Office of the Corrections OMBUDS

Monthly Outcome Report

July 2026

UNEXPECTED FATALITY REVIEWS: 2

CASE INVESTIGATIONS: 121

Assistance Provided: 5
Information Provided: 36
DOC Addressed the Complaint: 18
Insufficient Evidence to Substantiate: 19
No Violation of DOC Policy: 42
Substantiated: 1

INTAKE INVESTIGATIONS: 163

Declined: 59
No Jurisdiction: 11
Complaint Withdrawn: 30
Technical Assistance Provided: 63

TOTAL RESOLVED INVESTIGATIONS: 286

Monthly Outcome Report: July 2026

	Complaint Summary	Outcome Summary	Case Closure Reason
Unexpected Fatality Reviews			
1.	An incarcerated individual passed away while in DOC custody.	This case was reviewed by the Unexpected Fatality Review Committee, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A public report regarding UFR-25-030 was delivered to the Governor and state legislators this month. It is also available in prison law libraries and at the end of the OCO's Monthly Outcome Report. The UFR Committee made three recommendations to DOC related to this review.	Unexpected Fatality Review
2.	An incarcerated individual passed away while in DOC custody.	This case was reviewed by the Unexpected Fatality Review Committee, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A public report regarding UFR-26-001 was delivered to the Governor and state legislators this month. It is also available in prison law libraries and at the end of the OCO's Monthly Outcome Report. The UFR committee did not issue any recommendations for corrective actions.	Unexpected Fatality Review
Case Investigations			
Airway Heights Corrections Center			
3.	An external person reported that their loved one is not receiving necessary dental care, and they requested that the person receive treatment.	DOC addressed the complaint prior to OCO action. OCO staff reviewed the person's specialist consultations and found that the patient required a higher level of care than what is available within the facility. OCO staff verified that he was already scheduled to see the requested specialist. OCO staff monitored the appointments and found that the outside clinic canceled the original appointment and immediately rescheduled. OCO staff continued to monitor the appointment until it was confirmed that the patient was able to receive treatment.	DOC Addressed the Complaint
4.	Incarcerated individual shared concerns about issues with DOC staff and a desire to transfer.	DOC staff addressed this concern prior to OCO action. Following a review of DOC records, this office was able to confirm that this individual has transferred to a different facility per their request.	DOC Addressed the Complaint
5.	Incarcerated individual shared concerns regarding potentially being moved.	DOC staff addressed this concern prior to OCO action. After speaking with this individual, this office was informed that the concern has been resolved.	DOC Addressed the Complaint
6.	Person reported DOC staff were acting inappropriately during his stay at an outside hospital. The person stated that he lost his store and messaging privileges.	The OCO provided the person with information about the OCO investigation. OCO staff reviewed the person's concern and contacted DOC facility leadership. The OCO was able to partially substantiate the person's concern. However, there was insufficient evidence to substantiate the entirety of the reported concern. OCO staff were unable to confirm that the actions of DOC staff were related to the sanctions this person received.	Information Provided
7.	Person reported concerns regarding his access to proper footwear. The person states he has been struggling to get shoes	The OCO provided technical assistance to the person regarding the use of the resolution program and DOC's property policy. OCO staff reviewed the person's concern and found this issue	Information Provided

	that fit because neither DOC nor Union Supply sells shoes in half sizes.	does not meet the criteria for shoes to be provided through DOC medical.	
8.	Incarcerated individual relayed concerns regarding receiving a WAC 603 infraction.	The OCO reviewed the individual's infraction history and confirmed that their infraction occurred in February, and WAC 603s were discontinued on June 24, 2026, due to this the infraction they received was valid.	Information Provided
9.	Incarcerated individual relayed concerns regarding a WAC 752 infraction.	The OCO reviewed the individual's infraction history and were unable to find an infraction matching this description.	Insufficient Evidence to Substantiate
10.	An incarcerated individual shared concerns that the DOC had not provided him with the public records he requested.	The OCO reviewed existing evidence and was unable to substantiate the concern. After outreach to DOC staff, this office was informed that DOC had no responsive records for this individual's request. The individual was informed of this information, and DOC told them how they could potentially obtain the records they seek.	Insufficient Evidence to Substantiate
11.	Person reported that their counselor made a false statement in their records, negatively impacting their release hearing. This person is requesting that the statement be removed from their record.	The OCO reviewed existing evidence and was unable to substantiate the concern. OCO staff reviewed the person's records and found that the reported entry was not a deciding factor in the board's decision. OCO staff found that DOC staff considered the person's request to remove the entry but declined to change the record.	Insufficient Evidence to Substantiate
12.	Incarcerated individual shared concerns regarding being wrongly infracted and not hearing back from DOC on their infraction appeal.	The OCO reviewed existing evidence and was unable to substantiate the concern. DOC records indicate that this individual appealed the infraction, and it was upheld. This office also confirmed that DOC staff had found contraband within this individual's cell, and this individual had also displayed signs of inebriation. Due to these circumstances, this individual was given an infraction per DOC policy 450.050.	Insufficient Evidence to Substantiate
13.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as two small squares were found during a cell search that tested positive for spice with a presumptive positive test.	No Violation of DOC Policy
14.	The person reported that DOC is trying to transfer him despite having a medical hold for surgery. The person is requesting to stay at his current facility until his surgery is completed.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 610.110 and WAC 388-875-0070. OCO staff reviewed the person's record and found that the person's medical needs were considered throughout the classification and transfer process. OCO staff verified the person is scheduled for their procedure and has an approved transfer order to return to the original facility. OCO staff verified that the transfer plan was reviewed by the Facility Medical Director at the receiving facility.	No Violation of DOC Policy
15.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000, as two small squares were found during a cell search and tested presumptive positive for spice.	No Violation of DOC Policy
16.	Incarcerated individual shared concerns regarding DOC staff giving them a negative behavioral observation entry (BOE) and upholding it following an appeal.	The OCO reviewed the complaint and found that DOC actions are currently allowed within DOC policy 300.010. Following a review of DOC records, this office confirmed that this individual appealed the BOE and received an appeal response.	No Violation of DOC Policy

17.	Person reported that DOC is requiring him to complete programming unrelated to his current conviction. The person is requesting permission to attend a camp setting to receive programming.	The OCO reviewed the complaint and found that DOC actions are currently allowed within DOC policy 300.380. OCO staff reviewed the person's classification review and found that the custody level decision was made by DOC headquarters, with the stipulation that treatment needed to occur prior to being allowed a lower level of custody.	No Violation of DOC Policy
Cedar Creek Corrections Center			
18.	Person reported that DOC is not allowing him to change his county of origin so that he can be accepted into GRE.	The OCO reviewed the complaint and found DOC actions or inactions are currently allowed within DOC policy 300.380. OCO staff reviewed the person's records and found that the decision to deny GRE was made based on the person's criminal history, not on the location of his victims.	No Violation of DOC Policy
Clallam Bay Corrections Center			
19.	An external person shared concerns on behalf of an incarcerated individual regarding their classification.	DOC staff addressed this concern prior to OCO action. After speaking with the incarcerated individual, it was confirmed that their concern was resolved following their conversation with DOC staff.	DOC Addressed the Complaint
20.	Incarcerated individual relayed concerns regarding safe harbor placement.	The OCO reviewed the individual's custody facility plan and confirmed that they are not identified as a member of a security threat group, making them ineligible for safe harbor placement. For protective custody, the OCO informed the individual that they would need to reach out to the special investigative services through the local facility's intelligence and investigation unit to provide verifiable information to support such a designation.	Information Provided
21.	Incarcerated individual relayed concerns regarding safe harbor placement.	The OCO reviewed the individual's custody facility plan and confirmed that they are not identified as a member of a security threat group, making them ineligible for safe harbor placement. For protective custody, the OCO informed the individual that they would need to reach out to the special investigative services through the local facility's intelligence and investigation unit to provide verifiable information to support such a designation.	Information Provided
22.	Incarcerated individual relayed concerns regarding safe harbor placement.	The OCO reviewed the individual's custody facility plan and confirmed that they are not identified as a member of a security threat group, making them ineligible for safe harbor placement. For protective custody, the OCO informed the individual that they would need to reach out to the special investigative services through the local facility's intelligence and investigation unit to provide verifiable information to support such a designation.	Information Provided
23.	Person reported being harassed and requested keep separate orders regarding specific individuals.	The OCO provided information about the keep separate process and what was found during the OCO's investigation. The OCO reviewed DOC records and found that this person is not currently at the same facility as the two individuals named in the original complaint. The OCO also found that this person has not filed a keep separate.	Information Provided
24.	The person reported having a property concern and said that the resolutions program was rejecting his resolution requests about his property.	The OCO reviewed the complaint and found that DOC actions or inactions are currently allowed within the Resolutions Program Manual and DOC policy 550.100. The OCO reviewed this individual's resolution requests and could not substantiate that DOC violated policy by rejecting them as duplicates.	No Violation of DOC Policy

