Office of the Corrections OMBUDS

Monthly Outcome Report

August 2026

Case Investigations: 131

Assistance Provided: 13

Information Provided: 43

DOC Addressed the Complaint: 24

Insufficient Evidence to Substantiate: 21

No Violation of DOC Policy: 28

Substantiated: 2

Intake Investigations: 114

Declined: 17

No Jurisdiction: 13

Complaint Withdrawn: 20

Technical Assistance Provided: 64

Total Resolved Investigations: 245

Monthly Outcome Report: August 2026

	Complaint Summary	Outcome Summary	Case Closure Reason
	Case Investigations		
Airway Heights Corrections Center			
1.	Patient reported concerns about access to a specialist appointment and accommodation for a single cell related to medical conditions and a disability.	The OCO provided assistance by elevating the concerns through DOC health services leadership. After OCO outreach, DOC agreed to initiate a single cell review since they could not identify any recent reviews for this accommodation. This office also confirmed DOC is working to schedule the patient's specialist appointment after being denied by a local clinic. The patient's pending appointment was added to OCO's medical appointment tracker to ensure scheduling is completed and the patient receives the appointment.	Assistance Provided
2.	Person reported Health Services staff threw away his medical property and has not provided a replacement. The person requested that the staff member be suspended and that he receive the new equipment.	DOC staff addressed this concern prior to OCO action. The OCO reviewed the person's records and contacted DOC Health Services staff. OCO staff were informed the person had more than the allowable amount of this medical item and the extra non-working item needed to be placed in storage. OCO staff confirmed the person received the replacement item and that it was working as expected.	DOC Addressed the Complaint
3.	Person reported concerns regarding their classification counselor's inaction, delaying their release. The person requested to be released as soon as possible.	DOC addressed this concern prior to OCO outreach. OCO staff reviewed the person's record and found they had been released. 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 DOC staff conduct complaints.	DOC Addressed the Complaint
4.	Incarcerated individual shared concerns regarding not being provided pain management care.	DOC staff addressed this concern prior to OCO action. Following a conversation with DOC staff and a review of DOC records, this office confirmed that this individual has met with DOC medical staff on various occasions to discuss their concerns. This office encouraged this individual to continue working with DOC medical staff to address any concerns that may arise. This office also informed this individual that the OCO has no impact on DOC clinical decisions.	DOC Addressed the Complaint
5.	Incarcerated individual shared concerns regarding DOC not providing them with pain management treatment.	DOC staff addressed this concern prior to OCO action. Following a review of DOC records, this office was informed that this individual's pain management request is actively being reviewed. This office encouraged this individual to continue working with DOC medical staff to address any potential medical concerns.	DOC Addressed the Complaint
6.	External person reported their loved one is not receiving medical treatment for Opioid Use Disorder. The person	The OCO provided information to the impacted person regarding the current status of his request. The OCO reviewed the person's record and found that his request is currently pending review by the Addiction Medicine Care Review Committee. The clinical decisions of this committee cannot be impacted by the OCO. The	Information Provided

	requested that their loved one be placed on the Medication Assisted Treatment (MAT) program.	OCO is in ongoing discussions with DOC regarding the planned expansion of the MAT program.	
7.	Person reported they are not receiving medical treatment for Opioid Use Disorder. The person requests to be placed on the Medication Assisted Treatment (MAT) program.	The OCO provided information to the impacted person regarding the current status of his request. The OCO reviewed the person's record and found that his request has been reviewed by the Addiction Medicine Care Review Committee. The clinical decisions of this committee cannot be impacted by the OCO. The OCO is in ongoing discussions with the DOC regarding the planned expansion of the MAT program.	Information Provided
8.	Individual expressed disagreement that he has to submit a public disclosure request to review his central file.	The OCO reviewed the complaint and informed the individual that per DOC policy 280.510(B) Incarcerated individuals may request to inspect their own central file by completing and submitting DOC form 05-066 Public Records Request to the facility's records unit. This office provided this information to the individual so they can follow the process.	Information Provided
9.	Person reported they were injured due to broken pavement at work. The person stated that the resolution process had not been helpful in getting the issue repaired and the person asked to have the resolution specialist removed from their job.	The OCO provided information to the person regarding their complaint. OCO staff reviewed the person's resolution concerns and contacted facility leadership. OCO staff were informed that the work order was placed when they were notified of the issue, and the repair had taken place. OCO staff visited the facility and confirmed the area had been repaired. The OCO provided tort claim information to the person who was injured prior to the repair.	Information Provided
10.	Incarcerated individual relayed concerns regarding placement in protective custody (PC).	The OCO reviewed the individual's PC screening and confirmed that they were denied PC due to not providing enough information to show there was a safety concern. The OCO informed the individual that they must provide sufficient information to demonstrate a safety concern.	Information Provided
11.	Incarcerated individual relayed concerns regarding a behavior observation entry (BOE).	The OCO reviewed the neutral BOE confirmed that the individual was warned about watching staff members and making them uncomfortable showing that the individual had a warning of the behavior which is why it was a neutral rather than negative BOE.	Information Provided
12.	Incarcerated individual shared concerns regarding DOC not investigating a PREA concern.	The OCO provided information regarding how to file a PREA concern. After speaking with DOC staff, this office was unable to confirm that this individual filed any PREA concerns.	Information Provided
13.	Incarcerated individual shared concerns regarding DOC not answering their resolution request.	Following a review of DOC records, this office was unable to confirm that DOC failed to provide a response to this individual. Records indicate that DOC provided this individual with a resolution rewrite request but the rewrite was never received. Due to this, the resolution was closed out.	Insufficient Evidence to Substantiate
14.	Incarcerated individual relayed concerns regarding a delayed infraction appeal response.	The OCO reviewed the infraction materials, confirmed that the appeal was received and responded to and found no violation of DOC policy 460.000 as there is evidence to substantiate the infractions.	No Violation of DOC Policy
15.	Incarcerated individual shared concerns regarding DOC taking their release	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 570.000. Records indicate that due to this individual's criminal history and failure to complete	No Violation of DOC Policy

	date away and placing them under the End of Sentence Review Committee (ESRC).	programming in relation to those crimes, this individual is going to be placed under the ESRC for any potential release planning.	
16.	Incarcerated individual shared concerns regarding DOC opening their legal mail and providing them with a copy of it instead of the original document.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 450.100. Following a review of DOC records, this office was able to confirm that this individual's mail was unable to be verified as legal mail. Due to this, it was treated as general mail and a copy was provided to them per policy.	No Violation of DOC Policy
17.	Incarcerated individual shared concerns regarding another incarcerated individual falsely filing a PREA against them.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 490.850. Following a review of DOC records, this office confirmed that DOC staff received information that was determined to warrant an investigation. Due to this, the PREA allegation was investigated.	No Violation of DOC Policy
Clallam Bay Corrections Center			
18.	Patient reported concerns about access to a single cell and mental health medications.	The OCO provided assistance by elevating the concerns through facility health services leadership. After OCO outreach, DOC agreed to schedule the patient for medication referral after transferring facilities. The OCO does not have authority to override single cell screening decisions.	Assistance Provided
19.	Person reported that he has both a medical and dental issue that are causing him concern. He has been seen by medical staff and given a diagnosis but was not given treatment. The person reports that his kites are not getting responses from DOC staff.	DOC staff addressed this concern prior to OCO action. OCO staff reviewed the person's appointments and found that the requested treatment appointments had occurred.	DOC Addressed the Complaint
20.	Incarcerated individual shared concerns regarding being placed in the intensive management unit (IMU).	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 moved out of the IMU.	DOC Addressed the Complaint
21.	Incarcerated individual shared concerns regarding their review and transfer.	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 and requested the case be closed.	DOC Addressed the Complaint
22.	Person reported that he is unable to complete court ordered programming due to the program not being available in his current facility. The person also requested information about the ISRB.	The OCO provided information to the person regarding the availability of his requested programming. The OCO reviewed the concern and found that the person's custody level prevents him from being transferred to a location where this programming is available. Currently, there are no plans for a remote version of this programming to become available. The OCO informed the individual that information about the ISRB can be found in DOC policy 320.100.	Information Provided
23.	Person reported safety concerns with their housing assignment.	The OCO provided information to the person regarding the steps to address his safety concerns with DOC. There was insufficient evidence to substantiate that DOC was not following through on	Information Provided

		reported safety concerns. OCO staff confirmed the person's segregation reviews were occurring within policy timelines. OCO staff encouraged the person to continue to work with DOC staff to address his housing concerns.	
24.	Person reported they are not receiving medical treatment for Opioid Use Disorder. The person requested that they be placed on the Medication Assisted Treatment (MAT) program.	The OCO provided information to the impacted person regarding the current status of his request. The OCO reviewed the person's record and found that his request is currently pending review by the Addiction Medicine Care Review Committee. The clinical decisions of this committee cannot be impacted by the OCO. The OCO is in ongoing discussions with the DOC regarding the planned expansion of the MAT program.	Information Provided
25.	Person reported concerns regarding their access to the Medication Assisted Treatment (MAT) program.	The OCO provided information to the person about the DOC's current protocols for medications for opioid use disorder (MOUD). The OCO reviewed the person's record and found that they do not yet meet the criteria for induction onto the Medication Assisted Treatment (MAT) program. The OCO provided the steps the person needs to take when he does meet the time eligibility window. OCO staff verified this person is currently pending review by the Care Review Committee for the requested treatment.	Information Provided
26.	Incarcerated individual relayed concerns regarding staff not letting them file mental health emergency requests.	The OCO spoke to DOC about this concern and confirmed that the individual is able to file mental health emergencies without restriction and as a result, they are seen by mental health nearly daily.	Insufficient Evidence to Substantiate
27.	Incarcerated individual relayed concerns regarding staff telling them a PREA concern was not a legitimate investigation.	The OCO attempted to review any documentation the individual made with DOC of this concern but were unable to find any attempt of the individual filing a PREA or a grievance. As a result, there was insufficient evidence to review this concern.	Insufficient Evidence to Substantiate
28.	Incarcerated individual relayed concerns regarding excessive time in segregation.	The OCO reviewed the individual's placement in segregation and confirmed that they are to maintain level 2 only due to an aggravated assault on staff. Because they have not met all the program requirements of that MAX program, they are to maintain placement in segregation.	No Violation of DOC Policy
29.	Incarcerated individual shared concerns regarding debriefing and not being placed in protective custody.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 470.500. After speaking with DOC staff, this office was informed that this individual did debrief but failed to provide adequate information to warrant protective custody placement. This office provided information regarding how they can potentially obtain protective custody.	No Violation of DOC Policy
30.	Incarcerated individual shared concerns regarding DOC attempting to place them in a housing situation they do not agree with.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 300.380. Following a review of DOC records, this office was able to confirm that this individual had been demoted to MAX custody and moved to a facility that DOC determined meets their needs and addresses any safety concerns. This office informed this individual that facility placement decisions cannot be appealed.	No Violation of DOC Policy
Coyote Ridge Corrections Center			
31.	External person reported concerns about an incarcerated individual's	The OCO provided assistance by elevating the concerns through DOC health services leadership. This office confirmed the patient is scheduled for a GI consult and DOC agreed to re-review the wet cell	Assistance Provided

