Office of the Corrections OMBUDS

Monthly Outcome Report

June 2026

CASE INVESTIGATIONS: 138

Assistance Provided: 17

Information Provided: 33

DOC Addressed the Complaint: 31

Insufficient Evidence to Substantiate: 11

No Violation of DOC Policy: 42

Substantiated: 4

INTAKE INVESTIGATIONS: 61

Declined: 11

No Jurisdiction: 7

Complaint Withdrawn: 10

Technical Assistance Provided: 33

TOTAL RESOLVED INVESTIGATIONS: 199

Monthly Outcome Report: June 2026

	Complaint Summary	Outcome Summary	Case Closure Reason
Case Investigations			
Airway Heights Corrections Center			
1.	Incarcerated individual reported concerns about a scabies outbreak at the facility. The person requested that the facility send communications out to the population and create a plan to address the outbreak.	After OCO outreach, DOC staff agreed to create a flyer with useful information for the population. The OCO met with DOC facility leadership to gather information and updates about DOC's infectious disease mitigation plan.	Assistance Provided
2.	Incarcerated individual relayed concerns regarding seeking placement in safe harbor.	The OCO reviewed the individual's placement and confirmed that they have been placed in a safe harbor unit.	DOC Addressed the Complaint
3.	Incarcerated individual relayed concerns regarding seeking placement in safe harbor.	The OCO reviewed the individual's placement and confirmed that they have been placed in a safe harbor unit.	DOC Addressed the Complaint
4.	Incarcerated individual shared concerns regarding being held in segregation.	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 released from administrative segregation.	DOC Addressed the Complaint
5.	The person reported that he was returned to prison, and he should have been allowed to pay his bail and be released rather than returned to confinement. He wants DOC to reverse their decision and let him out on graduated reentry (GRE).	The OCO confirmed that the individual is no longer in prison and is currently housed in a reentry center.	DOC Addressed the Complaint
6.	Incarcerated individual relayed concerns regarding an investigation impacting their ability to transfer out of segregation.	The OCO reviewed the individual's placement and confirmed that they have released from segregation.	DOC Addressed the Complaint
7.	Incarcerated individual relayed concerns regarding extended placement in segregation.	The OCO reviewed the individual's placement and confirmed that they have released from segregation.	DOC Addressed the Complaint
8.	Incarcerated individual shared concerns regarding WAC changes and their custody facility plan (CFP) taking an extended period of time to finalize.	DOC staff addressed this concern prior to OCO action. Following a review of DOC records, this office was able to confirm that this individual had received a timely CFP but their eventual transfer took an extended period of time. This office also provided information regarding the WAC changes and their planned implementation.	DOC Addressed the Complaint
9.	Incarcerated individual shared concerns regarding receiving a negative Behavioral Observation Entry (BOE) and not being provided with the proper opportunity to appeal it.	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 this individual was provided the opportunity to appeal the BOE and it was upheld following review.	Insufficient Evidence to Substantiate
10.	External person reported that they were not contacted when their loved one was in the	The OCO reviewed the complaint and found DOC inactions are currently allowed within DOC policy	No Violation of DOC Policy

	hospital. The person requested to be notified if their loved one is kept overnight at the hospital.	610.600. OCO staff reviewed the patient's hospital records and found that there was no seriously ill or critical care notification made to the prison and the patient was considered stable for entire period of admission.	
11.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of DOC Policy
12.	Incarcerated individual relayed concerns regarding an infraction. The individual states that it was a cell tag, but their cellmate took responsibility.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the pruno was found in a common area and neither the individual nor their cellmate took responsibility.	No Violation of DOC Policy
Cedar Creek Corrections Center			
13.	Incarcerated individual relayed concerns regarding WAC 603s still being issued despite a change in law.	The OCO requested DOC provide clarification about when the WAC changes will be implemented. At OCO request DOC provided a memo to all incarcerated individuals on May 11, 2026 explaining that the WAC changes have not yet gone into effect and as a result, WAC 603s are still valid.	Assistance Provided
14.	Incarcerated individual relayed concerns regarding WAC 603s still being issued despite a change in law.	The OCO requested DOC provide clarification about when the WAC changes will be implemented. At OCO request DOC provided a memo to all incarcerated individuals on May 11, 2026 explaining that the WAC changes have not yet gone into effect and as a result, WAC 603s are still valid.	Assistance Provided
15.	Individual reported concerns regarding his special diet and DOC staff misconduct.	The OCO reviewed the individual's records and spoke with this person numerous times. The person filed many grievances about this issue and the Department substantiated that they made a mistake and gave him the incorrect item unintentionally. The individual was transferred to a different facility, and this person has continued having issues surrounding his special diet. The OCO addressed this concern systematically and recently published a report on Therapeutic Diets. One of the recommendations was to create a new health status report (HSR) for prescribed diets. The self-selection option currently being used is inadequate to meet the needs of the population, and OCO's recommendation would make it possible to accommodate patients who have combinations of allergies and clinical needs.	Information Provided
16.	Incarcerated individual relayed concerns regarding their wife being taken off their extended family visit (EFV) list.	The OCO reviewed the EFV denial and confirmed that per DOC policy 590.100 and 450.300 the visitor must have visited the incarcerated individual a minimum of 6 days in the past 12 months with at least 1 of the visits being in person. The individual and their wife did not meet these requirements and thus the EFVs were not approved.	Information Provided
17.	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 failed to participate in the DOSA program and committed other acts that violated the DOSA	No Violation of DOC Policy