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 video summary showed a mutual fight.	No Violation of DOC Policy
Coyote Ridge Corrections Center			
26.	External person reported that their loved one has cancer and DOC is not providing treatment, only diagnostics. The family is requesting that the person be transferred out of state to receive treatment at a specialized hospital.	The OCO provided the impacted person with information about his active consultations. OCO staff reviewed the person's medical records and found that the specialist consultation had already been scheduled before the issue was reported to the OCO. OCO staff reviewed the person's medical history and found that the patient had been seen and that his medical provider had initially treated his symptoms with a different rationale than the one he later provided. When that treatment proved ineffective, further testing was conducted, and a referral for specialist consultation was submitted as a result. The person has seen the specialist and has been referred for more diagnostics and to see an additional specialist for treatment consideration. At the time of review, no treatment had been ordered. There is insufficient evidence to substantiate that the DOC medical provider did not act on the person's initial report of symptoms.	Information Provided
27.	A case was opened based on closed-case monitoring conducted by the OCO regarding an individual's access-to-care issue. A case was originally opened by the affected person, who stated he was not being given access to specialist-recommended imaging. The OCO found conflicting information within the system, and this case was opened to address the concern.	The OCO provided the impacted person with information about his appointment. The OCO found that no action had been documented for moving the scheduling forward and contacted the facility. OCO staff confirmed the documentation was added to reflect the current status of the specialist's consultation and that the person was scheduled for the recommended procedure. This case will be monitored until attendance is verified.	Information Provided
28.	Person reported that they submitted a resolution request that was automatically escalated because DOC staff could not meet policy timelines, and then was administratively withdrawn. The person states DOC told him they closed the resolution because he did not answer their questions, he had not received any communication from the resolution department. The person requested that this resolution remain open for investigation.	The OCO provided the person with information regarding the filed resolution. OCO staff reviewed the resolution documents and found the decision to withdraw the resolution had been overturned on appeal, and it was reviewed through level 3. The OCO provided tort claim information to the person. Individuals who have been harmed or who have suffered a loss as a result of negligent actions by a state employee or agency can submit a tort claim to the Office of Risk Management (ORM). ORM is required by law (RCW Chapter 4.92) to receive these claims.	Information Provided
29.	Person reported struggling to use the DOC resolutions program effectively. The person stated that the resolutions specialists are not helping him understand the rules of the resolutions	The OCO provided the person with information about the DOC resolutions program.	Information Provided

	program. and will not provide him with the resolutions program manual.		
30.	An external party reported concerns about an incarcerated individual being able to participate in Graduated Reentry (GRE) or other reentry programs.	The OCO provided information about DOC policy 390.590 and what this individual needs to do to be considered for GRE. OCO staff reviewed DOC records and could not substantiate that this individual has been screened for GRE. The OCO encouraged this individual to take specific actions to be eligible and screened for GRE.	Information Provided
31.	An external person shared concerns on behalf of an incarcerated individual regarding being held in segregation.	The OCO reviewed existing evidence and was unable to substantiate the concern. Following a review of DOC records, this office was unable to confirm that this individual has ever been placed in segregation.	Insufficient Evidence to Substantiate
32.	An incarcerated individual shared concerns regarding the DOC not providing them with adequate care for their hand.	The OCO reviewed existing evidence and was unable to substantiate the concern. Following a review of DOC records, this office confirmed that this individual met with medical staff regarding their concern. This individual received DOC-approved clinical care. This office informed this individual that the OCO has no impact on DOC clinical decisions.	Insufficient Evidence to Substantiate
33.	Incarcerated individual shared concerns regarding DOC staff targeting them.	The OCO reviewed existing evidence and was unable to substantiate the concern. This office confirmed that staff had entered two neutral behavioral observation entries (BOE), which should have been entered as negative, given the incident documented by DOC staff. This office confirmed that these BOEs were appealed and upheld. Records did not indicate any indication that staff are targeting this individual.	Insufficient Evidence to Substantiate
34.	An external person shared concerns on behalf of an incarcerated individual regarding the DOC not giving them care for their medical concerns.	The OCO reviewed existing evidence and was unable to substantiate the concern. Following a review of DOC records, this office confirmed that this individual has met with medical staff numerous times regarding their concerns. This office reminded this individual that DOC clinical staff make determinations on an individual's care, and the OCO has no impact on DOC clinical decisions.	Insufficient Evidence to Substantiate
35.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000, as suspected spice paper was found in the cell and tested positive for spice, as confirmed by the lab.	No Violation of DOC Policy
36.	An incarcerated individual shared concerns regarding the DOC not providing them with medical footwear despite their medical concern.	The OCO reviewed the complaint and found that DOC actions are currently allowed within the WA DOC Health Plan and the Health Status Report (HSR) Guidelines. DOC records indicate that DOC clinical staff informed this individual that this individual's condition is not eligible for clinically indicated footwear. This office provided this individual with alternative options they can potentially utilize.	No Violation of DOC Policy
37.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as there is evidence to substantiate the infraction.	No Violation of DOC Policy
38.	Incarcerated individual shared concerns regarding a charge related to their transfer.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 440.020. The OCO also provided this individual with information regarding why they were charged additional fees upon their transfer.	No Violation of DOC Policy

39.	Person reported receiving an infraction for not accepting a new cell placement and stated that he had a Health Status Report (HSR) that mandated what cell placement he would receive.	The OCO reviewed the complaint and found DOC actions or inactions are currently allowed within DOC policy 460.000. The OCO reviewed DOC documents, including his infraction and HSRs, and reached out to DOC staff, who verified that he did not have this HSR on the date he received the infraction.	No Violation of DOC Policy
GRE/CPA			
40.	Incarcerated individual shared concerns regarding DOC miscalculating their earned release date (ERD).	The OCO reviewed existing evidence and was unable to substantiate the concern. Following a review of DOC records, this office confirmed that DOC staff provided this individual with specific calculations for their release date.	Insufficient Evidence to Substantiate
Monroe Correctional Complex			
41.	An external person shared concerns on behalf of an incarcerated individual regarding being held in segregation.	DOC staff addressed this concern prior to OCO action. Following a review of DOC records, this office confirmed that this individual has been transferred out of a segregation setting.	DOC Addressed the Complaint
42.	An external person shared concerns on behalf of an incarcerated individual regarding a lack of proper treatment for their medical concern.	DOC staff addressed this concern prior to OCO action. Following a review of DOC records, this office was able to confirm that this individual is actively receiving care for their concern. This office encouraged this individual to continue working with DOC medical staff to address their concerns if they arise.	DOC Addressed the Complaint
43.	An external person shared concerns on behalf of an incarcerated individual regarding an infraction.	DOC staff addressed this concern prior to OCO action. Following a review of DOC records, this office was able to confirm that the infraction has been removed from their record.	DOC Addressed the Complaint
44.	Incarcerated individual shared concerns regarding not hearing back on a Care Review Committee (CRC) request and DOC not providing them with their medication.	DOC staff addressed this concern prior to OCO action. Following a review of DOC records, this office confirmed that this individual has begun receiving their requested medication.	DOC Addressed the Complaint
45.	Incarcerated individuals shared concerns regarding the DOC removing their health status reports (HSRs).	DOC staff addressed this concern prior to OCO action. Following a review of DOC records, this office was able to confirm that this individual's HSRs had expired. DOC medical staff renewed this individual's HSRs.	DOC Addressed the Complaint
46.	Incarcerated individual shared concerns regarding wanting to receive pain management treatment.	DOC staff addressed this concern prior to OCO action. Following a review of DOC records, this office confirmed that this individual met with DOC staff and received care for their concern. This office informed this individual that the OCO has no impact on DOC clinical decisions.	DOC Addressed the Complaint
47.	Incarcerated individual shared concerns regarding not receiving responses from the resolutions program and not having access to resolution services.	The OCO reviewed existing evidence and was unable to substantiate the concern. Following a review of DOC records, this office confirmed that this individual has been utilizing the resolution program, and several of their resolution requests have been investigated.	Insufficient Evidence to Substantiate
48.	Incarcerated individual shared concerns regarding DOC staff not following the manufacturer's instructions for medication administration.	The OCO reviewed existing evidence and was unable to substantiate the concern. Following a review of DOC records and speaking with DOC staff, this office was able to confirm that DOC staff had reviewed the manufacturer’s instructions to confirm proper administration. This office also reviewed the	Insufficient Evidence to Substantiate

		manufacturer's instructions and confirmed that the administration was correctly done.	
49.	Incarcerated individual shared concerns regarding DOC wrongly infracting them.	The OCO reviewed existing evidence and was unable to substantiate the concern. Following a review of DOC records, this office was unable to see any infraction that matched the complaint description.	Insufficient Evidence to Substantiate
50.	Incarcerated individual shared concerns regarding DOC staff not acting appropriately during clothing exchanges and their newly issued clothes being used.	The OCO reviewed existing evidence and was unable to substantiate the concern. Following a review of DOC records, this office was unable to confirm that the clothes displayed any evidence of being used prior to being issued. This office was able to confirm that the staff conduct concern was substantiated by DOC leadership and was handled accordingly.	Insufficient Evidence to Substantiate
51.	Incarcerated individual shared concerns regarding DOC staff targeting them.	The OCO reviewed existing evidence and was unable to substantiate the concern. DOC records indicate that this individual was sent to a facility where they are safe. This individual has limited facility placement options due to past incidents and their current needs. Records also indicate that staff are actively working with this individual to ensure they are safe and able to comfortably live in their current environment. This office encouraged this individual to share any concerns with staff if they arise.	Insufficient Evidence to Substantiate
52.	Incarcerated individual shared concerns regarding DOC staff withholding their legal mail.	The OCO reviewed existing evidence and was unable to substantiate the concern. DOC records indicate that this individual received their legal mail, and this office was unable to confirm any sort of delay.	Insufficient Evidence to Substantiate
53.	Incarcerated individual relayed concerns regarding an extended family visit (EFV) denial.	The OCO reviewed the EFV denial materials, spoke to DOC about this, and found no violation of DOC policy 590.100, as due to domestic violence history, the EFVs were denied per policy.	No Violation of DOC Policy
54.	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 tablet had a missing plastic piece that allowed them access to a button to surpass security measures, along with multiple missing screws.	No Violation of DOC Policy
55.	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 tablet had a missing plastic piece that allowed them access to a button to surpass security measures along with multiple missing screws.	No Violation of DOC Policy
56.	Person reported he was taken off a medication that was effective and it was replaced with one that does not work. The person is requesting to be placed back on the previous medication.	The OCO reviewed the concern and found that DOC's actions are supported by the DOC formulary. The OCO reviewed the formulary and found the person's previous medication is no longer covered by the DOC health plan. OCO staff provided information to the person about DOCs non-formulary review process.	No Violation of DOC Policy
57.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as there is evidence to substantiate the infraction.	No Violation of DOC Policy
58.	Incarcerated individual relayed concerns regarding a negative behavior observation entry (BOE).	The OCO reviewed the BOE and found no violation of DOC policy 300.010 as there is evidence to substantiate the behavior described.	No Violation of DOC Policy
59.	Incarcerated individual shared concerns regarding DOC wrongly infracting them.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 460.050. Following a review of DOC records, this office confirmed that DOC staff discovered a	No Violation of DOC Policy