	access to a wet cell.	request. The OCO provided the patient with information about their next steps. DOC agreed to either re-review through the DOC Care Review Committee or wait for the results of the upcoming consult, findings of which could impact the facility level decision without need for further CRC review.	
32.	Incarcerated individual shared concerns regarding being assessed incorrectly by DOC and wanting to be reassessed.	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 reassessment and provided their signature for agreement during their last custody facility plan (CFP).	DOC Addressed the Complaint
33.	Person reported that he was injured because DOC did not honor his HSR (Health Status Report).	The OCO provided information about this situation. By reviewing DOC records, the OCO substantiated the reported incident but could not substantiate that DOC denied accommodating the HSR. The OCO reached out to multiple DOC staff to confirm that he received treatment for any injuries sustained during this incident and also verified he is now in housing that accommodates his HSR.	Information Provided
34.	Incarcerated individual shared concerns regarding being labeled as a security threat group (STG) member.	The OCO provided information regarding how this individual could potentially get their STG tag removed. Following a review of DOC records, it was unclear if this individual took the steps necessary to get their tag removed.	Information Provided
35.	Person reported concerns regarding their medical treatment. The person is requesting specific Health Status Reports (HSRs), ongoing physical therapy, and surgery.	The OCO provided information to the person regarding their requested care. OCO staff reviewed the person's medical records and specialist consultations. OCO staff found that the person was seen by the Facility Medical Director and a new consultation was placed to have the person evaluated in the community for the requested surgery. OCO staff monitored the consultation until it was confirmed the patient was scheduled; it will continue to be monitored as a closed case to verify attendance. OCO staff provided information to the person about the DOC Health Plan limitations on physical therapy and DOC protocols that hold the criteria for Health Status reports.	Information Provided
36.	Incarcerated individual shared concerns regarding their safety being jeopardized due to the unit they are living in.	The OCO provided information regarding how this individual can request a living unit change. The OCO informed this individual that facility placement decisions cannot be appealed and that they can request certain placement, but it is the discretion of DOC staff to accommodate those requests.	Information Provided
37.	Person reported they have a serious chronic illness for which they had established care with a specialist prior to incarceration. The person states that he has a court order to be at a specific facility, but he is facing a transfer to a location that will not allow him to see his existing provider. The person is requesting to be transferred closer to his specialist's clinic.	The OCO provided information to the person about their reported concern. OCO staff reviewed the person's records and were not able to substantiate that there was a court order for specific facility placement due to evidence that contradicts what the person reported was written by the courts. The person's placement is supported by DOC policy 300.380. OCO staff confirmed that DOC is working to establish care with a specialist in the local area.	Information Provided
38.	Person reported that DOC	The OCO reviewed the complaint and found DOC actions are	Information

	is not providing the recommendations from a community medical provider. The person is also requesting assistance with getting sunglasses ordered by his medical provider.	currently allowed within the DOC Health Plan. OCO staff reviewed the DOC Health Plan and related Health Services protocols. OCO staff found that the interventions requested by the patient are not supported by the DOC Protocols. All community specialist treatment recommendations must be reviewed for coverage by the DOC Health Plan and protocols and ordered by a DOC medical provider.	Provided
39.	Incarcerated individual shared concerns regarding their sanctions.	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 the sanctions this individual is serving are within the guidelines written in DOC policy 460.050.	No Violation of DOC Policy
Monroe Correctional Complex			
40.	A loved one reported concerns about an incarcerated individual being transferred to a different facility.	The OCO provided assistance by talking to this individual about what facility they would agree to be transferred to and then worked with DOC to ensure they were transferred to that facility. The OCO reached out to multiple DOC staff and found that this individual was getting transferred out of Residential Treatment Unit (RTU) care per policy. This office was in communication with this individual and the facility and ensured they were transferred to an appropriate facility and unit.	Assistance Provided
41.	A loved one reported concerns about an incarcerated individual being transferred to a different facility. They also reported concerns about a search preference form not being followed by DOC.	The OCO provided assistance by talking to this individual about what facility they would agree to be transferred to and then working with DOC to ensure they were transferred to that facility. The OCO reached out to multiple DOC staff and found that this individual was getting transferred out of Residential Treatment Unit (RTU) care per policy. This office was in communication with this individual and the facility and ensured they were transferred to an appropriate facility and unit. The OCO provided information about the investigation regarding the search form. The OCO communicated with multiple DOC staff and ensured that this individual had access to the process regarding this specific search form. This individual also reported concern about a Behavioral Observation Entry (BOE). OCO staff reviewed the BOE and found that it did not violate DOC policy 300.010 and was upheld by facility leadership.	Assistance Provided
42.	A loved one reported concerns about an incarcerated individual being transferred to a different facility.	The OCO provided assistance by talking to this individual about what facility they would agree to be transferred to and then working with DOC to ensure they were transferred to that facility. The OCO reached out to multiple DOC staff and found that this individual was getting transferred out of Residential Treatment Unit (RTU) care per policy. This office was in communication with this individual and the facility and ensured they were transferred to an appropriate facility and unit.	Assistance Provided
43.	Person reported concerns regarding not being provided with ADA accommodations. The person made specific requests to DOC and has not received the responses or items.	The OCO provided assistance by contacting DOC staff to inquire into the status of the approved ADA property. This outreach resulted in the person receiving the property. The OCO verified all other ADA requests had been reviewed by DOC and responses had been sent to the person.	Assistance Provided
44.	Incarcerated individual	The OCO reviewed the infraction materials and found the appeal	Assistance

	relayed concerns regarding an infraction for a positive urinalysis (UA) in which they believe procedure surrounding the specimen cup was not followed appropriately.	did not address the individual's concerns about where the cup is during the one hour waiting period to provide the UA. The OCO then spoke to DOC about the specifics of the procedure surrounding the sample cup for when an individual is unable to provide a UA. DOC confirmed that the cup is left in the bathroom if the individual cannot provide but it is sealed and an officer is in the bathroom with it the whole time. As a result of this conversation, DOC is considering adding a new procedure where the individual would have to sign off on the seal if they are unable to provide to confirm no one opened it during the one hour waiting time.	Provided
45.	External person reported concerns regarding their loved one's end of life care. They are requesting the person be released to their home.	DOC staff resolved this concern prior to OCO action. OCO staff reviewed the person's record and found that he was already approved for graduated reentry and had a planned transfer date. OCO staff verified the person was transferred to GRE.	DOC Addressed the Complaint
46.	External person reported concerns regarding their loved one's medical care. The person reported their loved one is not being treated for symptoms that he reported to medical.	DOC staff resolved this concern prior to OCO action. OCO staff reviewed the person's record and found they were already admitted to the hospital. OCO staff also found that he was approved for graduated reentry and had a planned transfer date. OCO staff verified the person was transferred to GRE.	DOC Addressed the Complaint
47.	Incarcerated individual shared concerns regarding DOC not providing them with care for their concern.	After speaking with DOC staff and reviewing DOC records, this office was able to confirm that this individual has been seen various times regarding their concern and is scheduled to receive further treatment.	DOC Addressed the Complaint
48.	Incarcerated individual shared concerns regarding being potentially moved 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 was retained at their facility.	DOC Addressed the Complaint
49.	Person reported getting injured during a crisis and that DOC did not provide medical care for the injury. The person is requesting to be evaluated.	DOC staff addressed this concern prior to OCO action. OCO staff reviewed the person's records and contacted DOC Health Services staff. OCO staff were informed the person had already been evaluated by medical staff and received pain medication orders and x-rays with no concerning results.	DOC Addressed the Complaint
50.	Person reported concerns about being discharged from SOTAP programming and requested his appeal be heard.	The OCO confirmed the individual's appeal was heard by DOC, however, there was no change in DOC's decision after reviewing the appeal. The OCO cannot override SOTAP treatment decisions.	DOC Addressed the Complaint
51.	Person reported that DOC is no longer providing a treatment that was previously approved by the Care Review Committee (CRC). The person is requesting to have the previous approval to be honored.	The OCO provided information to the person regarding their requested medical treatment. OCO staff reviewed the person's Care Review Committee (CRC) referral and found that it was determined to be level 3, not medically necessary. OCO staff contacted DOC Health services staff and were informed that the requested treatment is no longer covered by the DOC health plan. OCO staff encouraged the person to work with their medical provider to find an alternative treatment plan.	Information Provided
52.	Incarcerated individual shared concerns regarding	The OCO provided information regarding how to file a tort claim. Following a review of DOC records, this office was able to confirm	Information Provided

