)(c) due to the nature and quality of the evidence as without identifying information provided by the individual the OCO was unable to further investigate the concern.	Declined

	Stafford Creek Corrections Center		
256.	The individual reported concerns about a medical appointment he attended and having issues with DOC medical staff. This person said the appointment was abruptly cut short as soon as he began talking to the medical provider about letters he had sent to the FBI. Additionally, this person reports that he does not know why his medical appointments were even scheduled.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
257.	An Incarcerated person reported to the OCO that DOC staff had removed or lost some of his property at a recent pack out.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. Additionally, the OCO verified at level 1 response DOC documented that the missing property had been found and returned to the incarcerated person.	Administrative Remedies Not Pursued
258.	An incarcerated person reports they are missing property after a move and have filed a tort claim for an item that was reported as broken by DOC staff at the time of the move. The person is requesting compensation for missing and broken items.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. Additionally the OCO is not able to assist with seeking compensation, the person was provided with information on how to file a tort claim after exhausting administrative remedies.	Administrative Remedies Not Pursued
259.	Incarcerated individual relayed concerns regarding staff conduct when a staff member allegedly lost their program application.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
260.	Incarcerated individual relayed concerns regarding staff conduct when the individual reports another incarcerated individual was allegedly allowed to hit them.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued

261.	Incarcerated individual relayed concerns regarding staff conduct as the individual reports staff are not doing tier checks properly.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
262.	The individual reports concerns regarding medical protocols and feels that medical is used as a punishment.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
263.	Incarcerated individual relayed concerns regarding a disagreement with the outcome of a closed case review the OCO conducted regarding the individual's case.	The OCO declined to investigate this concern per WAC 138-10-040(3)(g) as OCO closed case reviews are final decisions.	Declined
	Washington Corrections Center		
264.	An incarcerated person reached out to the OCO and relayed concerns regarding law library access and accessing phone numbers for his family's attorney.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
265.	An incarcerated person requested assistance with an infraction but did not appeal the infraction prior to reaching out to the OCO.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
266.	Incarcerated individual relayed concerns regarding their sentence.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
	Washington Corrections Center for Women		
267.	Incarcerated individual relayed concerns regarding staff conduct when the individual reports a staff member issues frequent infractions.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued

268.	Both an incarcerated person and their family member reached out to the OCO relating concerns with DOC staff treatment, issues with a cell mate, and expressing general dissatisfaction with the living conditions that the incarcerated person was experiencing.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
	Washington State Penitentiary		
269.	Incarcerated individual expressed concerns about not being allowed to attend an infraction hearing.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
270.	Incarcerated individual relayed concerns regarding an infraction.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
271.	An incarcerated person reported to the OCO that their family member is being blocked from being able to contact them due to I&I accusing them of bringing in drugs which they state is not true.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
272.	An incarcerated person reports DOC took 30 days to issue them a tablet, their radio was removed after receiving a tablet and that the quality of the headphones/tablet are poor.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Administrative Remedies Not Pursued
273.	An anonymous individual reported concerns in the facility about individuals entering units they are not allowed to.	The OCO declined to investigate this concern per WAC 138-10-040(3)(c) due to the nature and quality of the evidence as the individual was unwilling to provide specific details about the concern and was unwilling to tell DOC about the concern. Without specific details, the OCO would be unable to investigate this concern properly.	Declined
274.	Loved one expressed disagreement with a sentence an incarcerated individual received	The OCO declined to investigate this concern per WAC 138-10-040(3)(e) as the requested resolution is not within the ombuds' statutory power and authority.	Declined

	and a desire for the OCO to review it.		
275.	Person reported issues with medical staff response to emergencies and is concerned that medical has prevented him from going to his desired custody setting.	The incarcerated individual advised the OCO they did not want the OCO to investigate the complaint. During the OCO review of the concern the person had a facility plan review and was transferred to his preferred facility.	Person Declined OCO Assistance
276.	Person reports he was put on an inappropriate dose of medication for mental health causing long term health problems.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO contacted the person requesting a release of information. Due to the medication of concern, the OCO cannot investigate this concern without a signed release of information. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance
277.	A loved one reported an issue with DOC handling property disrespectfully and losing it.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
278.	Person reports he got an infection in his unit that lead to an amputation. The person requested that the OCO review why so many people are getting infections.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-012

Report to the Legislature

As required by RCW 72.09.770

March 3, 2024

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
cheryl.strange@doc.wa.gov

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Unexpected Fatality Review Committee Report