		controlled substance after a cell search. DOC staff discovered this within this individual's possessions. As a result, this individual was issued an infraction.	
Olympic Corrections Center			
60.	Incarcerated individual shared concerns regarding not being seen by dental.	DOC staff addressed this concern prior to OCO action. After speaking with DOC staff and reviewing DOC records, this office was able to confirm that this individual met with dental staff. This individual had transferred, and due to that, their dental care had been delayed.	DOC Addressed the Complaint
61.	Person reported concerns regarding his access to dental care. The person is requesting a root canal.	The OCO provided information to the person regarding the DOC health plan and resolution process. OCO staff reviewed the person's concern and found they had not filed a resolution request regarding their access to a dentist. OCO staff also reviewed the DOC health plan and found that root canals are considered level 3 and are not covered by the DOC health plan. The person will need to explore other treatment options with their medical and dental providers or self-pay through the Patient-Paid Healthcare Process.	Information Provided
62.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as an inventory search resulted in the finding of extra unauthorized clothing that was not issued to the individual and belonged to other incarcerated individuals.	No Violation of DOC Policy
Other			
63.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.130.	No Violation of DOC Policy
64.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.130.	No Violation of DOC Policy
Reentry Center - Helen B. Ratcliff - King			
65.	Incarcerated individual relayed concerns regarding being sanctioned for each violation rather than the most serious.	The OCO reviewed the infraction and sanction materials. As this was a partial confinement hearing prior to January 1, 2026, DOC policy 460.135 allowed stacking of sanctions, unlike the full confinement policy of being sanctioned only for the most serious infraction.	No Violation of DOC Policy
Reentry Center - Reynolds - King			
66.	Individual reported that he is having issues with staff and was told to communicate with the staff who are not helping him in the first place.	The OCO reviewed this person's records and confirmed that he filed a resolution request and resolved the issue with the staff at this facility.	DOC Addressed the Complaint
Stafford Creek Corrections Center			
67.	Person reported concerns regarding not receiving accommodations for his medical condition. The person stated he has unique needs that are well documented with medical, however he is struggling to get the facility to actually make changes to his housing to accommodate him.	The OCO provided assistance by contacting facility and health services leadership. OCO staff confirmed that the clinical need had already been established, it was not fully communicated to leadership, who had to approve the change. OCO staff requested that the clinical input be shared with the facility leadership and followed up with the impacted person a few weeks later to confirm the change had taken place.	Assistance Provided

68.	Incarcerated individual shared concerns regarding DOC staff not addressing their medical concern.	The OCO provided assistance. After reviewing DOC records and speaking with DOC staff, this office confirmed that this individual had an unscheduled appointment to address their concern. OCO staff worked in collaboration with DOC staff to prompt scheduling and ensured this individual has been seen. This office also informed this individual that the OCO has no impact on DOC clinical decisions and encouraged them to continue working with DOC staff to address their concerns as they arise.	Assistance Provided
69.	Incarcerated individual shared concerns regarding not having a sponsor for their cultural group and requesting the OCO provide temporary assistance so they can meet.	The OCO provided assistance by providing temporary sponsorship for the cultural group and ensuring their ability to meet. This office attempted to find a permanent sponsor for this cultural group and assist community members in the volunteer application process. This office also provided information regarding the continued work this office is doing with DOC headquarters regarding specific policies related to these instances.	Assistance Provided
70.	Incarcerated individual relayed concerns regarding not getting a response back on an infraction appeal.	The OCO spoke with DOC regarding the appeal and requested they accept a resubmitted appeal. DOC stated that if the individual includes the signed appeal receipt and a description as to why they have waited so long to inquire into the appeal status, they will consider accepting the resubmitted appeal.	Assistance Provided
71.	Incarcerated individual shared concerns regarding DOC not providing them with care for their medical concern.	DOC staff addressed this concern prior to OCO action. Following a review of DOC records, this office was able to confirm that this individual has been seen regarding his concern and has future care already scheduled out.	DOC Addressed the Complaint
72.	Person reported that DOC medical staff incorrectly dressed his wound which could negatively impact the healing process. The person also reported that he was not given any mobility aids to help with ambulation after surgery.	The OCO provided information to the person regarding the post-surgical orders provided to DOC. OCO staff reviewed the person's records and found that the wound care orders provided by the surgeon did not include specific instructions that would have prevented this complication. OCO staff confirmed that nursing staff provided the wound care that was ordered by the medical provider. OCO staff also found he was returned to the specialist the same day he reported the issue to the OCO. OCO staff also could not substantiate that the person was ordered to be non-weight bearing, which is necessary to receive mobility aid in this situation.	Information Provided
73.	Incarcerated individual relayed concerns regarding a WAC 603 infraction.	The OCO reviewed the infraction materials and confirmed that the 603 was written per DOC policy 460.000 as the WAC 603 changes went into effect June 24, 2026.	Information Provided
74.	Incarcerated individual shared concerns regarding DOC not providing them with medical care for their concern.	The OCO provided information regarding this office's investigative findings. Following a review of DOC records and speaking with DOC staff, this office was informed that DOC medical staff are aware of the concern but due to potential medical complications, they are unable to provide this individual with their desired treatment. This office encouraged this individual to continue working with DOC medical staff to find potential alternative treatment options.	Information Provided
75.	Incarcerated individual relayed concerns regarding an infraction that their cellmate tried to take responsibility for.	The OCO reviewed the infraction materials and was unable to find evidence that shows their cellmate tried to take responsibility for the drugs.	Insufficient Evidence to Substantiate

76.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as there is evidence that substantiates the infraction elements.	No Violation of DOC Policy
77.	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 was observed in a physical altercation with their cellmate.	No Violation of DOC Policy
78.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as there is evidence that shows the individual shoulder checked a staff member, became static and aggressive and used a threatening tone to talk to staff.	No Violation of DOC Policy
79.	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 entered another individual's cell and committed an assault that resulted in the other individual needing outside medical attention.	No Violation of DOC Policy
80.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as a summary of the video evidence shows it was a mutual fight.	No Violation of DOC Policy
81.	Incarcerated individual shared concerns regarding DOC not providing them with their requested accommodations.	The OCO reviewed the complaint and found DOC actions are currently allowed within the WA DOC health plan. Following a review of DOC records, this office was able to confirm that this individual has been provided with some of their requested accommodations but not all of them. DOC records confirm that this individual has had their requests reviewed but denied by DOC clinical staff. This office informed this individual that the OCO has no impact on DOC clinical decisions.	No Violation of DOC Policy
Washington Corrections Center			
82.	Person reported mental health concerns and stated that force was used on him after he declared a mental health emergency.	The OCO provided assistance by requesting and reviewing the documentation of this use of force incident, which resulted in corrective action. The OCO reviewed all of the documentation related to this incident and substantiated that discrepancies with the documentation that did not meet the requirements of the restricted policy. OCO staff discussed this incident with facility leadership and ensured that corrective action was taken. The OCO was also able to confirm that this individual received mental health care for this incident.	Assistance Provided
83.	A loved one reported concerns about an incarcerated individual's Health Status Report (HSR) not being followed. They also requested that this individual be transferred to a reentry center.	The OCO reviewed DOC records and substantiated that this individual was infracted for an incident related to his HSR but confirmed that the infraction was dismissed after DOC reviewed his HSR. The OCO also confirmed that this individual is not currently eligible for reentry center placement.	DOC Addressed the Complaint
84.	Incarcerated individual shared concerns regarding not getting the mental health support they need.	DOC staff addressed this concern prior to OCO action. After speaking with the incarcerated individual, this office was informed that the concern has been resolved.	DOC Addressed the Complaint
85.	External person reported that DOC staff did not appropriately respond to a mental health emergency that resulted in a person being injured. The person reported that DOC was	The OCO provided information to the impacted person about the OCO investigation. OCO staff reviewed the related records and contacted DOC facility leadership. OCO staff were informed that corrective action had been taken.	Information Provided