	falling and getting injured due to a crack in the walkway.	that this individual received care for the injuries. Due to a lack of evidence, this office is unable to determine what specifically caused the fall.	
53.	An incarcerated individual reached out to the OCO to gain information on filing a claim with Labor & Industries (L&I).	The OCO provided information regarding the L&I workers claim process. This office encouraged this individual to continue working with DOC medical staff and provide timely information to L&I whenever requested.	Information Provided
54.	Person reported concerns about a search preference form not being followed by DOC.	The OCO provided information about this office's investigation regarding the search form. The OCO communicated with multiple DOC staff and ensured that this individual had access to the process regarding this specific search form.	Information Provided
55.	Incarcerated individual shared concerns regarding DOC not properly investigating a PREA concern.	This office reviewed DOC records, including the PREA investigation, and confirmed that DOC staff conducted the investigation in accordance with DOC policy 490.860.	Insufficient Evidence to Substantiate
56.	Incarcerated individual shared concerns regarding DOC blocking their access to their legal documents.	This office reviewed DOC records and were unable to confirm any impediment to this individual's records by DOC staff. DOC records indicate that they met with this individual various times regarding their legal documents and provided them with numerous opportunities to go through their documents.	Insufficient Evidence to Substantiate
57.	Patient reported that their medical provider changed their treatment plan without notifying them. The person did not provide a suggested resolution.	The OCO reviewed existing evidence and was unable to substantiate the concern. OCO staff reviewed the person's records and found that during the period of concern the patient had active orders for the requested medications. OCO staff did note a treatment plan change, however, clinical rationale was documented by the medical provider. There was insufficient evidence to substantiate that the patient was not given access to the requested medication, though not in the quantity he would have preferred.	Insufficient Evidence to Substantiate
58.	Incarcerated individual relayed concerns regarding various infractions that they state are resulting in staff referring them for prosecution for new criminal charges.	The OCO reviewed the infraction materials and found no information showing the infractions resulted in a persistent prison misbehavior (PPM) referral.	Insufficient Evidence to Substantiate
59.	Incarcerated individual relayed concerns regarding a denial of extended family visits (EFVs).	The OCO reviewed the EFV denial and found no violation of DOC policy 590.100 as the denial was per policy due to a robust domestic violence history.	No Violation of DOC Policy
60.	Incarcerated individual relayed concerns regarding their wife being removed from their visitor list.	The OCO reviewed the visitation denial and found no violation of DOC policy 450.300 as the individual's wife was denied visitation due to safety concerns and providing false information.	No Violation of DOC Policy
61.	Person reported concerns about his classification. The person reports being kept on maximum custody despite scoring medium points. The person is	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 300.380. OCO staff reviewed the person's records and found that his current custody level is due to a housing refusal without validated safety concerns. The person's facility transfer request cannot be considered until he agrees to be housed in general population.	No Violation of DOC Policy

	requesting to be placed at a specific facility.		
Olympic Corrections Center			
62.	Incarcerated individual shared concerns regarding DOC processes for receiving timely health status reports (HSRs) and processes for preventing overdoses.	The OCO provided information regarding how this individual can share their policy ideas with DOC. This office informed this individual that the OCO is in constant collaboration with DOC to discuss ways that policy can be updated, or changed, to better serve the needs of staff, incarcerated individuals, and any other parties.	Information Provided
63.	An incarcerated individual shared concerns regarding being infracted for their clothes being damaged and DOC staff interrupting their hearing.	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 the circumstances of the incident did warrant the infraction given. This office was also unable to confirm that DOC interrupted this individual's hearing.	No Violation of DOC Policy
Other			
64.	Anonymous individual reported concerns about staff being retaliated against for speaking out about health, safety and welfare concerns regarding incarcerated individuals.	Due to the anonymity of this concern, there was insufficient evidence to properly investigate this concern.	Insufficient Evidence to Substantiate
Reentry Center - Reynolds - King			
65.	Individual reported issues with staff, a false positive urine analysis (UA), and lack of options to report concerns about the facility.	The OCO confirmed that this person used the resolution program and resolved his issues with the Reentry Center Manager prior to his departure from this facility. The OCO provided information on the new process for filing a resolution request while living in a Reentry Center.	Information Provided
Reentry Center - Tacoma - Pierce			
66.	Individual reported numerous concerns surrounding the Tacoma Reentry Center's implementation of unusual policies, retaliation from staff members, DOC opening OCO mail, and fear of submitting a resolution request because those go straight to the reentry center manager (RCM).	The OCO confirmed that the graduated reentry policy was updated to require that an individual have at least 3 months remaining on the sentence before the time of transfer. The OCO worked with DOC on a process that allows incarcerated individuals to file a resolution request and send it directly to DOC headquarters rather than submitting it directly to the RCM. This office noted that the individual successfully left the reentry center and transitioned to the community.	Assistance Provided
67.	Individual reported concerns regarding the graduated reentry policy and how the updates have impacted their ability to leave the reentry center sooner. The individual also reported concerns	The OCO confirmed that the graduated reentry policy was updated to require that an individual have at least 3 months remaining on the sentence before the time of transfer. The OCO worked with DOC on a process that allows incarcerated individuals to file a resolution request and send it directly to DOC headquarters rather than submitting it directly to the RCM. This office noted that the individual successfully left the reentry center and transitioned to the community.	Information Provided

	regarding filing a resolution request and staff retaliation. This person was concerned they would not get a job within the reentry center handbook's stated timeframes, and about going back to prison.		
Stafford Creek Corrections Center			
68.	Patient reported concerns about access to wound care and later reported updates about a medical emergency.	The OCO provided assistance by elevating the concerns through facility health services leadership and reviewing access to medical appointments and care. While reviewing the patient's case, the OCO found that a medical hold was preventing the patient from transferring facilities. OCO staff met with unit leadership to address the handling of the reported medical emergency. After OCO outreach, DOC lifted the medical hold and the patient was transferred.	Assistance Provided
69.	Patient reported concerns related to a colostomy bag and supplies.	The OCO elevated the concerns through facility health services leadership and substantiated ordering delays. DOC agreed to ensure the appropriate medical supplies were provided.	Assistance Provided
70.	Person reported he is in need of a new CPAP machine. The process has taken more than a year and he still has not received the machine.	DOC addressed the complaint prior to OCO action. The person contacted the OCO and informed this office that he was issued a new machine.	DOC Addressed the Complaint
71.	Person reported wanting to move to a different unit.	DOC staff addressed this concern prior to OCO action. The OCO reviewed DOC records and found that this individual has been moved to a different unit in the facility.	DOC Addressed the Complaint
72.	Incarcerated individual shared concerns regarding DOC not seeing them for their medical concern.	DOC staff addressed this concern prior to OCO action. After speaking with DOC medical staff, this office was informed that this individual had scheduled appointments for their concerns. This office also provided this individual with information about urgent care at their facility if they wish to be seen more promptly for a medical concern.	DOC Addressed the Complaint
73.	Person reported concerns about DOC not providing medical shoes.	DOC staff addressed the concern prior to OCO action. OCO staff contacted DOC staff and were informed that the person had picked up their shoes.	DOC Addressed the Complaint
74.	An external person shared concerns on behalf of an incarcerated individual regarding their transfer to an unsafe facility.	This office provided information regarding how this individual can request safe harbor placement. This office reviewed DOC records and was unable to confirm that this individual expressed any safety concerns to DOC staff before and after their move to their new facility.	Information Provided
75.	An external person shared concerns on behalf of an incarcerated individual regarding not being treated fairly in regard to their placement in segregation.	The OCO provided information regarding this individual's placement in segregation. Following a review of DOC records, this office was able to confirm that this individual had been moved to a segregated setting due to a safety concern raised by DOC staff. Records indicate that this individual is actively pending a transfer to another facility.	Information Provided
76.	An external person shared concerns on behalf of an incarcerated individual	DOC staff addressed this concern prior to OCO action. After outreach to DOC staff, this office confirmed that this individual met with DOC regarding their concern and was provided with the HSR	Information Provided

	regarding not being provided with a health status report (HSR).	they requested.	
77.	Person reports that he has been requesting a Health Status Report (HSR) for a long time. The refusal to issue this person an HSR has resulted in further injury.	The OCO provided information to the person about current DOC Health Services protocols. OCO staff reviewed this person's medical records and found that he was evaluated for the requested HSR by a medical provider and denied due to not meeting the criteria for approval. Per WAC 138-10-040(3)(d) as the complaint does not allege a violation of policy, procedure of law. The Washington DOC Health Plan describes the criteria and process for determining what health services the department will provide. The OCO cannot advocate for treatment not supported by the DOC Health Plan or DOC policies/protocols.	Information Provided
78.	Person reported that their placement in segregation prevents them from being able to properly manage a chronic medical condition. The person reported his durable medical equipment request was denied by DOC medical leaving him with no way of getting exercise.	The OCO provided information to the person regarding his concern. OCO staff reviewed the person's record and found they have been moved from segregation. OCO staff found that the person's request for durable medical equipment was reviewed by a medical provider and denied. However, the person was provided with an alternative mobility aid that met their medical needs. This denial is supported by DOC policy 600.000.	Information Provided
79.	Person reported concerns about DOC not providing a necessary surgery.	OCO staff provided information to the impacted person about their consultation. OCO staff reviewed the person's specialist consultation requests and found that the person had been evaluated by a specialist who declined to accept the patient for surgery. OCO staff confirmed that follow up with the specialist is planned for continued monitoring of the person's condition.	Information Provided
80.	Person reported timelieness concerns regarding their access to the Medications for Opioid Use Disorder (MOUD).	The OCO provided information to the person about the related DOC Health Services Protocol. OCO is in ongoing discussion with the DOC regarding the expansion of access to MOUD medications statewide.	Information Provided
81.	An external person shared concerns on behalf of an incarcerated individual regarding DOC not properly investigating their PREA concern.	The OCO reviewed existing evidence and determined that the concern was adequately investigated by DOC staff. Numerous concerns were cited by this individual and each concern received an individual investigation.	Insufficient Evidence to Substantiate
82.	Incarcerated individual shared concerns regarding not being provided with their medication and durable medical equipment (DME).	This office reviewed DOC records and was unable to confirm that DOC failed to provide them with their medication. This office confirmed that this individual has attended an off-site clinical visit to be fitted for their requested DME. This office encouraged this individual to continue working with DOC staff and be specific regarding their request to ensure they are on the same page as their provider.	Insufficient Evidence to Substantiate
83.	Incarcerated individual relayed concerns regarding improper interpretation at an infraction hearing.	The OCO spoke to DOC about this concern. DOC extensively reviewed the infraction hearing and confirmed that the individual was given a fair hearing due to confirmation that they were able to clearly converse with the hearings officer in English, multiple interpreters being provided, with whom they were able to converse, and documentation that they are able to speak, read, and	Insufficient Evidence to Substantiate