UFR-23-012 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. Under federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying 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 January 25, 2024:

DOC Health Services

- Dr. Frank Longano, Chief Medical Information Officer representing the Chief Medical Officer
- Melissa Freeman, Registered Nurse 3
- Dawn Williams, Program Administrator – Substance Abuse Recovery unit
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Office of the Secretary

- Megan Pirie, Director – Person Centered Services

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Eric Jackson, Deputy Assistant Secretary
- Lorne Spooner, Correctional Operations Program Manager
- Rochelle Stephens, Project Manager

DOC Women's Prison Division

- Melissa Andrewjeski, Assistant Secretary
- Deborah Jo Wofford, Deputy Assistant Secretary

DOC Risk Mitigation

- Mick Pettersen, Director

DOC Reentry Division (Reentry Centers)

- Danielle Armbruster, Assistant Secretary
- Scott Russell, Deputy Assistant Secretary
- Susan Leavell, Senior Administrator – Reentry

DOC Community Corrections Division

- Kelly Miller, Administrator – Graduated Reentry
- Dell-Autumn Witten, Administrator

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director, Office of the Corrections Ombuds
- Elisabeth Kingsbury, Senior Corrections Ombuds - Policy
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services
- Ellie Navidson, Nursing Consultant Institutional, Healthy and Safe Communities

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: 1958 (64-years-old)

Date of Incarceration: January 2018

Date of Death: August 2023

At the time of his death, this incarcerated individual was housed in a prison facility. The cause of death was hypertensive cardiovascular disease. The manner of death was natural.

Below is a brief timeline of events leading up to the incarcerated individual's death:

Day of death	Event
0550 hours	• Alert button in the incarcerated individual's cell was activated. • Custody officer checked on him in cell and noticed he appeared to have mobility issues and was holding the wall for stability. • The custody officer reported the incarcerated individual stated multiple times that he must have accidently pressed the button and advised the officer he was not declaring a medical emergency.
0618 hours	• Tier check completed.
0717 hours	• Tier check completed.
0750 hours	• Custody officers were advised by another resident from his unit to check on the incarcerated individual. • Custody staff found him nonresponsive, radioed for a medical emergency, and began life saving measures.
0751 hours	• DOC Health Services staff arrived and assumed responsibility for aid.
0758 hours	• EMS arrived and assumed care.
0826 hours	• EMS pronounced the incarcerated individual deceased.

UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee. The UFR Committee members considered information from the review 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's high blood pressure management was complicated by his

lung disease and his blood pressure control was not optimal.

b. A medication previously discontinued by the consulting cardiologist was restarted by the DOC primary care provider because the provider thought it had dropped off the active medication list during one of his hospitalizations.
c. The primary care provider ordered monitoring of his blood pressure with a follow-up visit with them scheduled in two months. Documentation does not show the primary care provider received and acted on results of the blood pressure monitoring prior to the scheduled follow-up visit.
d. DOC's paper health record makes trending vital signs hard to follow over time and makes medication reconciliation between multiple care venues more difficult.

2. The Mortality Review Committee recommended:

    a. A referral to the Unexpected Fatality Review Committee.
    b. DOC Health Services should monitor the effectiveness of blood pressure treatment.
    c. DOC Health Services should identify a process to support the management of patients with high blood pressure while using a paper health record.

B. Independent of the mortality review, 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. DOC unit post orders were not clear regarding logging an alert call button activation nor conducting a tier check.

2. The CIR recommended updating the unit post orders.

C. The Department of Health (DOH) representative agreed with the proposed recommendations and emphasized the need for an electronic health record (EHR). The representative acknowledged the difficulty of tracking continuity of care for multiple doctors without an EHR. The DOH representative asked how DOC coordinates when there are multiple providers. DOH encourages DOC Health Services to continue identifying processes to support use of a paper health record until DOC implements an EHR.

Note: Historically the DOC primary care provider was responsible for care coordination. As DOC continues to implement the Patient Centered Medical Home model of care, incarcerated individuals are supported by an integrated care team who work together to support care coordination.

D. The Health Care Authority (HCA) representative was present for the discussion and did not offer additional recommendations for improvement.

E. The Office of the Corrections Ombuds (OCO) representative asked about whether tier checks were correctly conducted and asked for a description of the response process when an individual hits

the “emergency” button in their cell.

The OCO representative would like to see improvements to documentation of “emergency” call button response and clear guidance for clinical assessments/notification. If a call button is accidentally pressed, is there a way to document the accident along with a patient signature.