	notified by other incarcerated people, as well as family members, that the person needed to be seen.		
86.	Incarcerated individual shared concerns regarding DOC losing their property following a transfer.	The OCO provided information regarding tort claims. This office also confirmed that this individual has released.	Information Provided
87.	Incarcerated individual relayed concerns regarding extended placement in the receiving units.	The OCO spoke to DOC about this concern and confirmed that it is a 9-12 month wait to transfer to close custody and DOC is unwilling to add any additional privileges at this time for individuals in the receiving units.	Information Provided
88.	Person reported that DOC is not allowing him to be on the MAT program.	The OCO provided information about the DOC protocol for Medication Assisted Treatment (MAT). The OCO reviewed the person's record and found that he has been informed of the required process to have his request reviewed by the Addiction Medication Care Review Committee. The person does not currently meet criteria to receive the requested medication per DOC protocol.	Information Provided
89.	Incarcerated individual shared concerns regarding DOC not removing a vacated charge from their record and it affecting their classification.	The OCO provided information as to why the charge may still be on their electronic record. This office reviewed DOC records and confirmed that DOC staff are aware of the vacated charge and confirmed that it is not affecting their classification at all. Due to physical limitations of the virtual machine DOC utilizes, DOC is unable to remove the charge from their electronic record. This office also confirmed that the charge is connected to a larger cause which has charges that are still active which further complicates full removal from their electronic record.	Information Provided
90.	Incarcerated individual relayed concerns regarding safe harbor placement.	The OCO spoke to DOC regarding the individual's placement and confirmed that the individual has requested safe harbor placement while still admitting to participating in a security threat group, which is not allowed.	Information Provided
91.	Incarcerated individual relayed concerns regarding not being able to attend an infraction hearing.	The OCO reviewed the infraction materials and was unable to find evidence that shows the individual attempted to attend the hearing as DOC form 20-051 states that the individual refused to attend the hearing.	Insufficient Evidence to Substantiate
92.	Incarcerated individual relayed concerns regarding not getting notification of a negative behavior observation entry (BOE).	The OCO reviewed the BOE and was unable to find evidence indicating whether the individual was notified of the BOE prior to being given a copy. The individual was informed at the time of the behavior that they were in an area that was both closed and out of bounds, and when staff informed them of this, the individual stated "I don't care," showing that they had a warning of the prohibited behavior.	Insufficient Evidence to Substantiate
93.	Incarcerated individual shared concerns regarding DOC utilizing excessive force and incorrect procedure during a use of force incident.	The OCO reviewed existing evidence and was unable to substantiate the concern. Following a review of DOC records, this office was able to confirm that staff utilized force that was in compliance with restricted DOC policy.	Insufficient Evidence to Substantiate
94.	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 had a burnt toilet paper roll on their bunk.	No Violation of DOC Policy

95.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as there is camera evidence showing the individual throwing a closed fist strike on the other individual that was not a mutual fight.	No Violation of DOC Policy
96.	Incarcerated individual relayed concerns regarding extended family visit (EFV) denial.	The OCO reviewed the EFV denial and appeal and found no violation of DOC policy 590.100 due to concerns with behavior between the individual and their wife.	No Violation of DOC Policy
97.	Person reported that his medications for a chronic medical condition were changed without his knowlede. The person is requesting that his medication return to what it was, as well as receiving a Health Status Report.	The OCO reviewed the complaint and found that DOC actions are currently allowed within the DOC health plan. OCO staff reviewed the person's record and found the medication he is requesting is not covered by the DOC formulary, necessitating a change after the initial grace period. The OCO cannot impact clinical decisions, and the person can request a non-formulary review if the trial on the formulary medication is not successful.	No Violation of DOC Policy
98.	Incarcerated individual shared concerns regarding being restrained for an extended period of time and DOC staff utilizing Oleoresin Capsicum (OC) spray on them.	The OCO reviewed the complaint and found DOC actions are currently allowed within restricted DOC policy. Following a review of DOC records, this individual had been placed in a setting that they could be closely monitored for their safety. This office also reviewed the events where DOC staff utilized OC and confirmed that the utilization was within DOC policy. These events were also reviewed by facility leadership and determined to be in compliance with DOC policy.	No Violation of DOC Policy
99.	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 was on tablet sanction restrictions but was in possession of a tablet (WAC 658), that tablet belonged to another person (WAC 555) and there was a battery removed from a tablet in their cell (WAC 554).	No Violation of DOC Policy
100.	Person reported issues with his vision decreasing. The person is requesting advanced imaging to find the cause.	The OCO provided information to the person regarding his specialist consultation. OCO staff reviewed the person's records and contacted DOC Health Services staff. OCO staff were informed of the rationale for the delay in scheduling the consultation and told that a process review will be taking place to address the prioritization of scheduling patients. The OCO is in ongoing discussion with DOC leadership regarding the delays impacting multiple patients.	Substantiated
Washington Corrections Center for Women			
101.	External person reports their loved one was infracted for not being able to provide a drug screening specimen due to past trauma. The person requested that their loved one be released from segregation and for DOC to use an alternative way to test for drugs.	The OCO provided the impacted person with information about the necessary steps to get a health status report (HSR) to access an alternative testing method. The OCO reviewed the person's record and found that they did not have the necessary HSR to have mouth swab drug screens rather than urinalysis.	Information Provided
102.	External person reported concerns with the medical treatment their loved one has been receiving. They reported that medical provider was unprofessional and dismissive of	The OCO provided the impacted person with information about their medical care. OCO staff reviewed the person's records and found that no follow up appointment was ordered by the medical provider and that they would need to contact medical for additional follow up. Individuals who have been harmed or who have suffered a loss as a result of negligent actions by a	Information Provided

	their family member. The person is requesting that their loved one be seen for a known medical issue.	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. OCO staff also provided information about the resolution program and how to get staff conduct complaints reviewed at higher levels than the initial informal resolution.	
103.	Incarcerated individual relayed concerns regarding being assaulted by another incarcerated individual and wanting to press charges against the individual.	The OCO reviewed the records related to this incident and informed the individual that the OCO cannot assist in pressing charges against an individual. The OCO did verify that a keep separate was created after the incident and remains active.	Information Provided
104.	Person reported that DOC has reversed their correspondence approval for contacting their spouse, who is also incarcerated.	The OCO reviewed the complaint and found that DOC actions or inactions are currently allowed within DOC policy 410.100. OCO staff reviewed the person's records and found that the approval was reversed due to the couple's use of unauthorized communication channels. This decision is supported by DOC policy.	No Violation of DOC Policy
105.	Incarcerated individual relayed concerns regarding two infractions.	The OCO reviewed the infraction materials for both infractions and found no violation of DOC policy 460.000, as there is evidence to substantiate both infractions.	No Violation of DOC Policy
Washington State Penitentiary			
106.	An external person shared a concern on behalf of an incarcerated individual regarding not receiving adequate medical treatment.	DOC staff addressed this concern prior to OCO action. Following a review of DOC records, this office was able to confirm that this individual was seen numerous times regarding their concern.	DOC Addressed the Complaint
107.	External person shared concerns on behalf of an incarcerated individual regarding not receiving adequate medical care.	DOC staff addressed this concern prior to OCO action. Following a review of DOC records, this office was able to confirm that this individual was seen regarding their concerns.	DOC Addressed the Complaint
108.	Incarcerated individual shared concerns regarding DOC not providing them with medical care for their concern.	DOC staff addressed this concern prior to OCO action. Following a review of DOC records, this office was able to confirm that this individual has received care for their concern and have continued care scheduled out.	DOC Addressed the Complaint
109.	An external person shared concerns on behalf of an incarcerated individual regarding wanting to take Medication for Addiction Treatment (MAT).	The OCO provided information to this individual regarding how they can potentially obtain the treatment option they seek.	Information Provided
110.	Incarcerated individual relayed concerns regarding placement in a particular unit.	The OCO spoke to DOC regarding the individual's placement and confirmed that they have not raised any safety concerns that could be validated.	Information Provided
111.	Person reported that DOC's inaction during a medical emergency caused lasting injury. The person requested to be released and receive financial compensation.	The OCO provided tort claim information to the person. The OCO cannot release a person or sue the DOC on behalf of an incarcerated individual. Individuals who have been harmed or who have suffered a loss as a result of negligent actions by a state employee or agency can submit a tort claim to the Office of Risk Management (ORM). ORM is required by law (RCW Chapter 4.92) to receive these claims.	Information Provided