		understand English without interpretation.	
84.	An external person reported that her loved one was put in segregations for no reason, as there was no infraction or incident. The loved one does not understand why DOC is demoting the incarcerated individual to close custody.	The OCO contacted DOC and confirmed that the individual was identified as a security threat group (STG) member and was being transferred to close custody despite being eligible for a lower level of custody. DOC policy 300.380 says that DOC can use an Institution Security override reason for custody assignments. Institution Security (INT) represents that the individual is scored and time eligible to be assigned one custody level, but a more restrictive custody level is necessary as the individual poses a risk to safety or security. The OCO contacted DOC, which confirmed that several affiliated members were being transferred out of the facility to close custody due to security concerns.	No Violation of DOC Policy
85.	An external person reported that her loved one was put in segregations for no reason, as there was no infraction or incident. The loved one does not understand why DOC is demoting the incarcerated individual to close custody.	The OCO contacted DOC and confirmed that the individual was identified as a security threat group (STG) member and was being transferred to close custody despite being eligible for a lower level of custody. DOC policy 300.380 says that DOC can use an Institution Security override reason for custody assignments. Institution Security (INT) represents that the individual is scored and time eligible to be assigned one custody level, but a more restrictive custody level is necessary as the individual poses a risk to safety or security. The OCO contacted DOC, which confirmed that several affiliated members were being transferred out of the facility to close custody due to security concerns.	No Violation of DOC Policy
86.	The person reported concerns about specific religious services being canceled. Person stated that he wanted these services back at the facility.	The OCO reviewed the complaint and found DOC actions or inactions are currently allowed within DOC policy 560.200. The OCO reached out to DOC staff at Headquarters and at the facility, who shared multiple concerns about these services, and found that DOC is within policy to discontinue these services. DOC policy 560.200 IV. D. states “3. Religious programs and services may be canceled and not rescheduled due to: e. Other reasons as determined by the Superintendent/designee”. DOC policy 560.200 IV. G. states “5. If there is a conflict between a legitimate religious interest and a facility interest related to security, safety, health, or orderly operations of the facility, the matter will be resolved by the Superintendent, in consultation with the Chaplain and the Headquarters Program Manager for Religious Programs.” OCO staff confirmed that DOC is still offering similar services of the same religious faith at this facility.	No Violation of DOC Policy
87.	Person reported an injury he sustained at the facility and stated his resolution request was denied because the incident occurred the year prior and was outside the timeframe listed in the Resolution Program Manual.	The OCO reviewed the individual's resolution request and confirmed it was appealed and denied multiple times, as the event reported was outside of timeframes outlined in the resolution program manual which states the initial resolution request “must be filed within 20 working days of the incident/action or when they should have been aware of the incident.”	No Violation of DOC Policy
88.	Incarcerated individual shared concerns regarding being held in administrative segregation (Ad Seg) due to a false PREA investigation.	The OCO reviewed the complaint and found that DOC actions are currently allowed within DOC policy 320.200. Following a review of DOC records, this office confirmed that DOC staff received information that warranted an investigation per DOC policy 490.860. Due to this, this individual was removed from their unit and placed in Ad Seg for the duration of the investigation. This	No Violation of DOC Policy

		office confirmed that this individual was released from Ad Seg for that investigation, as it was concluded.	
89.	Incarcerated individual shared concerns regarding being in administrative segregation (Ad Seg) for an extended period of time without an infraction.	The OCO was able to substantiate this concern but was unable to achieve a resolution. Following a review of DOC records, this office confirmed that this individual had been housed in Ad Seg for an extended period without any pending or current infraction. This office then reached out to facility leadership and were informed that this individual is actively in Ad Seg due to a pending investigation. This office spoke with DOC headquarters to remove this individual from Ad Seg while they were pending an infraction, but were unable to do so as this individual moved due to various factors that DOC staff determined would be detrimental to their safety and health if housed in the general population.	Substantiated
Washington Corrections Center			
90.	Person reported concerns about DOC denying him the opportunity to be publicly recognized for his accomplishments in education. The person requested that the school be able to publish his accomplishments or for DOC to provide a reason for the denial.	DOC staff addressed the complaint prior to OCO action. The OCO contacted DOC and were informed that the decision had already been reversed and that additional care is being taken in the screening process to prevent further misinterpretations of the policy.	DOC Addressed the Complaint
91.	Person reported concerns regarding their access to medications for opioid use disorder. The person is requesting that the OCO ensure his Care Review Committee (CRC) request is looked at by the DOC.	OCO staff provided information to the person about his active consultations. OCO staff reviewed the person's record and found that his Care Review Committee (CRC) request is currently awaiting review. OCO staff contacted DOC about needed follow-up from a different consultation and were informed that the facility had a plan to offer a telehealth option for the treatment needed before the person could see the specialist again.	Information Provided
92.	Person reported concerns regarding their access to medications while temporarily housed at WCC. The person stated that the unit is experiencing multiple issues such as flooding and lock downs that are creating an inhumane situation.	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 resolution requests. OCO staff brought the reported concerns about the living conditions to the attention of DOC management.	Information Provided
93.	Person reports concerns regarding an injury he received using a product that was recalled by the manufacturer. The person is requesting an investigation into negligence of DOC around the handling of the recall.	OCO staff provided information to the person about the requested investigation. OCO staff reviewed the person's records and contacted DOC staff. OCO staff found DOC notified the population of the recall the same day DOC was notified by the manufacturer and they were given a process for getting refunds. OCO staff also found the person has been receiving ongoing medical care for the reported injury. There is insufficient evidence to substantiate that the DOC mishandled the recall of a product. There is also insufficient evidence to substantiate that the person has not	Information Provided

		received medical care for the reported injury. OCO staff provided tort claim information to the person.	
94.	An external person shared concerns on behalf of an incarcerated individual regarding being infracted for failing to provide a urine analysis (UA) despite having a health status report (HSR) for extended timeframes.	This office reviewed DOC records and was unable to confirm that this individual had an HSR at the time of the infraction. This office was able to confirm that this individual did receive an HSR for these circumstances in the future.	Insufficient Evidence to Substantiate
95.	Incarcerated individual shared concerns regarding DOC canceling their visitation with their significant other despite not being infracted and no evidence supporting that cancellation.	This office reviewed DOC records and were able to confirm that this individual's infractions were directly tied to their communication with their significant other. Due to this, their visitation was canceled and communications were suspended. This office confirmed that these infractions were appealed but upheld by DOC.	Insufficient Evidence to Substantiate
96.	An external person shared concerns on behalf of an incarcerated individual regarding being placed on MAX custody.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 300.380. Following a review of DOC records, this office was able to confirm that this individual had been demoted to MAX custody and moved to a facility that DOC determined meets their needs and addresses any safety concerns. This office informed this individual that facility placement decisions cannot be appealed but custody facility plans can be appealed by using DOC form 07-037.	No Violation of DOC Policy
97.	Incarcerated individual shared concerns regarding being infracted for defending themselves.	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 determined the circumstances of the incident met the criteria for the WAC infraction issued.	No Violation of DOC Policy
98.	Incarcerated individual shared concerns regarding being wrongly infracted.	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 determined the circumstances of the incident met the criteria for the WAC infraction issued.	No Violation of DOC Policy
99.	Incarcerated individual relayed concerns regarding their wife being denied visitation.	The OCO reviewed the visitation denial and spoke to DOC about this concern. The OCO found no violation of DOC policy 450.300 as the individual's wife assisted them in absconding from community custody which makes her ineligible for visits.	No Violation of DOC Policy
Washington Corrections Center for Women			
100.	Person reported concerns regarding receiving an infraction that is interfering with their ability to work. They are requesting the infraction be dismissed.	DOC addressed the concern prior to OCO action. OCO reviewed the person's record and found that the infraction was no longer on the person's record, indicating it had been dismissed during the regular hearings or appeal process.	DOC Addressed the Complaint
101.	Person reported that DOC staff have been referring them to mental health services which is interfering	DOC addressed the concern prior to OCO action. OCO reviewed the person's concern and found that a plan was already in place to transfer the person into regular housing. OCO staff monitored the person's situation until they were transferred out of close	DOC Addressed the Complaint

	with educational opportunities.	observation.	
102.	Person reports concerns regarding the amount of extra steps she has to take before she can see a specialist. The person states that she is being told she has to do physical therapy before she can get an MRI.	DOC addressed the complaint prior to OCO action. OCO reviewed the person's records and appointments and found the person was already scheduled to see the requested specialist. The OCO monitored the appointment and verified attendance. OCO staff provided information the person about the consultation process and informed them that DOC often requires conservative treatment measures before advanced imaging can be approved for coverage by the DOC Health Plan.	DOC Addressed the Complaint
103.	An external person shared concerns on behalf of an incarcerated individual regarding DOC staff sexually harassing them.	The OCO reviewed video and other relevant documentation from the incidents sited by this individual and were unable to substantiate any wrongdoing by DOC staff. This office was also able to confirm that DOC staff did an internal investigation into the matter and were determined that the concern was also unsubstantiated.	Insufficient Evidence to Substantiate
104.	Incarcerated individual shared concerns regarding DOC staff targeting them and causing them to be assaulted.	This office reviewed DOC records and was unable to substantiate the concern due to the lack of evidence. Records indicate that this individual has since moved to another part of the facility and is no longer around those staff members or the individual that assaulted them.	Insufficient Evidence to Substantiate
105.	Incarcerated individual shared concerns regarding DOC staff destroying their property.	This office reviewed DOC records and was unable to confirm that DOC staff damaged their property. This office provided this individual with tort claim information.	Insufficient Evidence to Substantiate
106.	Person reported that they were sent to segregation for an investigation that is still pending and that they do not even know what it is about.	The OCO reviewed records and confirmed the individual was placed in segregation because of a PREA allegation. DOC policy 490.850 says “in prisons, the accused may be placed in restrictive housing per DOC 320.200 Administrative Segregation, and placement decisions will be based on the seriousness of the allegation.” The OCO reviewed documentation related to this incident and confirmed that the action was within DOC policy.	No Violation of DOC Policy
107.	Incarcerated individual shared concerns regarding being infracted for failing to provide a urine analysis (UA).	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 420.380. Following a review of DOC records, this office confirmed that this individual had failed to provide a UA without having a DOC approved clinical reason for denial. Due to this, this individual was given an infraction.	No Violation of DOC Policy
Washington State Penitentiary			
108.	The individual met with OCO during a monitoring visit and reported that he was not approved to send money to his immediate family after the death of an immediate family member.	DOC policy 200.000 states that savings subaccounts will be available to an individual only if a Superintendent can determine that an emergency exists, including the death of an immediate family member. The Department’s policy glossary defines an immediate family member as: “an incarcerated individual's children, stepchildren, grandchildren, great-grandchildren, parents, stepparents, grandparents, great-grandparents, siblings, aunts, uncles, etc.” The OCO confirmed the individual's positive programming and lack of recent infractions, and requested a review of the original savings subaccount denial. The Department reviewed and agreed to allow the individual to submit a new form 06-070 to send emergency funds to their family.	Assistance Provided
109.	Patient reported concerns	The OCO confirmed the patient's surgery was rescheduled and	Assistance