		agreement terms which was a court required program.	
Clallam Bay Corrections Center			
18.	While in person at the facility, several individuals expressed concerns about people being found guilty of an infraction without the evidence being reviewed due to too many infractions being written and the hearings officer saying that it was the Superintendent's job to review the evidence on appeal.	The OCO elevated this concern to DOC leadership and confirmed that any concerns regarding infractions have since been addressed and DOC policy 460.000 is being followed to ensure individuals have a fair infraction hearing.	Assistance Provided
19.	Incarcerated individual relayed concerns regarding extended placement in segregation and inability to access the level system.	The OCO reviewed the individual's placement and had numerous conversations with DOC leadership regarding their placement in segregation and related level limitations. The OCO confirmed that DOC released the individual from segregation and transferred them to a facility where they are safe at.	Assistance Provided
20.	Person rereported a concern regarding their access to medications for opioid use disorder.	DOC staff addressed this complaint. OCO staff contacted DOC Health Services staff and were informed that the patient had been started on medication for the reported issue.	DOC Addressed the Complaint
21.	An external person reported concerns about filing a hardship for visitation with their son.	The OCO contacted DOC staff, who confirmed the hardship paperwork could go directly to them. This office provided this information to the incarcerated individual.	Information Provided
22.	Incarcerated individual relayed concerns regarding wanting to get on a particular medication.	The OCO reviewed the related grievance and spoke with DOC staff. The OCO confirmed that DOC has been scheduling various appointments for the individual to see if the provider will prescribe their desired medication which remains a work in progress.	Information Provided
23.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the individual's infraction history but was unable to find any recent infractions matching the description the individual provided.	Insufficient Evidence to Substantiate
24.	Incarcerated individual shared concerns regarding DOC staff targeting them.	The OCO reviewed existing evidence and was unable to substantiate the concern. Following a review of DOC records, this office confirmed that DOC staff had responded to the numerous concerns that this individual brought forth. This office was unable to see any indication that staff had targeted this individual.	Insufficient Evidence to Substantiate
25.	Incarcerated individual shared concerns regarding DOC medical staff not providing them with medical care.	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 this individual was seen by DOC staff numerous times regarding their concern.	Insufficient Evidence to Substantiate
26.	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 the individual brought in drugs to substantiate the WAC.	No Violation of DOC Policy
27.	Incarcerated individual relayed concerns regarding an infraction and DOC not responding to their appeal.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as substance was found in their cell during a search that resulted in a presumptive positive for suboxone and was	No Violation of DOC Policy

		confirmed by the lab. DOC received the individual's appeal and responded to it the next day.	
28.	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 showing the individual conspired to introduce drugs through a visit.	No Violation of DOC Policy
Coyote Ridge Corrections Center			
29.	Incarcerated individual relayed concerns regarding WAC 603s still being issued despite a change in law.	The OCO requested DOC provide clarification about when the WAC changes will be implemented. At OCO request DOC provided a memo to all incarcerated individuals on May 11, 2026 explaining that the WAC changes have not yet gone into effect and as a result, WAC 603s are still valid.	Assistance Provided
30.	An external person reported concerns about their loved one being denied access to ADA accommodations and a lack of medical attention, and requested that this person receive all necessary mobility aids.	The OCO reviewed this person's records and confirmed that he has regular appointments with health services, and he was moved to a wheelchair-accessible cell. The OCO confirmed that the facility was unable to fulfill the request for ADA grab bars in his cell, but DOC has provided him with durable medical equipment that helps with his mobility issues.	DOC Addressed the Complaint
31.	Incarcerated individual shared concerns regarding DOC not providing them with hearing aids despite their imminent release.	DOC staff addressed this concern prior to OCO action. After speaking with this individual, this office was informed that DOC provided them with hearing aids. This office was also able to confirm that this individual has released.	DOC Addressed the Complaint
32.	Incarcerated individual relayed concerns regarding placement in segregation and feeling unsafe in their unit.	The OCO reviewed the individual's placement and confirmed that DOC transferred them to a facility where they are safe at.	DOC Addressed the Complaint
33.	Incarcerated individual relayed concerns regarding placement in segregation.	The OCO reviewed the individual's placement and confirmed that they were released from segregation and transferred.	DOC Addressed the Complaint
34.	Incarcerated individual relayed concerns regarding their kids being removed from a guest list for a visiting event.	The OCO reviewed the correspondence related to the grievance and confirmed that the escort for the minor children was not approved for visiting and as a result, the kids could not visit.	Information Provided
35.	Incarcerated individual relayed concerns regarding several infractions that resulted in the termination of their GRE.	The OCO reviewed the infraction materials and contacted DOC about the infraction. The OCO requested DOC dismiss a WAC 405 for possession of a knife as the individual confirmed that they made sure it was within the 3-inch guideline that is set out in the GRE Partial Confinement Conditions (DOC form 02-361) and the OCO verified with DOC staff that the knife that was confiscated was of a permissible length. DOC was unwilling to dismiss the WAC 405 from the infraction as the individual pled guilty to the infraction and did not appeal the infraction.	Information Provided
36.	Incarcerated individual relayed concerns regarding extended placement in segregation.	The OCO reviewed the individual's placement and confirmed that their placement in segregation was delayed due to offsite testing for the WAC 603 which was ultimately dismissed. The individual is now pending adjudication for a new infraction and then	Information Provided

		will need a new custody facility plan before leaving segregation.	
37.	An external person shared concerns on behalf of an incarcerated individual regarding DOC not addressing their medical concern and targeting 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 indication that DOC staff are targeting them. This office was informed by DOC staff that this individual was assessed for their medical concern and provided with treatment.	Insufficient Evidence to Substantiate
38.	Incarcerated individual relayed concerns regarding extended placement in segregation.	The OCO reviewed the individual's placement and found no violation of DOC policy 320.200 as the individual was placed in segregation due to an investigation. The OCO confirmed the individual's placement is properly being addressed.	No Violation of DOC Policy
39.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as there was behavior to substantiate each WAC violation.	No Violation of DOC Policy
40.	Incarcerated individual relayed concerns regarding extended placement in segregation.	The OCO reviewed the individual's placement and found no violation of DOC policy 320.200 as the individual was placed in segregation due to an investigation. The OCO confirmed the individual's placement is properly being addressed.	No Violation of DOC Policy
41.	Incarcerated individual relayed concerns regarding extended placement in segregation.	The OCO reviewed the individual's placement and confirmed that DOC is properly seeking new housing for them, but the OCO cannot impact transfer timelines.	No Violation of DOC Policy
42.	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 terminated from all programming at their school due to their behavior.	No Violation of DOC Policy
Monroe Correctional Complex			
43.	Patient reported concerns about access to an adequate diet and requested assisted suicide.	The OCO provided assistance by elevating the concerns through DOC health services leadership and confirming a suicide assessment occurred and the patient was able to speak with a provider directly.	Assistance Provided
44.	Incarcerated individual relayed concerns regarding a patient safety review that occurred after a suicide attempt and difficulties obtaining a copy of the record.	The OCO elevated this concern to DOC headquarters and requested that a patient safety review be conducted, and reviewed the records related to this incident including the patient safety review. The OCO confirmed that DOC conducted a patient safety review and the incident was properly reviewed. Regarding difficulties obtaining a copy of the record, the OCO informed the individual that they must submit a public records request through DOC who will disclose documents that are eligible for public disclosure. The OCO is unable to disclose any DOC records.	Assistance Provided
45.	Incarcerated individual relayed concerns regarding WAC 603s still being issued despite a change in law.	The OCO requested DOC provide clarification about when the WAC changes will be implemented. At OCO request DOC provided a memo to all incarcerated individuals on May 11, 2026 explaining that the WAC	Assistance Provided