112.	Incarcerated individual shared concerns regarding not being placed in a safe housing option despite sharing safety concerns.	The OCO provided information regarding why this individual is currently housed where they are. Following a review of DOC records, this office was able to confirm that DOC was not able to validate their safety concerns. Additionally, this individual accumulated several serious infractions which lowered their custody score. Due to this, this individual was demoted to MAX custody.	Information Provided
113.	Incarcerated individual relayed concerns regarding the outside yards only being accessible to those on level 3 while in segregation.	The OCO spoke to DOC about this concern and confirmed that, due to staffing, only level 3s are going out, but DOC is figuring out a plan to get more people out as two additional yards will open in the future.	Information Provided
114.	Incarcerated individual relayed concerns regarding protective custody placement.	The OCO spoke to DOC regarding this concern and confirmed that the individual was denied protective custody due to no validated safety concerns. The OCO informed the individual that they may be eligible for safe harbor placement but will need to debrief first by sending a kite to the local facility level intelligence and investigations unit.	Information Provided
115.	Anonymous individual requested a keep separate from another individual.	The OCO was unable to assist with this concern due to the lack of identifying details provided. The OCO informed the anonymous caller that OCO assistance would be limited without the person's identity, as the OCO must keep separate records of both parties' identities.	Information Provided
116.	Incarcerated individual shared concerns regarding being denied safe harbor.	The OCO provided information regarding why they were denied safe harbor. Following a review of DOC records, this office was able to confirm that this individual did not provide DOC with enough information to support their housing refusal. Due to this, this individual was demoted to MAX custody.	Information Provided
117.	An incarcerated individual relayed concerns regarding safety-related placement.	The OCO spoke to DOC about this concern and confirmed that the individual was demoted a custody level for a medical override because no other custody level facility could accommodate their needs as they transferred out of the unit for protection concerns.	Information Provided
118.	Person reported that DOC medical is trying to take him off of medication that he was approved for at his last facility. The person is requesting that the OCO prevent his medical provider from changing his medication order.	The OCO provided information to the person about the medication approval process. OCO staff cannot investigate a concern before any action is taken by DOC. The person was encouraged to work with his medical provider to have his request submitted to the Care Review Committee if necessary.	Information Provided
119.	Person reported that he was not allowed to perform music at the memorial of another incarcerated individual. Person requested financial compensation and for a DOC staff to be fired because of this incident.	The OCO provided information about DOC policy and about filing a tort claim. DOC policy 120.500 states "All incarcerated individual tort claims alleging personal property damage/loss must be filed by the individual with the Washington State Department of Enterprise Services (DES) Risk Management Division". RCW 4.92.100 states, "(1) All claims against the state, or against the state's officers, employees, or volunteers, acting in such capacity, for damages arising out of tortious conduct, must be presented to the office of risk management." The OCO reviewed this individual's resolution request regarding this incident and found that it was unsubstantiated at both the	Information Provided

		facility and headquarters level. The OCO could not substantiate that DOC violated DOC policy 540.105(VII).	
120.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as a cell search resulted in the finding of the following items used to smoke illicit substances: a plastic tube, a paper tube, a strip of paper, and burnt wires.	No Violation of DOC Policy
121.	Incarcerated individual relayed concerns regarding being level 2 only while in segregation.	The OCO reviewed the individual's custody facility plan and confirmed that they are to maintain level 2 only due to the usage of a weapon during a violent incident per DOC policy 320.250(IV)(B)(c)(1)(b).	No Violation of DOC Policy
122.	Incarcerated individual relayed concerns regarding the sanctions given for an infraction.	The OCO reviewed the infraction materials and sanctions and confirmed that all the sanctions are allowed per DOC policy 460.050.	No Violation of DOC Policy
123.	Person reported that he was terminated for programming and is facing revocation of his sentencing alternative. The person stated that they were trying to follow the directions given to them. However the staff member that he needed to contact was out of the office for an extended amount of time.	The OCO reviewed the complaint and found DOC actions or inactions are currently allowed within DOC policy 580.000. OCO staff reviewed the person's records and found the reason for program termination was a failure to progress and multiple infractions, which is supported by DOC policy.	No Violation of DOC Policy
	Intake Investigations		
	Airway Heights Corrections Center		
124.	A loved one reported concerns regarding the circumstances that led to the termination of their visitation privileges with this person.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
125.	Person reported that DOC is restricting the number of people who can go to the legal library, and this is causing people delays in accessing.	The incarcerated individual said they did not want the OCO to further investigate the complaint, and closed the case.	Complaint Withdrawn
126.	Person reported a banking concern.	The incarcerated individual said they did not want the OCO to further investigate the complaint.	Complaint Withdrawn
127.	An incarcerated individual shared concerns regarding testing positive on a urine analysis (UA) due to medication and being punished for it.	Per WAC 138-10-040(3)(f), the OCO declined to investigate the complaint beyond intake as the individual was released from DOC custody prior to the OCO investigating the concern.	Declined
128.	Loved one relayed concerns about a transfer of an individual away from family support.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing placement that is not safety related due to extremely limited resources.	Declined
129.	Loved one relayed concerns regarding wanting an incarcerated individual to switch jobs.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g), as the OCO is currently unable to investigate complaints regarding jobs due to extremely limited resources.	Declined

130.	Loved one relayed concerns about an incarcerated individual needing to transfer to a different facility due to programming that is offered there.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing placement concerns that are not safety related due to extremely limited resources.	Declined
131.	A loved one reported concern about staff conduct towards an incarcerated individual.	The OCO has reviewed this concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing staff conduct, aside from conduct concerns regarding uses of force or Residential Treatment Units due to extremely limited resources.	Declined
132.	A loved one reported concerns about an incident during visitation with an incarcerated individual that led to an infraction.	The OCO reviewed DOC records and found this infraction was reduced to a general infraction. The OCO has declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate this complaint, due to extremely limited resources.	Declined
133.	Incarcerated individual relayed concerns regarding a facility move due to programming offered there.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing placement not related to safety concerns due to extremely limited resources.	Declined
134.	Incarcerated individual relayed concerns about apps being removed from their tablet.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing Securus or tablets due to extremely limited resources.	Declined
135.	Incarcerated individual relayed concerns regarding wanting to go to minimum custody.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing placement unless safety related due to extremely limited resources.	Declined
136.	Incarcerated individual shared concerns regarding staff conduct concerns.	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake due to this office only reviewing staff misconduct concerns when there is an associated use of force incident or took place within an RTU setting.	Declined
137.	Incarcerated individual shared concerns regarding staff misconduct.	Per WAC 138-10-040(3)(f), the OCO declined to investigate the complaint beyond intake as the individual released from DOC custody prior to the OCO investigating the concern.	Declined
138.	Incarcerated individual relayed concerns regarding wanting to change custody levels.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing placement unless safety related due to extremely limited resources.	Declined
139.	Person relayed concerns about an infraction.	The OCO reviewed DOC records and found this individual plead guilty to this infraction. The OCO has declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate this complaint, due to extremely limited resources.	Declined
140.	Incarcerated individual relayed concerns regarding email rejections.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing mail due to extremely limited resources.	Declined

141.	Person reported concerns about classification, work release, and staff conduct.	The OCO has reviewed this concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing classification/facility placement, unless regarding safety concerns, or staff conduct, unless related to Residential Treatment Units (RTU) or Uses of Force, due to extremely limited resources.	Declined
142.	An external person shared concerns on behalf of an incarcerated individual regarding not getting proper medical attention.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC resolution program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about utilizing the resolution program and potentially obtaining medication for addiction treatment (MAT).	Technical Assistance Provided
143.	Person reported that they were wrongfully infracted.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the infraction process.	Technical Assistance Provided
144.	Person reported that DOC has not paid them for the work they have done.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the resolution program.	Technical Assistance Provided
145.	Person reported that they were double sanctioned for an infraction they received.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the infraction process.	Technical Assistance Provided
146.	Person reported that they were wrongfully infracted.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the infraction and visitation process.	Technical Assistance Provided
147.	Person reported that they have not received their money from DOC.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the tort claim process.	Technical Assistance Provided
148.	Person reported on behalf of the incarcerated individual that they are being targeted by DOC staff members.	Prior to OCO involvement, the incarcerated person has options to resolve the concern through the DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance regarding staff conduct concerns.	Technical Assistance Provided
149.	Person reported that they are being targeted by DOC staff members.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not	Technical Assistance Provided

		addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about staff conduct concerns.	
Cedar Creek Corrections Center			
150.	Incarcerated individual relayed concerns regarding a guitar case.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing property due to extremely limited resources.	Declined
151.	Incarcerated individual shared concerns regarding wanting to take a certain program.	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake due to this office not reviewing concerns regarding programming due to limited resources.	Declined
152.	Incarcerated individual relayed concerns regarding a GRE denial.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing GRE due to extremely limited resources.	Declined
153.	Person reported on behalf of the incarcerated individual that their medical needs were not met.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the resolution program.	Technical Assistance Provided
154.	Person reported that they are being targeted by a DOC staff member.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about staff conduct concerns.	Technical Assistance Provided
Clallam Bay Corrections Center			
155.	A friend or family member reported a concern on this person's behalf regarding not being able to access or be approved for necessary medical treatment and medication for pain management.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
156.	A friend or family member reported a concern regarding being suspended from visitation and communication with this person pending the completion of an investigation, and has not been informed of the outcome.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
157.	Incarcerated individual relayed concerns regarding their placement in segregation.	This case is a duplicate of one that already exists in the OCO case management system.	Complaint Withdrawn
158.	Incarcerated individual relayed concerns regarding wanting a new tablet.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing tablets due to extremely limited resources.	Declined

159.	Incarcerated individual shared concerns regarding DOC taking their tablet.	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake as the OCO is not investigating complaints related to property or tablets due to limited resources.	Declined
160.	Incarcerated individual relayed concerns regarding missing property.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing property due to extremely limited resources.	Declined
161.	Person reported that DOC staff keep shining their light in their face while they are sleeping.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the infraction process and staff conduct concerns.	Technical Assistance Provided
162.	Person reported that they are being harassed and targeted by DOC staff members.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about staff conduct concerns.	Technical Assistance Provided
163.	Person reported that they were sanctioned incorrectly.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the infraction process.	Technical Assistance Provided
164.	Person reported that they are being targeted by a DOC staff member.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about staff conduct concerns.	Technical Assistance Provided
Coyote Ridge Corrections Center			
165.	A loved one reported concerns about staff conduct.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
166.	A loved one reported on this person's behalf that he was placed in segregation without explanation initially. He was later told it was likely that he was going to be transferred out of that facility but was not told why.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
167.	A loved one reported several concerns regarding this person's health, wellbeing, missing property and staff conduct.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn

168.	A loved one reported concerns about staff conduct.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
169.	Incarcerated individual relayed concerns regarding extended placement in segregation.	This case is a duplicate of one that already exists in the OCO case management system.	Complaint Withdrawn
170.	A loved one relayed concerns regarding the pants an incarcerated individual was issued.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing property due to extremely limited resources.	Declined
171.	A loved one reported staff conduct concerns during visitation with an incarcerated individual.	The OCO has reviewed this concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing staff conduct, aside from conduct concerns regarding uses of force or Residential Treatment Units, due to extremely limited resources.	Declined
172.	Incarcerated individual relayed concerns regarding a GRE denial.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing GRE due to extremely limited resources.	Declined
173.	Incarcerated individual relayed concerns regarding wanting to transfer facilities.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing placement unless safety related due to extremely limited resources.	Declined
174.	Incarcerated individual relayed concerns regarding wanting to transfer to a lower custody level.	The OCO has reviewed your concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing placement unless safety related due to extremely limited resources.	Declined
175.	Incarcerated individual relayed concerns regarding a GRE denial.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing GRE due to extremely limited resources.	Declined
176.	Incarcerated individual relayed concerns regarding access to GRE.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing GRE due to extremely limited resources.	Declined
177.	Incarcerated individual relayed concerns regarding access to GRE.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing GRE due to extremely limited resources.	Declined
178.	Person reported a staff conduct concern.	The OCO has reviewed this concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing staff conduct, aside from conduct concerns regarding uses of force or Residential Treatment Units, due to extremely limited resources.	Declined

179.	A staff member reported concerns regarding targeted harassment by the administrative staff at a DOC prison facility.	The OCO was unable to investigate this concern as the OCO does not have jurisdiction to investigate DOC employment matters per WAC 138-10-040(3)(a).	No Jurisdiction
180.	Person reported on behalf of the incarcerated individual that they are being targeted and retaliated against by a DOC staff member.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about staff conduct concerns.	Technical Assistance Provided
181.	Person reported on behalf of the incarcerated individual that they would like to stay in their unit for medical reasons.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the classification process.	Technical Assistance Provided
182.	Person reported that they would like their cell to be searched before they move in.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the resolution process.	Technical Assistance Provided
183.	Person reported that they would like to go to a safe harbor unit.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about safety concerns.	Technical Assistance Provided
184.	Person reported that they are being targeted and harassed by a DOC staff member.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the PREA process.	Technical Assistance Provided
185.	Person reported that a DOC staff member violated policy by removing a bird's nest.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about staff conduct concerns.	Technical Assistance Provided
186.	Person reported that a DOC staff member is not opening the bathrooms during yard time.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about staff conduct concerns.	Technical Assistance Provided
GRE/CPA			
187.	Incarcerated individual relayed concerns regarding what job they are allowed to work.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing jobs due to extremely limited resources.	Declined

Monroe Correctional Complex			
188.	Family member relayed concerns regarding an infraction.	This case is a duplicate of one that already exists in the OCO case management system.	Complaint Withdrawn
189.	Family member relayed concerns regarding an infraction an incarcerated individual received.	This case is a duplicate of one that already exists in the OCO case management system.	Complaint Withdrawn
190.	Person reported concerns regarding accommodations for a disability.	The incarcerated individual said they did not want the OCO to further investigate the complaint and requested that the case be closed.	Complaint Withdrawn
191.	Incarcerated individual shared concerns regarding being approved for a treatment and not receiving such.	The incarcerated individual said they did not want the OCO to further investigate the complaint and closed the case.	Complaint Withdrawn
192.	A friend or family member reported a concern on this person's behalf regarding a serious infraction for withdrawing from the SOTAP program.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
193.	Incarcerated individual shared concerns regarding DOC not adequately investigating their PREA concern.	The OCO reviewed the related records and confirmed that he reported PREA did not occur while the individual was housed in full or partial confinement of a Washington State Department of Corrections prison. As a result, the OCO did not have jurisdiction over the concern per WAC 138-10-040(3)(a).	Declined
194.	Incarcerated individual shared concerns regarding DOC staff misconduct.	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake due to this office only reviewing staff misconduct concerns when there is an associated use of force or it took place in an RTU setting.	Declined
195.	Incarcerated individual shared concerns regarding DOC staff making him perform a test for no reason.	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake due to this office only reviewing staff misconduct concerns when there is an associated use of force or it took place in an RTU setting.	Declined
196.	Incarcerated individual died while in DOC custody.	When OCO criteria is met, this office refers cases labeled as "expected" by DOC to the UFR Committee for further review. The OCO reviewed relevant medical records and incident reports and found the case did not meet criteria for UFR referral. This case did not meet the definition of an "unexpected" fatality as outlined in RCW 72.09.770, therefore the OCO declined to refer this case to the UFR Committee.	Declined
197.	Incarcerated individual shared concerns regarding work programming.	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake due to this office not reviewing concerns regarding programming.	Declined
198.	Incarcerated individual died while in DOC custody.	When OCO criteria is met, this office refers cases labeled as "expected" by DOC to the UFR Committee for further review. The OCO reviewed relevant medical records and incident reports and found the case did not meet criteria for UFR referral. This case did not meet the definition of an "unexpected" fatality as outlined in RCW 72.09.770, therefore the OCO declined to refer this case to the UFR Committee.	Declined

199.	Person reported on behalf of the incarcerated individual that they were wrongfully infracted.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the infraction process.	Technical Assistance Provided
200.	Person reported on behalf of the incarcerated individual that the mail room is overcharging for postage.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about utilizing the resolution program.	Technical Assistance Provided
201.	Person reported that their visits were denied.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the visitation process.	Technical Assistance Provided
202.	Person reported that they had their infraction hearing past the due date.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the infraction process.	Technical Assistance Provided
203.	Person reported that they are being targeted by DOC staff members.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about staff conduct concerns.	Technical Assistance Provided
204.	Incarcerated individual shared concerns regarding DOC not providing them with a health status report (HSR).	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about utilizing the resolution program and the HSR approval process.	Technical Assistance Provided
205.	Person reported that they were infracted for failure to provide.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the infraction process and how to obtain a health status report.	Technical Assistance Provided
206.	Person reported that they are having a difficult time getting their HSR renewed.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about how to obtain a health status report.	Technical Assistance Provided
Olympic Corrections Center			
207.	A loved one reported concerns about this person's placement in	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to	Complaint Withdrawn

	segregation without due process first.	contact the OCO via mail or hotline if they would like to request assistance.	
208.	Incarcerated individual relayed concerns regarding GRE access.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing GRE due to extremely limited resources.	Declined
209.	Incarcerated individual relayed concerns regarding GRE access.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing GRE due to extremely limited resources.	Declined
210.	Incarcerated individual relayed concerns regarding GRE access.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing GRE due to extremely limited resources.	Declined
Other			
211.	Incarcerated individual relayed concerns regarding GRE access.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing GRE due to extremely limited resources.	Declined
212.	A friend or family member relayed concerns regarding community custody staff conduct.	Per WAC 138-10-040(3)(a), the OCO may not investigate because the ombuds does not have jurisdiction over the complaint as the complaint relates to an action that occurred while an individual was not in full or partial confinement of a Washington State Department of Corrections prison, such as jails or community custody.	No Jurisdiction
213.	An external person reported concerns regarding ongoing crimes against this person and their family.	Per WAC 138-10-040(3)(a), the OCO may not investigate because the ombuds does not have jurisdiction over the complaint as the complaint relates to an action that occurred while an individual was not in full or partial confinement of a Washington State Department of Corrections prison, such as jails.	No Jurisdiction
214.	Person reported staff conduct concerns regarding their CCO.	Per WAC 138-10-040(3)(a), the OCO may not investigate because the ombuds does not have jurisdiction over the complaint as the complaint relates to an action that occurred while an individual was not in full or partial confinement of a Washington State Department of Corrections prison, such as jails.	No Jurisdiction
215.	Person reported that they are being targeted and retaliated against by community correction officers and their supervisor.	Per WAC 138-10-040(3)(a), the OCO may not investigate because the ombuds does not have jurisdiction over the complaint as the complaint relates to an action that occurred while an individual was not in full or partial confinement of a Washington State Department of Corrections prison, such as jails.	No Jurisdiction
216.	Person reported that they are being targeted and retaliated against by community correction officers and their supervisor.	Per WAC 138-10-040(3)(a), the OCO may not investigate because the ombuds does not have jurisdiction over the complaint as the complaint relates to an action that occurred while an individual was not in full or partial confinement of a Washington State Department of Corrections prison, such as jails.	No Jurisdiction
217.	Person reported that they wanted our office to request DOC records on their behalf.	Per WAC 138-10-040(3)(a), the OCO may not investigate because the ombuds does not have jurisdiction over the complaint as the complaint relates to an action that occurred while an individual was not in full or partial confinement of a Washington State Department of Corrections prison, such as jails.	No Jurisdiction