	about delayed access to treatment for a hernia.	tracked the appointment to ensure it occurred. The OCO also confirmed the patient was scheduled for a post-op appointment.	Provided
110.	Person reported concerns with his medications.	DOC addressed this concern prior to OCO action. The OCO reviewed DOC records, including resolution requests and appointment records. OCO staff reached out to DOC staff at the facility and confirmed that this individual met with his provider to discuss his medication concerns.	DOC Addressed the Complaint
111.	Person reported a medical issue and requested help to see a specialist.	DOC staff addressed this concern prior to OCO action. The OCO reviewed DOC records and found that this individual is scheduled to see a specialist.	DOC Addressed the Complaint
112.	An external person reported concerns regarding the treatment of their loved one in the hospital unit. The person is requesting that the patient's diet be changed to support recovery.	The OCO provided information to the impacted person about the steps to request further review of his medical diet. OCO staff provided additional self-advocacy information to the impacted person.	Information Provided
113.	Incarcerated individual shared concerns regarding wanting to go to safe harbor.	The OCO provided information regarding how this individual can obtain safe harbor status. Following a review of DOC records, this office was able to confirm that this individual had been demoted after receiving serious infractions.	Information Provided
114.	Person reports being denied access to the Medication Assisted Treatment (MAT) program based on his time until release.	The OCO provided information to the person regarding his request. OCO staff reviewed the person's records and found that he does not meet the criteria for the MAT program by current DOC protocol. OCO staff found that the person had been scheduled to speak with staff about his request and did not attend the appointment. OCO staff confirmed a reschedule appointment is pending scheduling. OCO staff encouraged the person to attend the medical appointment to discuss options that are supported by the Health Plan and DOC protocols.	Information Provided
115.	Incarcerated individual shared concerns regarding DOC staff not utilizing plastic trays to serve food in their unit.	The OCO provided information regarding why plastic trays are not being utilized in their unit. After speaking with DOC staff, this office was informed that the hard plastic trays were posing a security risk within that unit. DOC staff confirmed that they alternated to paper trays and rubber trays that do not pose the same level of risk.	Information Provided
116.	Incarcerated individual shared concerns regarding DOC not providing them with safe harbor placement.	The OCO provided information regarding why this individual has not received safe harbor placement. After speaking with DOC staff, this office was informed that this individual has failed to provide information to DOC that validates any safety concerns. This individual was reviewed for safe harbor placement but denied.	Information Provided
117.	Person reported concerns regarding their access to the Medication Assisted Treatment (MAT) program.	The OCO provided information to the person about the DOC's current protocols for medications for opioid use disorder (MOUD). The OCO reviewed the person's record and found that they do not yet meet the criteria for induction onto the Medication Assisted Treatment (MAT) program. The OCO provided the steps the person needs to take when he does meet the time eligibility window.	Information Provided
118.	Person reported that he requested physical therapy for an injury and was denied by his medical provider.	The OCO provided information to the person regarding their treatment plan. OCO staff reviewed the person's records and contacted DOC Health Services staff. OCO staff were informed that the referral request had been placed but was denied due to a lack of clinical evidence to support the need for the requested	Information Provided

		treatment. OCO staff were also informed that the person was provided with a treatment plan. The OCO cannot overturn or countermand clinical decisions made by DOC healthcare providers. OCO staff encouraged the person to contact their provider if the proposed treatment plan does not work so that the plan can be updated with new information.	
119.	Person reported concerns regarding their access to the Medication Assisted Treatment (MAT) program for pain management.	OCO staff provided information to the person about the steps needed to have his treatment request considered by the DOC. OCO staff confirmed the person is receiving conservative treatment measures for the reported injury. Conservative treatment measures are often required before more intensive treatment can be approved.	Information Provided
120.	Patient reports concerns about staff conduct and isolation.	The OCO elevated the concerns through DOC leadership to ensure the patient was scheduled for and receiving care. This office found that the patient is housed in the in-patient unit for ongoing medical care after discharge from the SAGE unit. OCO staff met with the patient in-person during a monitoring visit to ensure the patient's concerns were addressed and to provide self-advocacy information. Some of the patient's requests are not within OCO jurisdiction and OCO provided additional information to the patient.	Information Provided
121.	An external person shared concerns on behalf of an incarcerated individual regarding DOC jeopardizing their safety.	This office reviewed DOC records and were unable to confirm that DOC staff are attempting to jeopardize this individual's safety. DOC records indicate that this individual had expressed safety concerns but these were investigated by DOC staff and determined to be insufficient to substantiate. This office provided this individual with information regarding how they can potentially obtain safe harbor placement.	Insufficient Evidence to Substantiate
122.	Incarcerated individual shared concerns regarding DOC not having their elevators inspected.	Following a review of DOC records, this office was able to confirm that DOC staff confirmed that all the inspections were up to date and completed by the Department of Labor and Industries.	Insufficient Evidence to Substantiate
123.	Incarcerated individual shared concerns regarding DOC attempting to move them to a location they will be unsafe.	This office reviewed DOC records and confirmed that DOC staff moved this individual to administrative segregation (Ad Seg) following their refusal to be housed in general population. DOC staff stated that this individual failed to provide any information that would corroborate any threats to their safety. DOC records also indicate that this individual received a completed custody facility plan (CFP) and is pending transfer to a facility they will be safe at.	Insufficient Evidence to Substantiate
124.	Incarcerated individual shared concerns regarding DOC not helping them with their L&I claim.	The OCO reviewed existing evidence and was unable to substantiate the concern. DOC staff additionally shared that a claim has been filed and they have sent all relevant documentation to L&I. This office confirmed that L&I had reached out to this individual numerous times but received no response regarding their claim.	Insufficient Evidence to Substantiate
125.	Person reported their provider took away their Health Status Reports and treatment plan. The person is requesting for his old approvals for equipment and medication to be honored at his new facility.	The OCO reviewed existing evidence and was unable to substantiate the concern. OCO staff reviewed the person's records and found he currently has the HSRs that he reported were removed. OCO staff provided information to the person about the process medical providers must follow to ensure treatment plans follow the DOC Health Plan.	Insufficient Evidence to Substantiate

126.	A loved one expressed concerns about her visitations with an incarcerated individual being terminated.	The OCO reviewed the complaint and found DOC actions or inactions are currently allowed within DOC policy 450.300 which states visitation can be terminated due to security or safety threats. The OCO reviewed DOC records, including visitation appeals and denials, and his infractions and found the termination was per policy.	No Violation of DOC Policy
127.	A loved one reported concerns about visitation and contact being terminated with an incarcerated individual.	The OCO reviewed the complaint and found DOC actions or inactions are currently allowed within DOC policy 450.050. The OCO reviewed DOC records and found that DOC is within policy to deny or restrict contact between this incarcerated individual and the loved one who reported this concern.	No Violation of DOC Policy
128.	Person reported concerns about his wife being denied in-person visitation due to an infraction from years ago.	The OCO reviewed the complaint and found DOC actions or inactions are currently allowed within DOC policy 450.300 which states visitation can be terminated due to a guilty finding of the introduction of contraband. The OCO reviewed DOC records, including visitation appeals and denials, and his infractions and found the termination was per policy.	No Violation of DOC Policy
129.	Person expressed safety concerns about his facility placement.	The OCO reviewed the complaint and found DOC actions or inactions are currently allowed within DOC policy 300.380. The OCO reviewed DOC records and found that his request for protective custody was denied, and he was put in solitary confinement for refusing housing, per policy. The OCO encouraged this individual to report any further safety concerns to staff.	No Violation of DOC Policy
130.	Incarcerated individual shared concerns regarding DOC infracting them despite their safety concerns.	The OCO reviewed the complaint and found DOC actions are currently allowed within DOC policy 450.050. Following a review of DOC records, this office was able to confirm that this individual had not provided DOC with any information regarding their safety concern. Due to them refusing housing without sufficient reason, they were given an infraction. This office provided this individual with information regarding how they could potentially acquire safe harbor placement.	No Violation of DOC Policy
131.	Person reported his medical provider changed his treatment plan after he transferred to the facility.	The OCO substantiated the person's concern. The OCO confirmed that several people's treatment plans had been changed after transferring to WSP. OCO reviewed this person's records and found that his previous treatment plan was approved at the facility level, rather than through the Care Review Committee process as outlined in DOC Protocol. The Facility Medical Director is able to change the treatment plan of patients within their facility to bring it in line with existing DOC protocol. Per WAC 138-10-040(3)(e) the individual's requested resolution is not within the ombuds' statutory power and authority as per DOC policy 600.000 Health Services Management states that "clinical decisions are the sole province of the responsible health care practitioner and are not countermanded by non-clinicians." This means that the OCO cannot override treatment decisions made by healthcare providers. The OCO can investigate situations where patients are unable to access care, however, cannot mandate the kind of treatment provided. The OCO cannot advocate for treatment not supported by the DOC Health Plan or DOC policies/protocols.	Substantiated
	Intake Investigations		
	Airway Heights Corrections Center		
132.	Incarcerated individual	This case is a duplicate of one that already exists in the OCO case	Complaint