The representative also recommended again to change the name of the tier check to a “wellness check” and asked what actions DOC can take when tier checks are conducted incorrectly. The OCO also asked if the concept of “wellness checks” can be part of all trainings.

Note: DOC responded that the tier checks had been conducted as logged but were not as thorough as desired. Custody officers respond immediately to an alert button activation to assess the individual’s need. If there had been a medical emergency, the custody officer would initiate a medical response via radio. In this case, the custody officer reported the individual stated multiple times that he was not having a medical emergency, he pressed the button accidentally and did not need any assistance.

DOC agrees that an entry should have been made in the unit logbook documenting the use of the in-cell alert button and the response. Corrective actions have been put in place to address staff training for maintaining unit logbooks. DOC has provided system wide training on the process for conducting tier checks. When tier checks are not conducted correctly, DOC will utilize the just cause process to hold individual staff members responsible.

Committee Findings

The manner of the incarcerated individual’s death was natural. The cause of death was hypertensive cardiovascular disease.

Committee Recommendations

1. DOC Health Services should update the performance metrics to monitor the effectiveness of blood pressure treatment.
2. DOC Health Services should adopt a statewide standard system to support the effective management of high blood pressure.

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

1. DOC should continue to pursue funding for an electronic health record (EHR) to replace paper health records and to support interface with community health systems.
2. DOC should ensure required tasks are completed and documented in accordance with policy and unit post orders.
3. DOC should review the process to improve paper record processes while awaiting an EHR.
4. DOC should review the process for documenting alert button activation including when an incarcerated individual declines services after activating the alert button.
5. The OCO requests DOC consider changing the name of “tier-checks” to “wellness-checks” to reinforce the purpose of the checks to ensure appropriate behavior and wellbeing of the incarcerated individual.

Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-23-012

Report to the Legislature

As required by RCW 72.09.770

March 13, 2024

DOC Corrective Action, Publication Number 600-PL001

Cheryl Strange, Secretary
cheryl.strange@doc.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 23-012 on March 3, 2024 (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-23-012-1
Finding:	The incarcerated individual's blood pressure control was not optimal.
Root Cause:	The initial Patient Centered Medical Home (PCMH) blood pressure metric was access to care (leading metric) rather than outcome measure (lagging metric). Success was defined as whether a visit occurred within the past 6 months rather than whether the treatment was effective in controlling the blood pressure.
Recommendations:	DOC should update the performance metrics to monitor the effectiveness of blood pressure treatment.
Corrective Action:	DOC will update the blood pressure (BP) management metric from access to care to effectiveness of care.
Expected Outcome:	Improved care outcomes for individuals diagnosed with high blood pressure.

CAP ID Number:	UFR-23-012-2
Finding:	Documentation does not show the primary care provider received and acted on the results of the blood pressure monitoring prior to the scheduled follow-up visit.
Root Cause:	The current process and tools for monitoring blood pressure treatment effectiveness are not optimally connected and staff use is inconsistent.
Recommendations:	DOC Health Services should adopt a statewide standard system to support the effective management of high blood pressure.
Corrective Action:	DOC Health Services will adopt the Patient Centered Medical Home blood pressure management pilot project as the statewide standard system.
Expected Outcome:	Improved monitoring and treatment for individuals diagnosed with high blood pressure.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-021

Report to the Legislature

As required by RCW 72.09.770

March 19, 2024

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
cheryl.strange@doc.wa.gov

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Unexpected Fatality Review Committee Report

UFR-23-021 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

This report describes the results of one such review 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. Under federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying 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 8, 2024:

DOC Health Services

- Dr. Frank Longano, Chief Medical Information Officer representing the Chief Medical Officer
- Patty Paterson, Director of Nursing
- Mark Eliason, Deputy Assistant Secretary
- Rae Simpson, Director – Quality Systems
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary

DOC Risk Mitigation

- Mick Pettersen, Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director, Office of the Corrections Ombuds
- Elisabeth Kingsbury, Senior Corrections Ombuds - Policy
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services
- Ellie Navidson, Nursing Consultant Institutional, Health 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: 1959 (64-years-old)

Date of Incarceration: 2008

Date of Death: November 2023

At the time of his death, the incarcerated individual was housed in a prison facility. His cause of death was metastatic liver cancer. The manner of death was natural.