		changes have not yet gone into effect and as a result, WAC 603s are still valid.	
46.	Incarcerated individual relayed concerns regarding a patient safety review that occurred after a suicide attempt and difficulties obtaining a copy of the record.	The OCO elevated this concern to DOC headquarters and requested that a patient safety review be conducted, and reviewed the records related to this incident including the patient safety review. The OCO confirmed that DOC conducted a patient safety review and the incident was properly reviewed. Regarding difficulties obtaining a copy of the record, the OCO informed the individual that they must submit a public records request through DOC who will disclose documents that are eligible for public disclosure. The OCO is unable to disclose any DOC records.	Assistance Provided
47.	Incarcerated individual relayed concerns regarding placement in segregation.	The OCO reviewed the individual's placement and confirmed that they have been released from segregation.	DOC Addressed the Complaint
48.	Incarcerated individual relayed concerns regarding placement in segregation.	The OCO reviewed the individual's placement and confirmed that the individual has been released from segregation.	DOC Addressed the Complaint
49.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and confirmed that the infraction was removed by DOC from the individual's record.	DOC Addressed the Complaint
50.	Incarcerated individual shared concerns regarding not hearing back on a Care Review Committee (CRC) request.	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 provided with a CRC decision and is actively working with health services to take care of their concern.	DOC Addressed the Complaint
51.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and confirmed that DOC removed the infraction from the individual's record.	DOC Addressed the Complaint
52.	Patient reported concerns about health complications after a DOC staff member removed her post-op supplies.	DOC staff addressed this concern prior to OCO action. The OCO confirmed the DOC resolution request was investigated and substantiated. Staff received supervisor follow up and training.	DOC Addressed the Complaint
53.	Incarcerated individual shared concerns regarding wanting to be transferred to a different facility.	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 transferred to a different facility.	DOC Addressed the Complaint
54.	Incarcerated individual shared multiple concerns relating to property and staff misconduct.	The OCO provided information regarding how this individual can share input on DOC policy as this individual disagreed with certain practices that are written within DOC policy.	Information Provided
55.	Person reported concerns regarding their access to gender affirming care.	The OCO provided information to the person about their active Care Review Committee (CRC) request. The OCO reviewed the person's consultations and found that the requested care was pending review by the CRC.	Information Provided
56.	Incarcerated individual relayed concerns regarding an infraction for a refusal of a urinary analysis (UA) despite having an HSR.	The OCO reviewed the infraction materials and requested DOC dismiss the infraction. DOC is unwilling to overturn an infraction if the HSR is not in effect at the time of the infraction, even if the	Information Provided

		individual is working with medical at the time. Because the individual's HSR did not go into effect until a month after the infraction, DOC was unwilling to dismiss the infraction.	
57.	Incarcerated individual shared concerns regarding DOC medical staff not providing them with medical access by not meeting with them.	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 this individual met with DOC medical staff but did not meet with their provider to discuss their concern. This office provided this individual with information pertinent to the appointment process.	Insufficient Evidence to Substantiate
58.	Incarcerated individual relayed concerns regarding DOC torturing incarcerated people and holding them hostage.	The OCO reviewed the individual's recent grievances and request from the OCO for additional information to better understand the concern. The OCO was unable to understand what the individual's concern was and thus had insufficient evidence to substantiate the concern.	Insufficient Evidence to Substantiate
59.	Incarcerated individual shared concerns regarding DOC not respecting their Health Status Report (HSR).	The OCO reviewed existing evidence and was unable to substantiate the concern. After speaking with DOC staff and reviewing DOC records, this office was informed that DOC staff are aware of the HSRs and they are being fulfilled. This office was unable to find any evidence indicating that this individual is being blocked from what is allowed in their HSR.	Insufficient Evidence to Substantiate
60.	Person reported concerns regarding how the nurse administered his medications. The person requested corrective action be taken. The person also reported concerns about the resolutions department denying his resolution appeal due to timelines.	The OCO reviewed the complaint and found DOC actions or inactions are currently allowed within DOC policy 550.100. The OCO verified the DOC denial of the resolution appeal is supported by DOC policy. OCO staff also found that the nurse's actions are common acceptable practice for the administration of medication.	No Violation of DOC Policy
61.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the procedure was properly followed for the UA testing.	No Violation of DOC Policy
62.	Incarcerated individual shared concerns regarding being infracted for something that was not their fault.	The OCO reviewed the complaint and found DOC actions are currently allowed within the WAC 137-25-030. Following a review of DOC records, this office was able to confirm that DOC staff had discovered contraband within this individual's cell. Due to this, this individual was given the infraction.	No Violation of DOC Policy
63.	Individual reported that he has been in administrative segregation for several months, waiting to be transferred. DOC will not agree to give him an override and instead want to keep him for a couple of months until his points come back.	The OCO was unable to substantiate a DOC policy violation. The OCO reviewed the person's custody facility plan and DOC's reasons for continuing to house them in segregation. These decisions comply with DOC policy 300.380. This office confirmed that the individual is safe and working on a new custody facility plan.	No Violation of DOC Policy
64.	Incarcerated individual relayed concerns regarding 2 infractions that they state should have been included in the same infraction group number (IGN) rather than written separately.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the infractions are two separate incidents from two separate days, thus there would be two separate IGNs.	No Violation of DOC Policy