	relayed concerns regarding access to protective custody.	management system.	Withdrawn
133.	An incarcerated person reported an issue related to the driving of a DOC staff member during off site work.	The incarcerated individual said they did not want the OCO to further investigate the complaint and requested that no closing letter be sent to them.	Complaint Withdrawn
134.	Incarcerated individual reported concerns related to staff misconduct regarding a disciplinary process and a desire to be given financial compensation and copies of DOC investigative records.	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. The OCO cannot award financial compensation for damages or provide DOC investigative records.	Declined
135.	An attorney reported that they experienced difficulty when trying to schedule an attorney visit at the facility.	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. The OCO was unable to assist with scheduling an attorney visit within the requested two day timeframe.	Declined
136.	Person reported that they were not approved for a medication that they took in the community. The person is requesting that his Care Review Committee request be resubmitted with more information from his former providers in the community.	Per WAC 138-10-040(3)(e) as the requested resolution is not within the ombuds' statutory power and authority. DOC policy 600.000 Health Services Management states that "clinical decisions are the sole province of the responsible health care practitioner and are not countermanded by non-clinicians." This means that the OCO cannot override treatment decisions made by healthcare providers. The OCO can investigate situations where patients are unable to access care, however, cannot mandate the kind of treatment provided.	Declined
137.	Incarcerated individual shared concerns regarding DOC attempting to move them to a place they will not be safe at.	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.	An external person reported that their loved one was transferred to a new facility and has not been receiving his medications or the correct diet since he arrived.	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 submitting requests to DOC Health Services.	Technical Assistance Provided
139.	Person reported concerns about receiving two infractions for the same issue on different occasions. The person is requesting the infractions be dismissed and to change units.	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 appealing infractions.	Technical Assistance Provided

140.	Person reported that they are being forced to pay into the DOC Crime Victims Compensation 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 banking process.	Technical Assistance Provided
141.	Person reported receiving an infraction that was incorrectly written and will be resubmitted at some point. The person is very near release and is concerned that DOC is waiting to serve the infraction to interfere with his release.	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 appealing infractions.	Technical Assistance Provided
142.	Person reported concerns regarding their provider declining to renew a Health Status Report (HSR). The person is requesting to have their HSR renewed as well as information about the policy that impacts HSR criteria.	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 (HSRs) and the Health Services resolution process.	Technical Assistance Provided
143.	Person reported that their visitation privileges were taken away.	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
Cedar Creek Corrections Center			
144.	Person reported that he filed a tort claim for lost property and has not yet received any information or response to the claim.	Per WAC 138-10-040(3)(a) as 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 (WADOC).	No Jurisdiction
145.	Person reported that they were in segregation for four days and were only let out once for an hour.	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
Clallam Bay Corrections Center			
146.	An external person reported that their loved one reported updates to an existing OCO case on behalf of the impacted individual.	The incarcerated individual said they did not want the OCO to further investigate the complaint and closed the case.	Complaint Withdrawn
147.	Person reported that policy prohibits incarcerated individuals from obtaining their social security number because they are	The individual called the OCO and said their counselor was able to help them. However, the government stopped providing covid relief checks in 2025. This person asked the OCO to close this case.	Complaint Withdrawn

	not 6 months from their release date.		
148.	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 the process of medical appointments and emergencies.	Technical Assistance Provided
149.	Person reported concerns regarding their access to dental care. The person reports that they were seen for an exam, however the treatment plan has not been carried out.	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 resolution requests.	Technical Assistance Provided
150.	Person reported that they were given the wrong 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 the tort claim process.	Technical Assistance Provided
151.	Person reported that they are not receiving the appropriate amount of 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 the resolution process.	Technical Assistance Provided
Coyote Ridge Corrections Center			
152.	Person reported he has not received his keep on person (KOP) medications despite putting in the refill three weeks ago.	The incarcerated individual said they did not want the OCO to further investigate the complaint because his provider updated his medications.	Complaint Withdrawn
153.	An external person shared concerns on behalf of an incarcerated individual regarding a safety concern.	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
154.	Person reported concerns about his 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
155.	Person reported concerns regarding their treatment for symptoms he developed since incarceration. The person is requesting to be seen by a medical provider for different treatment.	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 Health Services resolution requests and submitting requests for Health Services appointments.	Technical Assistance Provided
156.	Person reported concerns regarding their ongoing	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC	Technical Assistance

	treatment of chronic health issues. The person is requesting that more timely and complete care be provided.	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 resolution requests.	Provided
157.	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 staff conduct concerns.	Technical Assistance Provided
158.	Person reported that a DOC staff member is not giving the unit enough recreational 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 the resolution process.	Technical Assistance Provided
Monroe Correctional Complex			
159.	External person reported their loved one received a general infraction.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because of other reasons the ombuds deemed relevant to the complaint including, but not limited to, the priority and weight given to these and other relevant factors. The OCO only reviews serious infractions, not general infractions, after an appeal has been submitted and a response from DOC has been received.	Declined
160.	Incarcerated individual shared concerns regarding their release address not being added to the release plan.	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
161.	Person reported that the water at the facility is contaminated and wanted to know if there is a law firm handling a lawsuit regarding the contaminated water.	Per WAC 138-10-040(3)(g) 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. The OCO is unable to assist with providing information about lawsuits or referring an attorney.	Declined
162.	Person reported concerns regarding a general infraction.	The OCO has declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(g) as the OCO does not investigate general infractions, only serious infractions that have been appealed.	Declined
163.	Person reported concerns about receiving infractions during a mental health crisis. The person is requesting that their infractions be dismissed.	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 appealing infractions.	Technical Assistance Provided
164.	Person reported concerns regarding an infraction they received for failing to produce a specimen for a drug screen.	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 appealing infractions.	Technical Assistance Provided

165.	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 the appointment and medical emergency process.	Technical Assistance Provided
166.	Person reported being accused of smoking and was placed in segregation close to his release date. The person is requesting the infraction be overturned and he be returned to his previous housing assignment.	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 appealing infractions.	Technical Assistance Provided
167.	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 the appointment and medical emergency process.	Technical Assistance Provided
168.	Incarcerated individual shared concerns regarding DOC not providing them with medication for addiction treatment (MAT).	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 MAT treatment.	Technical Assistance Provided
169.	Person reported that they were sexually assaulted 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 how to obtain DOC public records.	Technical Assistance Provided
170.	Person reported that DOC changed their infraction charge after they plead guilty for a lesser charge.	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
171.	Person reported that they want to go back to their 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 the classification process.	Technical Assistance Provided
172.	Person reported that they did not receive a fair 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
173.	Person reported concerns with being infracted for contraband that does not meet the definition of the	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.	Technical Assistance Provided

	infraction he received and states the items were approved by the mailroom. The person is requesting a reduced infraction and to receive the items that do not meet the contraband description.	The OCO provided technical assistance about appealing infractions.	
174.	Person reported that DOC staff gave them frivolous infractions for failure to provide a urinary analysis sample.	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
Olympic Corrections Center			
175.	Person reported that their extended family visits 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 OCO for assistance. The OCO provided technical assistance about staff conduct concerns and the visitation process.	Technical Assistance Provided
Other			
176.	Anonymous person relayed concerns about incarcerated individuals asking neighborhood members for drugs.	The OCO was unable to investigate this concern due to no identifying information being provided that could be used to investigate the concern.	Declined
177.	Person reported on behalf of the individual that they are being targeted and harassed by 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
178.	Person reported that their incarcerated loved one did not receive adequate dental care while they were in 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
179.	A friend or family member reported concerns on this person's behalf regarding community custody staff conduct. Person stated that his community corrections officer (CCO) was interfering in the reunification process with his child and threatened to violate him.	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 while on community custody supervision.	No Jurisdiction
180.	Person reported concerns regarding community custody staff conduct. His community corrections officer (CCO) was	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 while on	No Jurisdiction

	interfering in the reunification process with his child and threatened to violate him if the child's mother was present at the scheduled visit.	community custody supervision.	
181.	Person reported concerns regarding community custody staff conduct. His community corrections officer (CCO) was interfering in the reunification process with his child and threatened to violate him if the child's mother was present at the scheduled visit.	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 while on community custody supervision.	No Jurisdiction
182.	Person reported a concern about a formerly incarcerated person's community corrections officer.	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 while on community supervision.	No Jurisdiction
183.	Person reported a concern regarding a positive urine analysis test and states staff refused to retest her or send the sample to a lab.	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 while on community supervision.	No Jurisdiction
184.	Person reported a concern regarding community supervision reporting and housing location requirements.	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 while on community supervision.	No Jurisdiction
185.	Person reported a concern about a county jail and his current court 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
186.	Person reported concerns regarding DOC being in violation of enforcing an illegal sentence and coercing him into a plea agreement. Person stated that a sexual motivation enhancement was applied to an assault charge which forced him to register as a sex offender.	Per WAC 138-10-040(3)(a) as 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 (WADOC) or occurred while an individual was not in full or partial confinement of a Washington State Department of Corrections prison, such as jails or while on community supervision.	No Jurisdiction
187.	Person reported a concern about being treated poorly by a police officer.	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	No Jurisdiction

		Department of Corrections prison, such as jails.	
188.	Person reported that DOC audited their sentence after they had been released and it was incorrect.	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
Reentry Center - Helen B. Ratcliff - King			
189.	Loved one relayed concerns about an event that occurred at a reentry center.	This case is a duplicate of a case that already exists in the OCO case management system.	Complaint Withdrawn
Reentry Center - Olympia - Thurston			
190.	Person reported concerns about staff conduct at a reentry center.	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
191.	An external person reported concerns regarding their loved one being infracted and returned to prison based on an accusation for which no charges were ever brought. They are requesting their loved one be returned to their previous classification assignment.	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 appealing infractions.	Technical Assistance Provided
192.	Person reported that he was infracted based on an accusation for which no charges were ever brought. The person is requesting for their infraction to be overturned and to be returned to his previous classification assignment.	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 appealing infractions.	Technical Assistance Provided
Stafford Creek Corrections Center			
193.	Person reported concerns about being required to see their primary care provider before going to a specialist appointment.	The incarcerated individual said they did not want the OCO to further investigate the complaint and closed the case.	Complaint Withdrawn
194.	An external person reported concerns about their loved one's access to mental health care.	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 requesting Health Services appointments.	Technical Assistance Provided

195.	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 appointments and emergencies.	Technical Assistance Provided
196.	Person reported concerns about an incident where his healthcare needs were not considered by DOC staff, resulting in an exacerbation of his medical condition.	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 staff conduct resolution requests.	Technical Assistance Provided
197.	Incarcerated individual shared concerns regarding one of their contacts being blocked from 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 how to take care of Securus concerns.	Technical Assistance Provided
198.	Person reported concerns regarding an infraction that was dismissed and then resubmitted without any additional evidence.	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 appealing infractions.	Technical Assistance Provided
199.	Person reported 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 process of extended family visits.	Technical Assistance Provided
200.	Person reported concerns that his treatment plan was not adequately managing his symptoms.	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 Health Plan approval and resolution request processes.	Technical Assistance Provided
201.	Person reported concerns regarding their access to advanced imaging as ordered by an outside medical specialist.	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 process for approving outside medical recommendations.	Technical Assistance Provided
202.	Person reported that they were wrongfully infracted and 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 the infraction process and staff conduct concerns.	Technical Assistance Provided
203.	Person reported concerns regarding a 603 infraction. The person is requesting information regarding if the 603 changes would be	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 appealing infractions.	Technical Assistance Provided

impacting his case.