Below is a brief timeline of events leading up to the incarcerated individual's death:

Approximate Months prior to death	Event
18 months prior	• Incarcerated individual was seen by his primary provider for weight loss, low energy, and abdominal pain. • An urgent referral was submitted to community gastroenterology and hematology for diagnostic consultation.
17 months prior	• Specialty medical consults occurred. • Additional diagnostic testing requested by specialty consultants.
15 months prior	• Abdominal ultrasound demonstrated abnormal findings. • Radiologist recommended a dedicated liver CT scan to evaluate further. • No documentation that this abnormal finding was received or reviewed by the requesting community consultant or by his DOC provider.
13 months prior	• Seen for follow-up at the request of the incarcerated individual to discuss ultrasound results, ongoing symptoms, and new swelling in neck. • No documentation that the abnormal ultrasound was discussed or further work-up of weight loss or dizziness was considered.
12 months prior	• The incarcerated individual was sent to a community hospital for abdominal pain and weight loss. • In the hospital, an abdominal ultrasound was performed, but it did not show the abnormal findings seen in the prior ultrasound. The quality of the ultrasound result was documented as "poor". • In the documentation, the emergency department provider noted the original abnormal ultrasound result and determined an additional CT scan was recommended and to follow-up on an outpatient basis.

	• Neither the community specialist nor DOC providers ordered the recommended CT scan.
9 months prior	• Diagnostic testing was completed by the community gastroenterologist. • Results indicated inflammation but no malignancy in the intestinal track.
8 months prior	• Follow up appointment with hematologist/oncologist who recommended a liver CT scan based on the original abnormal ultrasound findings. • Urgent CT scan ordered and scheduled. • Results revealed a large mass with possible metastatic growth in the liver. • Biopsy positive for liver cancer. • Follow-up and treatment with oncologist scheduled.
6-7 months prior	• Chemotherapy treatment initiated. • Second chemotherapy treatment was complicated by infection requiring hospitalization. • He declined further chemotherapy treatment due to side effect concerns which he felt would interfere with his family visits. He was counseled by DOC staff and signed an informed declination of care.
3- 5 months prior	• He continued to be monitored by his oncologist. • Follow-up CT scan indicated metastatic spread. • He elected to begin palliative treatment and supportive care.
2 months	• Multiple visits to the emergency room for symptom management. • Seriously ill notification initiated. • Extraordinary medial placement (EMP) was requested.
1 month	• Incarcerated individual requested full treatment and full code response. • EMP request passed clinical screening and was advanced to next step.
Final month	• The incarcerated individual updated his Physician Order for Life Sustaining Treatment (POLST) order to Do Not Resuscitate (DNR) and elected for comfort focused care. • His health continued to deteriorate. • The EMP process was stopped at the request of his family and care team due to concerns that transfer would cause more harm than benefit.
Day of death	**Event**
Day of death	• The incarcerated individual died while being cared for in the facility IPU.

UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee. The UFR Committee members considered the information from the review 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 CT scan recommended in the abnormal ultrasound report was not ordered resulting in a delay in care.
        b. The possible causes for the unintentional weight loss experienced by the incarcerated individual were not explored by the DOC primary care provider.
        c. The Department of Corrections lacks a standard process for receiving and reviewing consult reports and test results.

    2. The Mortality Review Committee recommended.

        a. A referral to the UFR committee.
        b. A multi-disciplinary Healthcare Failure Mode and Effect Analysis (H-FMEA) be conducted to look at the identified care delays related to system failures.
        c. DOC explore development of a statewide tracking tool to ensure that results are received and appropriately managed.

B. The Department of Health (DOH) representative discussed the large gaps in time between care and acknowledged the impact not having an electronic health record has on care delivery. The DOH representative asked that the gaps in care be explained and addressed.

    Note: DOC explained that currently there is no standard process for obtaining results from offsite visits which contributed to gaps in care. Ultimately it is the responsibility of all providers to follow-up on care requests and results. DOC Health Services is exploring options to improve care coordination with community consultants including obtaining results and reports from offsite care.

    The DOH representative asked DOC to describe the seriously ill notification process. DOH also asked why the incarcerated individual was found ineligible for Extraordinary Medical Placement (EMP) the first two times they applied and after he was approved by health services the process stopped.

    Note: The seriously ill notification is a status determined by clinicians when an incarcerated individual is significantly ill and has the potential to decline. This notification is a way for Health Services to notify custody, religious coordinators, and other partners of the incarcerated individual's status. This supports flexible visitation and facilitates provider communication with next of kin.