65.	Incarcerated individual relayed concerns regarding placement in segregation.	The OCO reviewed the individual's placement and found no violation of DOC policy 320.250 as the individual must maintain MAX custody while pending an out of state transfer due to a prohibited placement with the only close custody housing option in WADOC and ineligibility for an override to medium at this time.	No Violation of DOC Policy
Olympic Corrections Center			
66.	Individual reported that the phones have been broken and only three of them have been working for over six months.	The OCO confirmed the individual filed a resolution request, and DOC staff noted that Securus came to the facility twice to fix the broken phones.	DOC Addressed the Complaint
Reentry Center - Longview - Cowlitz			
67.	Individual reported that there is no access to resolution requests or a resolution box.	The OCO addressed this complaint by working with DOC leadership, who have approved a new process for resolution requests at all reentry centers. Individuals housed in a reentry center can write their resolution request and send it directly to the DOC headquarters. Residents also have access to a pre-stamped envelope, so they can use the process even if they have no money or stamps.	Assistance Provided
Reentry Center - Olympia - Thurston			
68.	Incarcerated individual shared concerns regarding being given an infraction despite not having the proper resources to fulfill the expectations.	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 this individual was made aware of the expectations and was provided with resources to fulfill the required programming. Due to these circumstances, this individual was given the infraction for failing to meet the agreed upon expectations of partial confinement per DOC policy 460.050.	Insufficient Evidence to Substantiate
Stafford Creek Corrections Center			
69.	Incarcerated individual shared concerns regarding not being given access to communication applications despite being the proper level and maintaining good behavior.	The OCO provided assistance by reaching out to the facility and working with DOC staff to understand why this individual's communications applications were deactivated. DOC staff shared that it was undetermined why they were deactivated and reactivated them following this office's outreach.	Assistance Provided
70.	Family member relayed concerns about the way that the facility is investigating PREA complaints.	Without any identifying information regarding who this concern was regarding or a specific PREA investigation, the OCO was unable to investigate the particular concern further. The OCO elevated this concern to the facility leadership and PREA staff at the headquarters level who will review this further.	Assistance Provided
71.	Incarcerated individual relayed concerns regarding WAC 603s still being issued despite a change in law.	The OCO requested DOC provide clarification about when the WAC changes will be implemented. At OCO request DOC provided a memo to all incarcerated individuals on May 11, 2026 explaining that the WAC changes have not yet gone into effect and as a result, WAC 603s are still valid.	Assistance Provided

72.	Person reported on behalf of the incarcerated individual that they were placed in restrictive housing without clear explanation.	The OCO verified that the individual is no longer housed in administrative segregation.	DOC Addressed the Complaint
73.	Incarcerated individual relayed concerns regarding placement in segregation.	The OCO reviewed the individual's placement and confirmed that they have been released from segregation and are back in general population.	DOC Addressed the Complaint
74.	Incarcerated individual shared concerns regarding being held in segregation.	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 released from segregation.	DOC Addressed the Complaint
75.	Person reported being denied a sleep specialist evaluation. The person stated that they have been seen before and was not provided with a CPAP and now their condition has worsened. The person is requesting to be sent to a specialist.	The OCO provided information to the person about their active consultation. OCO staff reviewed the person's active specialist consultations and found that the delay in scheduling was caused by the outside clinic failing to process the referral in a timely manner. OCO staff confirmed the appointment has been scheduled and will monitor the appointment to ensure the patient was able to attend.	Information Provided
76.	Individual reported that he does not know why he is in segregation and feels like this is retaliation for a grievance he filed.	The OCO reviewed the individual's placement and confirmed he remains in segregation after being caught with someone else's property in the transfer pod. This person will need to appeal their infractions if they disagree with the outcome and may also appeal the classification decision once their FRMT is complete.	Information Provided
77.	Incarcerated individual relayed concerns regarding denial of extended family visits (EFVs) with their wife.	The OCO reviewed the EFV denial and spoke to DOC about this concern and found no violation of DOC policy 590.100 as there are multiple reasons for the denial as outlined in policy and the denial letter.	No Violation of DOC Policy
78.	Incarcerated individual shared concerns regarding being wrongly infracted.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC 460.050. Following a review of DOC records, this office confirmed that this individual had actively been fighting and was given the infraction as their conduct fit the criteria of the infraction.	No Violation of DOC Policy
79.	Incarcerated individual relayed concerns regarding denial of extended family visits (EFVs) with their wife.	The OCO reviewed the EFV denial and spoke to DOC about this concern and found no violation of DOC policy 590.100 as there are multiple reasons for the denial as outlined in policy and the denial letter.	No Violation of DOC Policy
80.	Incarcerated individual relayed concerns regarding denial of extended family visits (EFV).	The OCO reviewed the EFV denial and found no violation of DOC policy 590.100 as there were multiple reasons for the denial.	No Violation of DOC Policy
81.	Incarcerated individual relayed concerns regarding an infraction and contradiction in the infraction report and search report.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as both the infraction report and search report confirm that a barcode sized paper/ID sized paper that was tested was found during the search of the individual's cell and was the item that tested positive.	No Violation of DOC Policy
82.	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 behavior to substantiate the infraction elements.	No Violation of DOC Policy

83.	Individual reported that he was having a seizure and DOC responded with the intoxication protocol. Staff performed a use of force, saying he was combative and infracted him.	The individual has been released from prison, however, the OCO reviewed records and confirmed that DOC treated his condition as if he were intoxicated. The OCO reviewed the Use of Force report and contacted DOC about this concern. It was confirmed that the individual was having a medical emergency and was not intoxicated. The OCO continues to monitor the intoxication protocol and communicates with DOC leadership regarding new concerns.	Substantiated
Washington Corrections Center			
84.	Family member reported concerns about their loved one's access to medical treatment for TB and single cell placement.	The OCO elevated the concerns through DOC health services leadership. Based on clinical review, there was no medical indication for single cell as the patient's TB is considered latent. After OCO outreach, the Facility Medical Director agreed to meet with the patient's provider to follow up on any treatment concerns. The OCO provided the patient with this information and details for following up if symptoms continue.	Assistance Provided
85.	Person reported concerns with his hip and wanted to see a specialist.	The OCO provided assistance by continually monitoring this individual's appointments to ensure that he saw a specialist. The OCO reviewed DOC documents regarding this individual's care and found that DOC substantiated his resolution request about not seeing a specialist about his hip. OCO staff extensively monitored his appointments and ensured that he had physical therapy appointments and specialist consults to develop a care plan moving forward.	Assistance Provided
86.	Incarcerated individual relayed concerns regarding the conduct of a certain staff member, wanting the outcome of that staff conduct investigation and wanting that staff member prosecuted.	The OCO spoke to DOC about this concern, monitored the staff conduct investigation and confirmed that DOC properly addressed the concern. The OCO informed the individual that this office cannot aid in the prosecution or pressing of criminal charges against anyone, nor is this office able to disclose the outcome of a staff conduct investigation.	DOC Addressed the Complaint
87.	Incarcerated individual relayed concerns regarding difficulties in segregation at a particular facility.	The OCO reviewed the individual's placement and confirmed that they have since transferred away from the facility of concern.	DOC Addressed the Complaint
88.	Incarcerated individual relayed concerns regarding extended wait times in the R-units and lack of programming.	The OCO spoke to DOC about the wait times to transfer to close custody and safe harbor that are impacting people in the R-units. DOC confirmed that the wait time to transfer to close custody is approximately 9-12 months due to a lack of bed space. The OCO requested that DOC provide additional programming or job opportunities for individuals that are awaiting transfer. DOC was unwilling to provide additional programming or job opportunities for those that are awaiting transfer.	Information Provided
89.	Incarcerated individual relayed concerns regarding extended wait times in the R-units and lack of programming.	The OCO spoke to DOC about the wait times to transfer to close custody and safe harbor that are impacting people in the R-units. DOC confirmed that	Information Provided