Washington Corrections Center			
204.	Friend or family member reported a concern related to the medical care of an incarcerated person.	This case is a duplicate of one that already exists in the OCO case management system.	Complaint Withdrawn
205.	An external person reported concerns regarding their loved one's access to necessary medication.	The incarcerated individual said they did not want the OCO to further investigate the complaint and closed the case. The person contacted the OCO and reported that his issue was resolved.	Complaint Withdrawn
206.	An external person reported concerns regarding their loved one's classification designation and facility transfer decision.	The incarcerated individual said they did not want the OCO to further investigate the complaint and closed the case.	Complaint Withdrawn
207.	An external person reported that their loved one reported updates to an existing OCO case on behalf of the impacted individual.	The incarcerated individual said they did not want the OCO to further investigate the complaint and closed the case.	Complaint Withdrawn
208.	An external person reported concerns regarding their loved one's classification designation and facility transfer decision.	The incarcerated individual said they did not want the OCO to further investigate the complaint and closed the case.	Complaint Withdrawn
209.	An external person reported concerns regarding their loved one's access to Health Status Reports (HSRs) that would prevent him from getting infracted for a medical condition.	The incarcerated individual said they did not want the OCO to further investigate the complaint and closed the case.	Complaint Withdrawn
210.	Individual relayed concerns about a charge on their record.	This case is a duplicate of one that already exists in the OCO case management system.	Complaint Withdrawn
211.	Person reported a concern about facility placement.	The incarcerated individual said they did not want the OCO to further investigate the complaint and requested that the case be closed.	Complaint Withdrawn
212.	Incarcerated individual shared concerns regarding DOC discriminating against them by applying a gang label on them.	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
213.	An external person reported concerns regarding their loved one's access to medical care.	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.	Technical Assistance Provided

	They requested that the person be seen by medical staff.	The OCO provided technical assistance about the resolution program and the steps to request a medical appointment.	
214.	An external person reported multiple concerns regarding their loved one's access to DOC Health Services. The person also reported concerns regarding the time calculation impacting their loved one's earned 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 to the impacted person about submitting a request to DOC Health Services and time calculation issues.	Technical Assistance Provided
215.	Person reported on behalf of the incarcerated individual a concern about their safety and their medical needs 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 utilizing the resolution program.	Technical Assistance Provided
216.	Person reported on behalf of the incarcerated individual 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
217.	An external person reported concerns regarding their loved one's access to durable medical equipment after a facility transfer. They requested for the equipment to be located and returned to the impacted person.	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 property concerns and filing resolution requests.	Technical Assistance Provided
218.	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
219.	Person reported that DOC is not honoring their legal name change.	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
220.	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 filing a resolution request and the infraction process.	Technical Assistance Provided
221.	Person reported that they are being targeted and	Prior to OCO involvement, the incarcerated person has options for resolving the concern through a DOC appeals process or the DOC	Technical Assistance

	retaliated against by a DOC staff member.	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.	Provided
222.	Person reported 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 assistance. The OCO provided technical assistance about staff conduct and safety concerns.	Technical Assistance Provided
223.	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
Washington Corrections Center for Women			
224.	A family member of an incarcerated person reported a DOC staff member's behavior towards family members during a cultural event. The concern did not name an incarcerated person and did not report a staff behavior related to an incarcerated person.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because the requested resolution was not within the ombuds' statutory power and authority.	Declined
225.	Person reported that they would like to make changes to their 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 the health status report (HSR) process.	Technical Assistance Provided
226.	Person reported concerns regarding her treatment plan being changed to a different dose form. The person is requesting to be on a different type of the same class of medication.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake. The requested resolution is not within the ombuds' statutory power and authority. DOC policy 600.000 states that "clinical decisions are the sole province of the responsible health care practitioner and are not countermanded by non-clinicians." This means that the OCO cannot override treatment decisions made by healthcare providers. The OCO can investigate situations where patients are unable to access care, however, cannot mandate the kind of treatment provided. The OCO provided technical assistance about the DOC Health Plan approval process and Health services protocols.	Technical Assistance Provided
227.	Person reported requesting a specific treatment and being denied by her medical provider. The person is requesting to have the treatment approved by 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 filing resolution requests and the approval process within DOC.	Technical Assistance Provided
228.	Person reported that their	Prior to OCO involvement, the incarcerated person has options for	Technical

	ADA accommodations are not being met.	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.	Assistance Provided
Washington State Penitentiary			
229.	An external person reported concerns regarding the treatment of their loved one in the hospital unit. The person is requesting that the patient's diet be changed to support recovery.	This case was a duplicate of one that already existed from the same complainant and for the same concern.	Complaint Withdrawn
230.	Loved one relayed concerns regarding the conduct of medical staff.	This case is a duplicate of one that already exists in the OCO case management system.	Complaint Withdrawn
231.	Loved one 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
232.	A loved one reported a concern regarding being wrongfully terminated from the visitors list as a disciplinary sanction.	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
233.	Person reported a concern related to religious meals being delivered to IMU cold, late, and/or undercooked during the month of Ramadan.	Person stated that they wanted to withdraw this concern as he was reporting it after DOC resolved the issue with a substantiated level 3 response and just wanted to make sure OCO had this complaint recorded.	Complaint Withdrawn
234.	Incarcerated individual shared concerns regarding not being released early.	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
235.	Person reported concerns about being terminated from his job.	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 employment, due to extremely limited resources.	Declined
236.	Person reported that they do not agree with their provider's treatment decision.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake because the requested resolution was not within the ombuds' statutory power and authority. The OCO cannot overturn or countermand clinical decisions made by DOC healthcare providers. OCO staff verified the patient has an active treatment plan in place for the reported injury.	Declined
237.	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
238.	Person reported concerns	Prior to OCO involvement, the incarcerated person has options for	Technical

	regarding not receiving results of testing done in a community healthcare setting.	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 requesting follow up from their medical provider and filing resolution requests. For the OCO to investigate healthcare concerns, the incarcerated person should contact the OCO after the DOC Resolution Program has provided a level one response or if more than 90 days have passed since filing the request. The person can also send a DOC healthcare kite while awaiting a DOC Resolution Request response.	Assistance Provided
239.	Person reported concerns regarding their medical provider changing their treatment plan.	Per WAC 138-10-040(3), the OCO declined to investigate the complaint beyond intake. The requested resolution is not within the ombuds' statutory power and authority. DOC policy 600.000 states that "clinical decisions are the sole province of the responsible health care practitioner and are not countermanded by non-clinicians." This means that the OCO cannot override treatment decisions made by healthcare providers. The OCO can investigate situations where patients are unable to access care, however, cannot mandate the kind of treatment provided. The OCO provided technical assistance about the DOC Health Plan approval process.	Technical Assistance Provided
240.	Person reported that their cell floods after it rains.	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.	Technical Assistance Provided
241.	Person reported a use of force after complying with directives several months ago. The person is requesting the infractions received during this event be dismissed. The person did not request a review of the use of force.	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 appealing infractions.	Technical Assistance Provided
242.	Person reported that DOC is taking him off his medication. The person is requesting to stay on his current treatment plan.	OCO staff provided technical assistance. OCO staff reviewed the person's record and found they had not filed a resolution request for this issue. OCO staff provided the person with information on the resolutions program.	Technical Assistance Provided
243.	Person reported concerns about DOC staff telling him he needed to purchase an over the counter medication from commissary. The person stated they have had this sent in by DOC pharmacy 5 times and was not informed that would change. The person is requesting to see 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 addressed by these DOC processes, they can then contact the OCO for assistance. The OCO provided technical assistance about filing resolution requests.	Technical Assistance Provided

	medical provider to discuss treatment options.		
244.	An external person reported concerns regarding the medical care being provided to their loved one. They requested that the incarcerated person be assigned to a different provider and receive a different treatment plan.	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 resolution requests and requesting additional review of their treatment plan by the Facility Medical Director.	Technical Assistance Provided
245.	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

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-25-027

Report to the Legislature

As required by RCW 72.09.770

August 25, 2026

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

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Unexpected Fatality Review Committee Report

UFR-25-027 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 virtually on July 23, 2026:

DOC Health Services

- Dr. Frank Longano, Interim Chief Medical Officer
- Alexis Telles, Chief of Nursing
- Ronna Cole, Deputy Assistant Secretary
- Dr. Ashley Espitia, Suicide Prevention Specialist
- Dr. Ryan Quirk, Chief of Forensic Psychology
- Rachel Lusk, Health Services Administrator
- Dr. Rae Simpson, Director – Quality Systems
- Mary Beth Flygare, Sentinel Event Program Manager

DOC Prisons Division

- Jason Bennett, Senior Director – Correctional Operations
- Rochelle Stephens, Men's Prisons Project Manager
- Paige Perkinson, Correctional Operations Program Manager

DOC Risk Mitigation

- Michael Pettersen, Director
- Elisabeth Kingsbury, Litigation Administrator

DOC Person Centered Services

- Megan Pirie, Director

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Kirstin McFarland, Injury and Violence Prevention Manager

Health Care Authority (HCA)

- Dr. Heather Schultz, Associate Medical Director
- Jessica Blanchard, Health Care Program Manager

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

Fatality Summary

Date of Birth: May 1979 (46-years-old).