218.	Person reported that they lost their housing and received a GPS violation.	Per RCW 43.06C.040(2)(e), the OCO may not investigate because the ombuds may not investigate any complaints relating to an individual's underlying criminal conviction.	No Jurisdiction
Reentry Center - Tacoma - Pierce			
219.	Person reported that they were wrongfully infracted.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the infraction process.	Technical Assistance Provided
Stafford Creek Corrections Center			
220.	A friend or family member reported a concern regarding this person's access to healthcare.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
221.	An external person shared concerns on behalf of an incarcerated individual regarding DOC targeting them and not reviewing their resolution request.	This case was a duplicate of one that already existed from the same complainant and for the same concern.	Complaint Withdrawn
222.	Incarcerated individual shared concerns regarding DOC performing an unauthorized strip search on them.	This case was a duplicate of one that already existed from the same complainant and for the same concern.	Complaint Withdrawn
223.	A case was opened by OCO staff in error.	A case was opened by OCO staff in error.	Complaint Withdrawn
224.	Incarcerated individual relayed concerns regarding GRE access.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing GRE due to extremely limited resources.	Declined
225.	Incarcerated individual relayed concerns regarding wanting to be able to purchase certain property items.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing property due to extremely limited resources.	Declined
226.	Incarcerated individual passed away while in DOC custody.	When OCO criteria is met, this office refers cases labeled as "expected" by DOC to the UFR Committee for further review. The OCO reviewed relevant medical records and incident reports and found the case did not meet criteria for UFR referral. This case did not meet the definition of an "unexpected" fatality as outlined in RCW 72.09.770, therefore the OCO declined to refer this case to the UFR Committee.	Declined
227.	Person reported that they were denied transitional housing.	Per WAC 138-10-040(3)(a), the OCO may not investigate because the ombuds does not have jurisdiction over the complaint as the complaint relates to an action taken by an agency other than the Washington State Department of Corrections.	No Jurisdiction
228.	Person reported on behalf of the incarcerated individual that their	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not	Technical Assistance Provided

	medical needs are not being met.	addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about appointments and emergencies.	
229.	Person reported on behalf of the incarcerated individual that DOC lost their important documents.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the resolution process.	Technical Assistance Provided
230.	Person reported on behalf of the incarcerated individual a concern about their safety.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about staff conduct concerns.	Technical Assistance Provided
231.	Person reported on behalf of the incarcerated individual that they are being targeted and retaliated against by a DOC staff member.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about staff conduct concerns.	Technical Assistance Provided
232.	Person reported that they would like to be placed in a safe harbor.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the classification and infraction processes.	Technical Assistance Provided
233.	Person reported on behalf of the incarcerated individual that their extended family visits were denied.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the extended family visit process.	Technical Assistance Provided
234.	Person reported that DOC did not refund the person who sent them money.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the banking process.	Technical Assistance Provided
235.	Person reported that they are being targeted by DOC staff members.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the infraction process.	Technical Assistance Provided
236.	Person reported that they would like to be placed in a safe harbor.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the classification and infraction processes.	Technical Assistance Provided

237.	Person reported that DOC staff have been changing their records request.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the records process.	Technical Assistance Provided
238.	Person reported that their medical needs were not met at the facility they were previously at.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the resolution process.	Technical Assistance Provided
Washington Corrections Center			
239.	A friend or family member reported a concern regarding this person's access to healthcare and staff conduct while they were in a DOC prison facility.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
240.	A loved one reported concerns on this person's behalf that medical staff has not provided his medically necessary CPAP machine since he arrived at the facility.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
241.	A loved one reported concerns about this person being placed in a unit that will compromise his safety because of a Security Threat Group (STG) tag although he is no longer affiliated.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
242.	An external person shared concerns on behalf of an incarcerated individual regarding their tablet.	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake due to this office not reviewing concerns related to property or tablets due to limited resources.	Declined
243.	Incarcerated individual shared concerns regarding their placement.	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake due to this office only reviewing placement if it is directly safety related.	Declined
244.	Incarcerated individual relayed concerns regarding difficulties making calls from the tablet.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing tablets due to extremely limited resources.	Declined
245.	Person reported that he is seeking an attorney to assist him with a lawsuit against a pharmaceutical company.	Per WAC 138-10-040(3)(e), the OCO declined to investigate the complaint beyond intake as the requested resolution is not within the ombuds' statutory power and authority.	Declined
246.	Incarcerated individual relayed concerns regarding access to GRE.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing GRE due to extremely limited resources.	Declined

247.	Incarcerated individual shared concerns regarding DOC staff misconduct.	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake due to this office only reviewing staff misconduct concerns when there is an associated use of force or it took place in an RTU setting.	Declined
248.	Incarcerated individual relayed concerns regarding wanting to go to a lower custody level.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing placement unless safety related due to extremely limited resources.	Declined
249.	Incarcerated individual shared concerns regarding their sentence calculation.	Per WAC 138-10-040(3)(f), the OCO declined to investigate the complaint beyond intake as the individual released from DOC custody prior to the OCO investigating the concern.	Declined
250.	Person reported on behalf of the incarcerated individual a concern about their safety.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the infraction process, appointments and emergencies, and the classification process.	Technical Assistance Provided
251.	Person reported that DOC is not giving them the media that was purchased through their account.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about filing a tort claim.	Technical Assistance Provided
252.	Person reported that they want to get back on their pain management medication.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about medical appointments and emergencies.	Technical Assistance Provided
253.	Person reported on behalf of the incarcerated individual that they would like it to be ensured that any applicable earned release provisions have been properly considered and applied.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the records process.	Technical Assistance Provided
254.	Person reported that they were wrongfully infracted.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the infraction process.	Technical Assistance Provided
255.	Person reported a concern about their safety.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about safety concerns.	Technical Assistance Provided
256.	Person reported that they were wrongfully infracted.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not	Technical Assistance Provided

	addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the infraction process.	
Washington Corrections Center for Women		
257. A loved one reported a concern that DOC is delaying dental care for this person who needs more immediate attention for an exposed root causing tooth pain.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
258. A loved one reported a concern on this person's behalf that she is being held past her earned release date (ERD) and was not told why she is still in isolation and in prison.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
259. Person reported concerns about staff conduct.	The OCO has reviewed this concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing staff conduct, aside from conduct concerns regarding uses of force or Residential Treatment Units, due to extremely limited resources.	Declined
260. A friend or family member reported a concern regarding DOC staff conduct toward them relating to the certification of a service animal.	Per WAC 138-10-040(3)(a), the OCO may not investigate because the ombuds does not have jurisdiction over the complaint as the complaint relates to an action taken by the Washington State Department of Corrections toward an individual not in full or partial confinement of a Washington State Department of Corrections prison, such as jails.	No Jurisdiction
261. Person reported that they were sexually assaulted by staff during their time at King County jail.	Per WAC 138-10-040(3)(a), the OCO may not investigate because the ombuds does not have jurisdiction over the complaint as the complaint relates to an action that occurred while an individual was not in full or partial confinement of a Washington State Department of Corrections prison, such as jails.	No Jurisdiction
262. Incarcerated individual shared concerns regarding DOC staff mistreating them.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about utilizing the resolution program and OCO requirements for investigation.	Technical Assistance Provided
Washington State Penitentiary		
263. A loved one reported a concern regarding access to meaningful support, programming, and resources that will aid in this person's rehabilitation while he is incarcerated.	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn
264. A loved one reported concerns regarding DOC staff not allowing this person to have a private conversation with classification staff while requesting a transfer	The incarcerated individual did not respond to the OCO's request for permission to investigate and/or additional information within 30 days. The OCO encouraged the incarcerated person to contact the OCO via mail or hotline if they would like to request assistance.	Complaint Withdrawn

	to a unit that meets his safety needs.		
265.	Family member relayed concerns regarding an incarcerated individual's medical care.	This case is a duplicate of one that already exists in the OCO case management system.	Complaint Withdrawn
266.	Incarcerated individual relayed concerns regarding an infraction.	This case is a duplicate of one that already exists in the OCO case management system.	Complaint Withdrawn
267.	A loved one reported concern about an incarcerated individual's facility placement	The OCO has reviewed this concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing facility placement, unless related to safety concerns, due to extremely limited resources.	Declined
268.	Incarcerated individual shared concerns regarding GRE.	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake due to this office not reviewing concerns related to GRE.	Declined
269.	Incarcerated individual died while in DOC custody.	When OCO criteria is met, this office refers cases labeled as "expected" by DOC to the UFR Committee for further review. The OCO reviewed relevant medical records and incident reports and found the case did not meet criteria for UFR referral. This case did not meet the definition of an "unexpected" fatality as outlined in RCW 72.09.770, therefore the OCO declined to refer this case to the UFR Committee.	Declined
270.	Incarcerated individual relayed concerns regarding wanting to go to a lower custody level.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing placement unless safety related due to extremely limited resources.	Declined
271.	Incarcerated individual relayed concerns regarding missing property.	The OCO has reviewed the concern and declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as at this time the OCO is unable to investigate complaints addressing property due to extremely limited resources.	Declined
272.	Incarcerated individual shared concerns regarding not being given special event items.	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake as the OCO is not investigating complaints related to property due to limited resources.	Declined
273.	Person reported that they want to be put back on the MAT program.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual’s concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the MAT program.	Technical Assistance Provided
274.	Person reported that DOC staff members did not help them when they were being assaulted.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual’s concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about safety and staff conduct concerns.	Technical Assistance Provided
275.	Person reported that their request to do their religious studies have been denied.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual’s concern is not addressed by these DOC processes, they can then contact the	Technical Assistance Provided