		the wait time to transfer to close custody is approximately 9-12 months due to a lack of bed space. The OCO requested that DOC provide additional programming or job opportunities for individuals that are awaiting transfer. DOC was unwilling to provide additional programming or job opportunities for those that are awaiting transfer.	
90.	Incarcerated individual relayed concerns regarding extended wait times in the R-units and lack of programming.	The OCO spoke to DOC about the wait times to transfer to close custody and safe harbor that are impacting people in the R-units. DOC confirmed that the wait time to transfer to close custody is approximately 9-12 months due to a lack of bed space. The OCO requested that DOC provide additional programming or job opportunities for individuals that are awaiting transfer. DOC was unwilling to provide additional programming or job opportunities for those that are awaiting transfer.	Information Provided
91.	External person reported that an individual was served with an improper 603 infraction with no evidence.	The OCO reviewed the individual's infraction report and appeal response. The OCO confirmed that the Department had several types of evidence to support a guilty finding, and DOC reviewed the appeal. The OCO provided contact information so that this person can write to the Prison Disciplinary Program Manager for a final review.	Information Provided
92.	Incarcerated individual relayed concerns regarding extended wait times in the R-units and lack of programming.	The OCO spoke to DOC about the wait times to transfer to close custody and safe harbor that are impacting people in the R-units. DOC confirmed that the wait time to transfer to close custody is approximately 9-12 months due to a lack of bed space. The OCO requested that DOC provide additional programming or job opportunities for individuals that are awaiting transfer. DOC was unwilling to provide additional programming or job opportunities for those that are awaiting transfer.	Information Provided
93.	Person reported concerns regarding his health care access. The person requested for his concern to be documented and did not request any action be taken.	The OCO provided information to the person about tort claims and the DOC health plan. 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
94.	Incarcerated individual relayed concerns regarding placement in safe harbor.	The OCO contacted DOC about this concern and confirmed that the individual was denied safe harbor placement due to inconsistent information provided in the process.	Information Provided
95.	Incarcerated individual relayed concerns regarding extended wait times in the R-units and lack of programming.	The OCO spoke to DOC about the wait times to transfer to close custody and safe harbor that are impacting people in the R-units. DOC confirmed that the wait time to transfer to close custody is approximately 9-12 months due to a lack of bed space. The OCO requested that DOC provide additional programming or job opportunities for individuals that are awaiting transfer. DOC was	Information Provided

		unwilling to provide additional programming or job opportunities for those that are awaiting transfer.	
96.	Individual reported he was given a negative behavior observation (BOE) and was not given proper notification.	The OCO confirmed that his BOE was neutral, not negative.	Information Provided
97.	Incarcerated individual relayed concerns regarding an infraction and the resulting MAX placement.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as there is video evidence showing that the individual swung first in the altercation and were not the victim. As a result, the MAX placement is valid per DOC policy 320.250.	No Violation of DOC Policy
98.	Incarcerated individual relayed concerns regarding an infraction. They state that the infraction report says they pled guilty when they actually pled not guilty.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual conspired with a visitor to introduce suboxone, the not guilty box is checked on the plea form and there is evidence to support the WAC.	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 a toilet paper roll with a hole is enough for a drug paraphernalia guilty finding even though the lab testing results were negative for drugs.	No Violation of DOC Policy
100.	Incarcerated individual relayed concerns regarding an infraction for refusing a urinary analysis (UA) but they state that they had an HSR for extra water that was not provided to them.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual was unable to provide a sample within the 1 hour timeframe and did not have a valid HSR at this time.	No Violation of DOC Policy
101.	Incarcerated individual relayed concerns regarding not being able to access level 3 while in segregation.	The OCO reviewed the individual's custody facility plan and found no violation of DOC policy 320.250 as the individual is to maintain level 2 only due to staff assaults.	No Violation of DOC Policy
102.	Incarcerated individual relayed concerns regarding extended placement in segregation.	The OCO reviewed the individual's placement and found no violation of DOC policy 320.250 as the individual was given another MAX plan due to not completing significant programming to reduce the risk associated with the threatening behaviors.	No Violation of DOC Policy
Washington Corrections Center for Women			
103.	Incarcerated individual relayed concerns regarding a flood that occurred in the unit after a fire sprinkler had a malfunction and the way that the emergency was responded to.	The OCO reviewed the video of the incident and related documentation and found no violation of DOC policy 400.100 (restricted) incident and significant event reporting as the situation was properly handled and all individuals were quickly escorted out of the unit. The OCO informed the individual that for any damaged items, a tort claim will need to be submitted.	Information Provided
104.	Person reported having an allergy to the cleaning solutions used widely across all facilities. This person requested accommodations to prevent the cleaning spray being used around her.	The OCO provided information to the person about her requested resolution. The OCO reviewed the person's medical records, Care Review Committee reviews, and resolution requests. OCO staff also contacted DOC Health Services staff and received clinical input on the patient's concern. OCO staff found that a clinical decision was made by multiple levels of review that there was not enough clinical evidence of the patient's reported concern for the	Information Provided

		requested accommodation. The OCO cannot countermand clinical decisions.	
105.	Multiple individuals relayed concerns regarding a flood that occurred in the unit after a fire sprinkler had a malfunction and the way that the emergency was responded to.	The OCO reviewed the video of the incident and related documentation and found no violation of DOC policy 400.100 (restricted) incident and significant event reporting as the situation was properly handled and all individuals were quickly escorted out of the unit. The OCO informed the individuals that for any damaged items, a tort claim will need to be submitted.	Information Provided
106.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as there were marks consistent with a mutual fight on both individuals.	No Violation of DOC Policy
107.	Person reported concerns with being asked to drink an extra glass of water after receiving medication prior to being released from the medication line.	The OCO reviewed the complaint and found DOC policy is currently limited or does not exist for this specific concern. OCO staff reviewed the manufacturer's information for the medication and found there was no contraindication listed for drinking additional water.	No Violation of DOC Policy
108.	External person reported concerns regarding their loves one's placement in segregation without an investigation. The person stated that their loved one's cellmate was not infracted for a cell tag and requested that the infraction be dropped.	The OCO reviewed the complaint and found DOC actions are currently allowed within restricted policy. The OCO reviewed the person's segregation placement and found there was an ongoing investigation that involved the incarcerated person. At the time of review the infraction had not yet been appealed; the OCO requires an infraction appeal decision be returned prior to reviewing a serious infraction.	No Violation of DOC Policy
109.	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 this individual had brought a controlled substance into the facility and tested positive for controlled substances following a drug test. Due to these circumstances, this individual was given an infraction.	No Violation of DOC Policy
110.	A loved one reported that an incarcerated individual was punished for using the bathroom during a facility lockdown.	The OCO reviewed this person's records and interviewed individuals from that living unit the day after the lockdown incident. The Department confirmed that the pod was locked down due to a police investigation. The OCO confirmed that this individual is no longer in administrative segregation and that their infraction was reduced from a major to a general infraction.	Substantiated
111.	A loved one reported that the incarcerated individual was punished for using the bathroom during a facility lockdown.	The OCO reviewed this person's records and interviewed individuals from that living unit the day after the lockdown incident. The Department confirmed that the pod was locked down due to a police investigation. The OCO confirmed that this individual is no longer in administrative segregation and that their infraction was reduced from a major to a general infraction.	Substantiated