Date of Incarceration: December 2023.

Date of Death: December 2025.

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

The cause of death is ligature hanging. The manner of death is suicide.

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

Days Prior to Death	Event
19 days	The decedent was found in their assigned cell with a ligature secured around their neck. DOC staff rendered aid until community emergency medical services arrived to transport the decedent to the hospital. The decedent was placed in the close observation area on a 1:1 watch for safety after they returned from the hospital.
18 - 14 days	The decedent was continued on a 1:1 safety watch. A DOC Psychology Associate met with the decedent and updated safety watch conditions daily.
13 days	During a crisis assessment, the decedent denied current suicidal thoughts. Safety watch conditions were updated to 15-minute checks.
12 days	The decedent was released from close observation and transferred back to their assigned living unit.
11 - 1 days	The decedent was seen for three follow-up visits with a Psychology Associate and continued to deny current suicidal thoughts.
Day of Death	**Event**
00:35 – 05:00 hours	Tier checks were conducted. Custody staff observed signs of life within the decedent's cell during the 05:00 tier check.
05:45 – 05:47 hours	During a routine tier check, the decedent was found unresponsive and suspended from a ligature.

	Custody staff made radio notification of a medical emergency, requested community emergency medical services (EMS) response and began rendering aid.
05:48 – 06:12 hours	DOC medical staff arrived and assumed life-saving efforts.
06:13 – 06:25 hours	Community EMS arrived and assumed life-saving efforts. The decedent's death was pronounced by EMS staff.

UFR Committee Discussion

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

A. The MRC reviewed the medical record and antecedent care delivered and provided the following findings:

    1. The decedent's antecedent medical history included hereditary neuropathy, major depressive disorder, generalized anxiety disorder and previous suicide attempts.
    2. At the time of death, the decedent was housed in a general population unit without a cellmate after their cellmate's request for a housing move was granted.
    3. DOC Policy 320.265 *Close Observation Areas* (COA) and Behavioral Health protocol BH113.001 *Suicide Assessment Protocol* were not followed during the decedent's placement in the Close Observation Area:
        a. The suicide risk assessments and safety plans required for both admission to and release from the COA were either incomplete or inconsistent.

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

    1. No contributing or causal factors were identified within the scope of the CIR.
    2. The following non-causal factors were identified:
        a. The required evaluation by the primary mental health provider was omitted prior to the decedent's transfer from the COA to their assigned living unit.
        b. The current DOC electronic case management system lacks visual indicators necessary to identify individuals who would have been recommended for shared housing.
        c. There is no standardized or formal notification system, outside of email, to ensure housing unit staff receive the aftercare plan following an individual's discharge from COA.

C. The UFR committee reviewed the unexpected fatality, the mortality review committee recommendations, and discussed the following:

2. Suicide Risk Detection:

    a. DOC mental health staff proactively conduct screening interviews to identify potential suicidality upon admission to DOC, placement in a restrictive housing unit, and during scheduled appointments.

    b. When there are indicators for potential suicidality, DOC requires a suicide risk assessment (SRA) to determine the current level of risk and document the plan to address the risk factors.

    c. Individuals who are assessed to be an imminent danger to themselves are placed on an observation/safety watch in the COA.

3. Aftercare:

    a. Once the individual is assessed for discharge from the COA, mental health staff and the individual collaboratively develop an individualized safety plan. This plan details specific steps the individual can take to manage symptoms and maintain safety, as well as instructions on how to alert staff if they feel unable to stay safe. The individual is provided with a copy of the safety plan, and a copy is filed in their health record.

    b. The mental health provider also establishes an aftercare plan and notifies the Shift Commander and the individual's Correctional Unit Supervisor (CUS) of any specific details necessary for continued care during their transition back to their living unit, which may include recommending a cellmate.

    While not directly causal to the fatality, the UFR Committee recommends DOC:

        i. Implement a form to standardize and document the communication of the Mental Health Aftercare Plan to housing unit personnel when an individual is discharged from the close observation area, and

        ii. Add a distinct visual indicator within the DOC electronic case management system to identify individuals who have been recommended for shared housing as a protective factor for suicide.

UFR Committee Findings

The decedent died as a result of ligature hanging. The manner of death is suicide.

UFR Committee Recommendations

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

Consultative remarks that do not directly correlate to the cause of death, that are being implemented by the Department of Corrections:

1. Implement a form to standardize and document the communication of the Mental Health Aftercare Plan to housing unit personnel when an individual is discharged from the close observation area.
2. Add a distinct visual indicator within the electronic case management system to identify individuals who have been recommended for shared housing as a protective factor for suicide.

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-26-003

Report to the Legislature

As required by RCW 72.09.770

August 4, 2026

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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Unexpected Fatality Review Committee Report

UFR-26-003 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

This report describes the results of one such review and presents recommendations.

Disclosure of Protected Health Information

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

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on July 23, 2026:

DOC Health Services

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- Alexis Telles, Chief of Nursing
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- Paige Perkinson, Correctional Operations Program Manager

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- Michael Pettersen, Director
- Elisabeth Kingsbury, Litigation Administrator

DOC Person Centered Services

- Megan Pirie, Director

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Kirstin McFarland, Injury and Violence Prevention Manager

Health Care Authority (HCA)

- Dr. Heather Schultz, Associate Medical Director
- Jessica Blanchard, Health Care Program Manager

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

Fatality Summary

Date of Birth: 1950 (75-years-old).

Date of Incarceration: October 2025.

Date of Death: April 2026.

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

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

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

Days Prior to Death	Event
3 days	The decedent was admitted to the close observation area and placed on 15 min custody checks by their mental health provider.
2 days	• They fell in their cell and reported hip pain. • They were evaluated by nursing staff and scheduled for x-rays the next business day. • They declined their evening meal tray.
Day of Death	**Event**
00:56 – 01:23 hours	• The decedent was found unresponsive in their cell by custody staff. • Custody staff radioed for a medical emergency response and a 911 call for community emergency medical services (EMS). • Life-saving efforts, including CPR provided by staff.
01:24 hours	• Community EMS arrived and assumed life-saving efforts.
01:47 hours	• The decedent was pronounced deceased.

UFR Committee Discussion

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

A. The MRC reviewed the medical record and antecedent care delivered and provided the following

findings. They did not identify any additional recommendations to prevent a similar fatality in the future.

1. The MRC found:

    a. The decedent's antecedent medical history included hyperlipidemia, benign prostate enlargement, osteoporosis, back pain, restless legs, migraine, idiopathic normal pressure hydrocephalus, difficulty ambulating, visual impairment and constipation.

    b. They were up to date on recommended screenings and immunizations.

    c. They had completed a Portable Order for Life-Sustaining Treatment (POLST) form stating do not resuscitate (DNR) during a previous incarceration that was not filed in the active medical chart. The POLST was not reviewed during this period of incarceration.

    d. They had various past mental health diagnoses including a history of ADHD, PTSD, OCD, Autism Spectrum Disorder and reported delusional disorder. They were no records of previous inpatient psychiatric hospitalizations.

    e. At the time of admission to the close observation area (COA), the decedent was reported to be losing weight, not eating, appearing confused and inconsistently taking prescribed medications. In retrospect, these symptoms could be indicative of psychiatric instability; they could also indicate failure to thrive in an elderly individual. The decedent's prior diagnosis of delusional disorder potentially influenced the clinical staff's interpretation during care plan formulation.

    f. The decedent had a history of selective care and meal declinations leaving them underweight at the time of COA admission. These health indicators were not documented on the nursing assessment form. This omission demonstrates that either the form does not adequately cover all the necessary elements of the assessment or that the nurses do not have a clear understanding of the specific clinical factors they must evaluate to safely clear an individual for placement in restrictive housing.

    g. The day prior to death, the decedent fell on their way to the restroom and reported hip pain. They were evaluated by nursing staff who determined they did not require emergent medical treatment. The decedent was scheduled for an x-ray the next business day.

    h. The decedent was found unresponsive in their cell and resuscitation efforts were unsuccessful.

    i. The autopsy determined the manner of death was natural and no fractures were identified.

j. 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. The Health Services (HS) Quality Committee should review the current process for POLST form storage and retrieval to identify gaps and make recommendations to ensure patient care directives are accessible.

   b. The Chief of Psychiatry should present a clinical overview of delusional disorder diagnoses at the DOC Behavioral Health Grand Rounds.

   c. Nursing leadership should review and update the Restrictive Housing Assessment and Daily Wellness Checks Nursing Protocol N-2008.001 to define the intent of the assessment and provide detailed guidance on the clinical indicators nurses must consider when evaluating an individual for restrictive housing placement.

B. Independent of the mortality review, DOC conducted a 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.

C. The UFR committee reviewed the unexpected fatality, the mortality review committee recommendations, and discussed the following:

   1. Care coordination:

      a. Although the decedent presented with complex, co-occurring medical and mental health conditions upon admission to the close observation area, the resulting care plan narrowly focused on psychiatric stabilization and lacked an integrated approach to manage their physical health.

      b. Committee members recommend DOC formalize multidisciplinary care planning that integrates input from medical, psychiatric, and nursing teams to ensure holistic assessment and care planning.

UFR Committee Findings

The decedent died of hypertensive and arteriosclerotic cardiovascular disease with diabetes as a contributing factor. The manner of death is natural.

UFR Committee Recommendations

The committee did not offer 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 should explore options to formalize multidisciplinary care planning that integrates input from medical, psychiatric, and nursing teams to ensure holistic assessment and care planning.

2. DOC nursing leadership should review and update the Restrictive Housing Assessment and Daily Wellness Checks Nursing Protocol N-2008.001 to define the intent of the assessment and provide detailed guidance on the clinical indicators nurses must consider when evaluating an individual for restrictive housing placement.

3. The DOC Chief of Psychiatry should present a clinical overview of delusional disorder diagnoses at the DOC Behavioral Health Grand Rounds.