    At the time of his initial application, the Extraordinary Medical Placement (EMP) law required an individual to be physically incapacitated in order to qualify. In 2023, the law changed to allow

eligible incarcerated individuals, who have prognosis of six months or less to live, to transition into an appropriate community setting. In addition to the medical criteria, approval to participate in the EMP program requires meeting custody and community safety criteria.

Once he was approved for EMP, the family requested to stop the placement process as it may do more harm than good to move him away from his care team. This request was supported by his care team.

The DOH representative was concerned that the incarcerated individual declined his third chemotherapy treatment to not miss an opportunity to visit with his family. The DOH representative asked if there is an option to extend family visits due to end-of-life care to avoid having to choose between care and visitation with loved ones.

Note: DOC shared that the incarcerated individual was experiencing side effects from the chemotherapy. He indicated he was too tired after treatment and chose to stop so he would feel well enough to visit with his daughter.

DOH would like to see the term "Offender" removed from the DOC electronic death report.

Note: DOC will explore the ability to change name of the death report in the software.

C. The Health Care Authority (HCA) representative asked if the incarcerated individual was tested for Hepatitis C.

Note: DOC stated that he was tested in 2022 and was positive for Hepatitis C antibodies with no evidence of active infection requiring treatment. DOC currently treats individuals with active Hepatitis C infections.

D. The Office of the Corrections Ombuds (OCO) supports the committee recommendations including the exploration of the development of a statewide tracking tool for test results and recommends including tracking of nutritional status and weight loss. The OCO representative asked if DOC is working on a corrective action plan to address monitoring nutritional status and weight loss.

Note: DOC has one dietician for the state. The CMO and dietician have discussed development of a support tool but no specific timeline for deployment. DOH representatives met with the DOC nutritionist and provided resources and tools available through DOH to support incarcerated individuals experiencing unintended weight loss.

The OCO representative reported they had received concerns from this family related to delays in his care and were able to elevate the concern to DOC Health Services. OCO wants to make sure that the provider investigation led to results within DOC.

Note: DOC investigated the reported concern, and the concern was appropriately addressed with the provider.

Committee Findings

The manner of the incarcerated individual's death was natural. The cause of death was metastatic liver cancer.

Committee Recommendations

1. DOC should conduct a multi-disciplinary Healthcare Failure Mode and Effect Analysis (H-FMEA) to look at this case in addition to two other cases previously identified with care delays.
2. DOC should explore the development of a tracking tool for external provider consult reports and test results.

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

1. DOC should look for opportunities to continue partnering with DOH on nutrition and unintended weight loss support resources.
2. DOC should continue to implement the Patient Centered Medical Home model of care to offer multidisciplinary team support and care planning for individuals with nutritional and weight related challenges.
3. DOC should explore removing the word "offender" from the DOC electronic death report.

Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-23-021

Report to the Legislature

As required by RCW 72.09.770

March 29, 2024

DOC Corrective Action, Publication Number 600-PL001

Cheryl Strange, Secretary
cheryl.strange@doc.wa.gov

Unexpected Fatality Review
DOC Corrective Action Plan

DOC Corrective Action Publication Number 600-PL001

Legislative Directive

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Unexpected Fatality Review Governance

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Unexpected Fatality Review Committee Report

The department issued the UFR committee report 23-021 on March 19, 2024 (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-23-021-1
Finding:	Care delays occurred during the course of the incarcerated individual's illness.
Root Cause:	Both DOC and community medical providers failed to follow-up on abnormal diagnostic test results.
Recommendations:	DOC should conduct a multi-disciplinary Healthcare Failure Mode and Effect Analysis (H-FMEA) to look at this case in addition to two other cases previously identified with care delays.
Corrective Action:	DOC will conduct a multidisciplinary Healthcare Failure Mode Effects and Analysis (H-FMEA) regarding care delays for this and two other identified cases.
Expected Outcome:	Improved coordination and timeliness of care delivery.

CAP ID Number:	UFR-23-021-2
Finding:	There was no evidence that the abnormal ultrasound result was received or reviewed by DOC providers.
Root Cause:	The DOC process for receiving and acting on reports and results from offsite visits with community providers contains an unacceptable level of variability.
Recommendations:	DOC should explore the development of a tracking tool for external provider consult reports and test results.
Corrective Action:	DOC will develop a standard process for obtaining and reviewing consult reports and test results.
Expected Outcome:	Improved care coordination and outcomes for individuals.

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 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.

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