112.	A loved one reported that the incarcerated individual was punished for using the bathroom during a facility lockdown.	The OCO reviewed this person's records and interviewed individuals from that living unit the day after the lockdown incident. The Department confirmed that the pod was locked down due to a police investigation. The OCO confirmed that this individual is no longer in administrative segregation and that their infraction was reduced from a major to a general infraction.	Substantiated
Washington State Penitentiary			
113.	External person reported concerns about an incarcerated patient's access to accommodations and treatment.	The OCO provided assistance by elevating the concerns through DOC health services leadership. After OCO outreach, the patient was reviewed and approved for transfer to a Residential Treatment Unit (RTU). This office was unable to influence the patient's HSR/ASRs. DOC agreed to a pathway for custody promotion and SOTAP treatment considerations and the OCO provided the patient with information about their next steps.	Assistance Provided
114.	Incarcerated individual relayed concerns regarding seeking placement in safe harbor.	The OCO reviewed the individual's placement and confirmed that they have been placed in a safe harbor unit.	DOC Addressed the Complaint
115.	Incarcerated individual relayed concerns about their placement and related safety issues.	The OCO reviewed the individual's placement and confirmed that they were transferred to a facility where they are safe.	DOC Addressed the Complaint
116.	Incarcerated individual shared concerns regarding DOC jeopardizing their safety by not moving them.	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 transferred to a location where they are safe.	DOC Addressed the Complaint
117.	Incarcerated individual shared concerns regarding not being provided with the opportunity to promote levels while in segregation.	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 transferred to a different facility.	DOC Addressed the Complaint
118.	Individual reported concerns regarding health services taking him off of necessary mental health medications.	The OCO confirmed the individual was moved to another facility, and DOC health services confirmed the individual is receiving both medications he requested.	DOC Addressed the Complaint
119.	Incarcerated individual relayed concerns regarding placement in segregation.	The OCO reviewed the individual's placement and confirmed that they have released from segregation.	DOC Addressed the Complaint
120.	Incarcerated individual relayed concerns regarding their safety related placement options.	The OCO reviewed the individual's placement and any debrief attempts. The OCO was unable to locate any information showing that they were screened for protective custody (PC) or safe harbor (SH). The OCO informed the individual that they will need to complete DOC form 21-169 for PC screening or kite their local IIU to get a debrief packet.	Information Provided
121.	Incarcerated individual relayed concerns regarding population changes for Victor and William units including the introduction of a new security threat group (STG).	The OCO spoke to DOC about this concern and confirmed that the STG they expressed concerns about are not new to the unit and have historically resided within the unit.	Information Provided
122.	Incarcerated individual relayed concerns regarding being given a level 1 only program.	The OCO spoke with DOC about this concern and confirmed that DOC did not solely utilize refusing	Information Provided

		housing infractions (WAC 724s) as the justification for the level 1 only program and instead substantiated the level 1 only program due to various factors including a fight while in protective custody.	
123.	Incarcerated individual relayed concerns regarding seeking safe harbor placement.	The OCO spoke with DOC about this concern and confirmed that DOC did not find the individual eligible for safe harbor placement due to not having a security threat group (STG) tag and did not find the individual eligible for protective custody due to not expressing safety concerns that could be validated.	Information Provided
124.	Incarcerated individual relayed concerns regarding seeking safe harbor placement.	The OCO spoke with DOC about this concern and confirmed that the debrief that was provided was insufficient for DOC to provide the individual with safe harbor placement.	Information Provided
125.	An incarcerated individual reported concerns about security enhancement plans and health status reports (HSRs) for quality of life conditions.	The OCO provided information about the HSR process, however, cannot override HSRs as they are clinical decisions.	Information Provided
126.	Person reported that he is not being provided with appropriate pain management despite believing that he meets DOC Health Plan criteria based on his diagnosis.	The OCO provided information to the person regarding his requested resolutions. OCO staff reviewed the person's records and found that the person was denied for a specific level of care by an external healthcare entity. The DOC cannot override this decision and the OCO does not have jurisdiction over that outside provider. Regarding the patient's pain management request, the OCO verified the patient was offered additional pain management options that his medical provider felt did not increase the risk of complicating the patient's condition, however the patient declined.	Information Provided
127.	Incarcerated individual shared concerns regarding not being able to get on MAT line.	The OCO provided information regarding how this individual can potentially obtain their desired treatment. This office also informed this individual that the OCO has no impact on clinical decisions and encouraged this individual to continue working with DOC medical staff to address their concern.	Information Provided
128.	Individual reported safety concerns and wants to be housed in a safe harbor unit.	This office confirmed that the individual has since been transferred and is safe at this time. The OCO provided instructions for appealing a classification decision to the Senior Director of Classifications on DOC Form 07-037.	Information Provided
129.	External person reported that their loved one is not receiving adequate medical care or consideration of his disabilities in the disciplinary process.	The OCO reviewed existing evidence and was unable to substantiate the concern. OCO staff reviewed the patient's medical records and found the patient had refused medication and assessment for the reported issue. OCO staff contacted DOC Health Services staff and were informed that the person was not following the ordered treatment plan, but his medical provider was continuing to try to work with him. OCO provided information to the patient about the Americans with Disabilities Act.	Insufficient Evidence to Substantiate