		OCO for assistance. The OCO provided technical assistance about utilizing the resolution program.	
276.	Person reported that the electrician is not fixing the cells without power.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about utilizing the resolution process.	Technical Assistance Provided
277.	Person reported that they want to get on the MAT program.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the MAT program.	Technical Assistance Provided
278.	Person reported that they have not yet had their infraction hearing.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the infraction process.	Technical Assistance Provided
279.	Person reported concerns regarding their access to the Medication Assisted Treatment (MAT) program.	The OCO provided technical assistance to the person to assist in resolving his concern. OCO staff reviewed the person's records and found that they do not meet the current protocol criteria for access to the program.	Technical Assistance Provided
280.	Person reported that they did not receive a response to a resolution request they submitted regarding their property.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the property process.	Technical Assistance Provided
281.	Person reported that their medical needs are not being met.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about medical appointments and emergencies.	Technical Assistance Provided
282.	Person reported that DOC is preventing them from getting out of segregation.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the resolution process.	Technical Assistance Provided
283.	Person reported that DOC will not give them their property.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the property process.	Technical Assistance Provided
284.	Person reported a concern about their safety.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the	Technical Assistance Provided

		OCO for assistance. The OCO provided technical assistance about safety concerns.	
285.	Person reported that they are being held past their early release date (ERD).	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about the tort claim process.	Technical Assistance Provided
286.	Person reported that their medical needs are not being met.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about medical appointments and emergencies.	Technical Assistance Provided

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

Case Closure Reason	Meaning
Unexpected Fatality Review	The incarcerated person died unexpectedly and the death was reviewed by the Unexpected Fatality Review Committee, as required by RCW 72.09.770.
Assistance Provided	The OCO achieved full or partial resolution of the person's complaint.
Information Provided	The OCO provided individualized self-advocacy or case-specific information.
DOC Addressed the Complaint	DOC staff addressed the concern prior to OCO action.
Insufficient Evidence to Substantiate	Available evidence was insufficient to substantiate the concern.
No Violation of DOC Policy	The OCO determined that DOC did not violate DOC policy or no applicable DOC policy existed.
Substantiated	The OCO verified the concern but was unable to achieve a resolution to the concern.
Complaint Withdrawn	The incarcerated individual did not provide permission to proceed with an investigation or asked OCO to close the complaint, or OCO staff opened the complaint in error.
Declined	The OCO declined to investigate the complaint per WAC 138-10-040(3).
No Jurisdiction	The complaint did not meet OCO's jurisdictional requirements set forth in RCW 43.06C.040(2)(e).
Technical Assistance Provided	The OCO provided general self-advocacy information to resolve the concern through a DOC process prior to OCO involvement.

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

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

Common DOC Acronyms & Glossary

ADA: Americans with Disabilities Act

ASR: Accommodation Status Report

BOE: Behavior Observation Entry

CI: Correctional Industries

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

CO: Correctional Officer

CPA: Community Parenting Alternative

CRC: Care Review Committee

CUS: Correctional Unit Supervisor

DES: Department of Enterprise Services

DOSA: Drug Offender Sentencing Alternative

EFV: Extended Family Visit

ERD: Earned Release Date

EMP: Extraordinary Medical Placement

GRE: Graduated Reentry

HCSC: Headquarters Community Screening Committee

HSR: Health Status Report

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

J&S: Judgment and Sentence

MAT: Medication Assisted Treatment

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

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

SARU: Substance Abuse Recovery Unit

SSOSA: Special Sex Offender Sentencing Alternative

SOTAP: Sex Offender Treatment and Assessment Program

SVP: Sexually Violent Predator

TC: Therapeutic Community

WaONE: Washington ONE ("Offender Needs Evaluation")

DOC Prisons

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

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-030

Report to the Legislature

As required by RCW 72.09.770

July 21, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

Table of Contents

Table of Contents 1
Legislative Directive and Governance 2
Disclosure of Protected Health Information 2
UFR Committee Members 3
Fatality Summary 4
UFR Committee Discussion 4
Committee Findings 6
Committee Recommendations 6
Consultative remarks that do not directly correlate to cause of death, but may be considered for review by the Department of Corrections: 6

Unexpected Fatality Review Committee Report

UFR-25-030 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

This report describes the results of one such review.

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held on July 9, 2026:

DOC Health Services

- Dr. Frank Longano, Interim Chief Medical Officer
- Dr. Zainab Ghazal, Administrator
- Dr. Rae Simpson, Director - Quality Systems
- Dr. Ashley Espitia, Psychologist 4, Suicide Risk Reduction
- Mary Beth Flygare, Sentinel Event Program Manager

DOC Prisons Division

- Deborah Wofford, Deputy Assistant Secretary - Women's prisons
- Paige Perkinson, Correctional Operations Program Manager
- Rochelle Stephens, Men's Prisons project Manager

DOC Risk Mitigation

- Michael Pettersen, Director
- Elisabeth Kingsbury, Litigation Administrator

DOC Person Centered Services

- Megan Pirie

Office of the Corrections Ombuds (OCO)

- Heather Bates, Interim Director
- EV Webb, Assistant Corrections Ombuds - Investigations
- Madison Vinson, Assistant Corrections Ombuds - Policy

Department of Health (DOH)

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

Health Care Authority (HCA)

- Dr. Judy Zerzan, Medical Director
- Jessica Blanchard, Health Care Program Manager

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

Fatality Summary

Year of Birth: 1968 (57-years-old)

Date of Incarceration: October 2017

Date of Death: December 2025

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

The cause of death was arteriosclerotic and hypertensive cardiovascular disease. The manner of death was natural.

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

1 Day Prior to Death	Event
Before 19:30 hours	• A custody staff member noted the decedent's behavior was off baseline. When asked, they stated they were tired.
19:30 hours	• During pill line the decedent continued to exhibit the same behavior. They were assisted back to their cell by an incarcerated peer.
19:53 hours	• A custody staff member declared a medical emergency when the decedent was seen falling in their cell as they were transferring out of their wheelchair.
19:56 – 20:37 hours	• DOC medical staff arrived on scene, performed an initial assessment, and transported the decedent to the medical clinic in preparation for ambulance transport to the local emergency room (ER).
Day of Death	**Event**
00:15 – 00:38 Hours	• While receiving treatment in the ER, the decedent's condition worsened. • Their heart stopped and resuscitation efforts were unsuccessful. • They were declared deceased by the ER physician.

UFR Committee Discussion

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

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

1. The committee found:

    a. The decedent's antecedent medical history was complex and included Type II Diabetes requiring insulin therapy, coronary artery disease requiring stent placement, hypertension, end-stage renal disease requiring dialysis three times per week, bilateral partial foot amputations secondary to chronic bone infection and poor circulation.

    b. They rarely requested care visits and their attendance to pill line for medication administration was inconsistent.

    c. They experienced challenges adhering to recommendations for dietary changes, insulin therapy and wound care treatment.

    d. DOC medical staff and consulting specialists provided counseling and discussed the risks of developing additional complications from uncontrolled blood sugar with the decedent.

    e. The decedent stated they wanted to maintain their lifestyle and were unwilling to make any changes or set health goals.

    f. DOC forms used to document wound care and care declinations were frequently incomplete or documented elsewhere in the medical record. Wound healing was not photographed consistently.

    g. Documentation of education provided by nursing staff within the notes was limited.

    h. No clinical care gaps were identified.

2. While not contributory to the cause of the decedent's death, the MRC identified the following opportunities for improvement and recommended:

    a. Publish a monthly "Best Practice" feature in the Health Services newsletter focusing on thorough and accurate clinical documentation.

    b. Consider developing wound imaging guidelines to improve monitoring of wound healing.

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

1. No contributing, causal or non-causal factors were identified within the scope of the CIR were found.

C. The committee reviewed the unexpected fatality, the MRC recommendations and discussed the following.

1. Cause of death:

    a. A committee member inquired why sepsis was noted as a possible cause for the decedent's symptoms by the Emergency Room physician but was not listed as the cause of death.

        1. DOC confirmed the decedent did not report any symptoms that raised concern for sepsis prior to the medical emergency. The mortality review committee did not find any missed opportunities for earlier intervention.

        2. In this case, the primary cause of death was determined by the county medical examiner's office.

        3. September is national Sepsis Awareness Month. Committee members recommend DOC provide education to staff and the incarcerated population about sepsis signs, symptoms and prevention during the month of September.

2. Wound care documentation:

    a. Committee members recommend DOC develop wound imaging guidelines and incorporate photographic documentation as part of the treatment plan to monitor wound healing.

3. Critical Incident Review:

    a. UFR Committee feedback indicated that the Health Services led critical incident report was narrow in its scope, as CIR Team did not interview all of the staff members who submitted incident reports. To broaden and improve future reviews, the committee recommends implementing targeted training for Health Services staff on comprehensive documentation and mandating interviews with all personnel involved.

Committee Findings

The decedent died as a result of arteriosclerotic and hypertensive cardiovascular disease. The manner of death was natural.

Committee Recommendations

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

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

1. DOC provide education to staff and the incarcerated population regarding sepsis signs, symptoms and prevention during the month of September in support of national Sepsis Awareness Month.

2. UFR Committee members recommend DOC develop wound imaging guidelines and incorporate photographic documentation as part of the treatment plan to monitor wound healing.
3. UFR Committee members recommend Health Services staff leading a critical incident review, receive targeted training on mandatory documentation requirements and ensuring interviews are conducted with all involved individuals.