130.	Incarcerated individual shared concerns regarding DOC staff threatening them.	The OCO reviewed existing evidence and was unable to substantiate the concern. Following a review of DOC records, this office was unable to locate any evidence indicating that this individual was threatened by DOC staff.	Insufficient Evidence to Substantiate
131.	Loved one reported that her husband received a positive urine analysis for drug use, which occurred prior to his arrival at the prison.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed the individuals' infraction and confirmed that the UA was sent to a lab and returned positive.	No Violation of DOC Policy
132.	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 behavior that substantiates each infraction.	No Violation of DOC Policy
133.	Incarcerated individual shared concerns regarding being infracted with an infraction that does not match the circumstances.	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 was able to confirm that this individual was involved in an altercation that involved numerous individuals. Due to this, the circumstances of the incident fit the criteria for the infraction.	No Violation of DOC Policy
134.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.050 as the individual would be sanctioned based off the most serious infraction and this was their third major infraction in 12 months so they would be sanctioned to the highest level. The OCO confirmed that WAC 137-28-350 permits a 1 year tablet restriction rather than 180 days.	No Violation of DOC Policy
135.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.050 as the sanctions are appropriate and an individual's sanctions are not impacted on what a similarly situated individual gets for sanctions.	No Violation of DOC Policy
136.	Incarcerated individual relayed concerns about a visit denial for their child.	The OCO reviewed the visitation denial and appeal paperwork and found no violation of DOC policy 450.300 as the child is a victim of the crime of conviction.	No Violation of DOC Policy
137.	Person states that it was not fair for him to receive an infraction for refusing directives to stop fighting due to a medical condition. The person requests that his disability be considered in the hearings process.	The OCO reviewed the concern and found that DOCs actions are supported by DOC policy 460.000. OCO staff reviewed the infractions and incident reports and found that the behavior described in the records fit the criteria for the WAC violation. The infracted behavior occurred prior to directives to stop were made.	No Violation of DOC Policy
138.	Person anonymously reported concerns about the dog program at WSP, particularly regarding compensation.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 700.350, which does not mandate any framework for compensation.	No Violation of DOC Policy

Intake Investigations

Airway Heights Corrections Center

139.	Person reported on behalf of the incarcerated individual that they were accused of something they did not do.	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
140.	Person reported that they would like access to 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
141.	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
142.	Person reported that they would like to be moved to another cell.	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 a courtesy cell move.	Technical Assistance Provided
143.	Person reported that DOC is not honoring their HSR for medical shoes.	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 health status reports.	Technical Assistance Provided
Cedar Creek Corrections Center			
144.	An external person shared concerns on behalf of an incarcerated individual regarding a Securus issue.	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake due to any other reasons the ombuds deems relevant to the complaint, including, but not limited to, the priority and weight given to these and other relevant factors.	Declined
Clallam Bay Corrections Center			
145.	Person reported on behalf of the incarcerated individual 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
Coyote Ridge Corrections Center			

146.	An external person shared concerns on behalf of an incarcerated individual regarding DOC not addressing their medical concern and targeting them.	This case was a duplicate of one that already existed from the same complainant and for the same concern.	Complaint Withdrawn
147.	Incarcerated individual relayed concerns regarding placement in segregation.	This case is a duplicate of one that already exists in the OCO case management system.	Complaint Withdrawn
148.	Incarcerated individual shared concerns regarding wanting their tablet back.	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake as due to limited resources, this office is not investigating concerns related to tablets.	Declined
149.	Incarcerated individual shared concerns regarding graduated reentry (GRE).	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake as due to limited resources, this office isn't investigating concerns related to GRE.	Declined
150.	Person reported on behalf of the incarcerated individual that DOC staff members did not allow them to drink water from the fountain.	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
151.	Person reported that the kitchen is mixing unsanitary food with their meals.	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
152.	Person reported 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
153.	Person reported that DOC is continuing to deduct legal financial obligation payments when they are not supposed to.	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
GRE/CPA			
154.	Incarcerated individual shared concerns regarding graduated reentry (GRE).	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake as due to limited resources, this office is not investigating concerns related to GRE.	Declined
Monroe Correctional Complex			
155.	Loved one 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

156.	Incarcerated individual shared concerns regarding medical not providing them with medical care for their concern.	This case was a duplicate of one that already existed from the same complainant and for the same concern.	Complaint Withdrawn
157.	Incarcerated individual shared concerns regarding DOC staff actively blocking their ability to release.	OCO staff opened this case in error.	Complaint Withdrawn
158.	Incarcerated individual relayed concerns regarding SOTAP access.	This case is a duplicate of one that already exists in the OCO case management system.	Complaint Withdrawn
159.	Incarcerated individual relayed concerns regarding time calculations.	This case is a duplicate of one that already exists in the OCO case management system.	Complaint Withdrawn
160.	Anonymous individual reported concerns about staff treating people differently because of their race.	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 staff conduct concerns not related to a use of force or RTU due to extremely limited resources.	Declined
161.	Person reported an incident that happened on McNeil Island nearly twenty years ago.	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
162.	Anonymous individual reported there not being heating in certain cells.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. The OCO provided the individual with technical assistance by sending them an OCO strategic priorities flyer and an OCO resolution program informational flyer.	Technical Assistance Provided
Olympic Corrections Center			
163.	Person reported on behalf of the incarcerated individual 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
Other			
164.	This person reported concerns that he was being harassed and targeted by a corrections officer at the Okanogan County Jail.	This is a duplicate of a case that already exists in the OCO case management system.	Complaint Withdrawn
165.	Person reported on behalf of the incarcerated individual that they are being harassed by a 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
166.	Person reported that they were harassed and retaliated against by an officer.	Per WAC 138-10-040(3)(a), the OCO may not investigate because the ombuds does not have	No Jurisdiction

		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.	
167.	Person reported that jail staff members made false statements about their drug screening results.	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
168.	Person reported that they were harassed and retaliated against.	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
169.	Person reported concern about corruption in their criminal case.	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
170.	Person reported that their time calculations are incorrect.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about records correction and time calculations.	Technical Assistance Provided
	Reentry Center - Bellingham - Whatcom		
171.	Person reported that they requested a 16-hour pass to attend an orientation, but it was 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 resolution process.	Technical Assistance Provided
	Reentry Center - Brownstone - Spokane		
172.	Person reported that a DOC staff member is not allowing them to send money to their family.	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
	Reentry Center - Olympia - Thurston		
173.	Person reported on behalf of the incarcerated individual that they are being targeted and retaliated against 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	Technical Assistance Provided

		assistance. The OCO provided technical assistance about staff conduct concerns.	
Stafford Creek Corrections Center			
174.	External person relayed concerns about documents they sent in to the prison.	This case is a duplicate of one that already exists in the OCO case management system.	Complaint Withdrawn
175.	An external person shared concerns on behalf of an incarcerated individual regarding mail.	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake as due to limited resources, this office is not investigating concerns related to mail.	Declined
176.	Person reported that some of their property was found broken.	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
177.	Person reported on behalf of the incarcerated individual 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
178.	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
179.	Person reported on behalf of the incarcerated individual that their time calculations are incorrect.	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
180.	Person reported on behalf of the incarcerated individual that they were given the wrong medication multiple times.	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 appointments and emergencies.	Technical Assistance Provided
181.	Person reported that their time calculations are incorrect.	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC Resolution Program. If the individual's concern is not addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about records correction and time calculations.	Technical Assistance Provided
Washington Corrections Center			

182.	Incarcerated individual shared concerns regarding wanting to go to a reentry center (RC).	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake as due to limited resources, this office is not investigating concerns regarding GRE or RC.	Declined
183.	Person reported that they need their legal paperwork to appeal their probation violation.	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
184.	Person reported on behalf of the incarcerated individual that their time calculations are incorrect.	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
185.	Person reported on behalf of the incarcerated individual that DOC has not fixed their plumbing issue in a timely manner.	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 resolution request for their concerns.	Technical Assistance Provided
186.	Person reported that they submitted two public record requests to DOC, but they have not responded.	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 DOC public records process.	Technical Assistance Provided
Washington Corrections Center for Women			
187.	Incarcerated individual shared concerns regarding GRE.	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake as due to limited resources, this office is not investigating concerns related to GRE.	Declined
188.	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 appointments and emergencies.	Technical Assistance Provided
189.	Person reported that DOC staff members are violating the DOC code of conduct.	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
Washington State Penitentiary			

190.	A loved one reported a concern related to a person's time calculation.	This case is a duplicate of one that already exists in the OCO case management system.	Complaint Withdrawn
191.	Incarcerated individual shared concerns regarding property.	Per WAC 138-10-040(3)(g), the OCO declined to investigate the complaint beyond intake as due to limited resources, this office is not investigating concerns related to property.	Declined
192.	Person reported concerns regarding his placement in a residential treatment unit. The person requests to be allowed to go to a camp setting.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because the complaint did not allege violation of policy, procedure, or law. and reasons the ombuds deemed relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors.	Declined
193.	Incarcerated individual relayed concerns regarding staff conduct.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. The OCO provided the individual with technical assistance by sending them an OCO strategic priorities flyer and an OCO staff conduct informational flyer.	Technical Assistance Provided
194.	Individual reported that they are in the IMU and are allowed to have their tablet, but DOC staff will not give it to them.	The OCO confirmed that the individual was being transferred, and DOC said that they would receive their tablet at their next facility. The OCO also provided this person with the email address for DOC's Correspondence unit so their family could contact DOC.	Technical Assistance Provided
195.	Person reported that it has been thirty days and they have not 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
196.	Person reported that they were forced to work in the kitchen.	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
197.	Person reported that they want to get into 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
198.	Person reported that he is being harassed 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	Technical Assistance Provided

		DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about staff conduct concerns.	
Not specified			
199.	Person reported that an individual is harassing victims.	Per WAC 138-10-040(3)(c), the OCO declined to investigate the complaint beyond intake due to the nature and quality of the evidence. The complaint did not include enough information to initiate an investigation. No contact or DOC number was provided in order to follow up.	Declined

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-26-001

Report to the Legislature

As required by RCW 72.09.770

June 5, 2026

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

Table of Contents

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

Unexpected Fatality Review Committee Report

UFR-26-001 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 virtual meeting held on April 30, 2026:

DOC Health Services

- Dr. Frank Longano, Interim Chief Medical Officer
- Poonam Bhagia, Deputy Chief Medical Officer
- Kellett Sayre, Interim Assistant Secretary
- Mark Eliason, Deputy Assistant Secretary
- Alexis Telles, Director of Nursing
- Dr. Rae Simpson, Director of Quality Systems
- Justin Wozab, Clinical Nurse Educator
- Arpan Aulakh, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Charles Anderson, Deputy Assistant Secretary
- Paige Perkinson, Correctional Relations Specialist

DOC Risk Mitigation

- Michael Pettersen, Director
- Elisabeth Kingsbury, Litigation Administrator

Office of the Corrections Ombuds (OCO)

- Ollie Webb, Assistant Corrections Ombuds - Investigations
- Madison Vinson, Assistant Corrections Ombuds - Policy

Department of Health (DOH)

- Karen Pastori, Health Services Consultant 3 – Prevention and Community Health

Health Care Authority (HCA)

- Dr. Sophie Miller, Medical Officer

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

Fatality Summary

Year of Birth: 1965 (60-years-old)

Date of Incarceration: November 2012

Date of Death: February 2026

At the time of death, the decedent was housed in a prison facility and receiving care in a community hospital.

The cause of death is exsanguination due to perforated left brachiocephalic vein during the placement of a tunneled hemodialysis catheter for the treatment of end-stage renal disease due to hypertension.

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

Day Prior to Death	Event
Day 28	• The decedent was seen by a vascular specialist and chose to have a surgical procedure to treat poor blood circulation.
Day 11	• The decedent was admitted to a community hospital for treatment of post-procedure complications.
Day 9	• They were discharged from the hospital and readmitted to the DOC facility infirmary for their ongoing care needs.
Day 0	• The decedent was transported to a community hospital for the scheduled surgical procedure. • Complications arose during the procedure, treatment was unsuccessful and they were declared deceased by hospital staff.

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 and the antecedent care delivered, and provided the following findings:

a. The decedent had complex health conditions including end-stage kidney disease following a failed kidney transplant, hypertension, vascular disease and heart disease.

b. The clinical care provided by DOC staff was appropriate and well-coordinated.

c. The review revealed no clinical care gaps and identified no opportunities for system improvement.

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

1. The review identified no contributing, causal or non-causal factors within the scope of the CIR and had no recommendations for corrective action.

C. The committee reviewed the circumstances of the unexpected fatality and discussed the following:

1. Complexity of Care:

a. Committee members recognized the decedent's complex medical needs and agreed that the care delivered by DOC staff and coordinated with community specialists was appropriate.

2. Scope of review:

a. The committee noted that evaluating the medical treatment provided by the community hospital falls outside the statutory scope of the UFR.

Committee Findings

This death was attributed to internal bleeding caused by an accidental tear of a major blood vessel during a surgery at a community hospital.

Committee Recommendations

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