Office of the Corrections
OMBUDS

Monthly Outcome Report

July 2024

Unexpected Fatality Reviews: 1

Case Investigations: 136

Assistance Provided: 15
Information Provided: 75
DOC Resolved: 18
Insufficient Evidence to Substantiate: 16
No Violation of Policy: 12
Substantiated: 0

Intake Investigations: 104

Administrative Remedies Not Pursued: 0
Declined: 0
Lacked Jurisdiction: 9
Person Declined OCO Assistance: 29
Person Released from DOC Prior to OCO Action: 3
Technical Assistance Provided: 63

Resolved Investigations:

241

Assistance Provided, Information Provided, or Technical Assistance Provided in

63%

of Investigations

OCO Casework Highlights

July 2024

Assistance Provided

Reported Concerns: Family members of an incarcerated person contacted the OCO with concerns related to an individual's placement in IMU. The incarcerated individual wanted assistance in removing themselves from any security threat group (STG) affiliation.
OCO Actions: Upon receiving the family member's concern, **t**he OCO scheduled a call with the incarcerated individual to better understand their concern as the OCO reviewed the individual's facility placement and found no violation of DOC policy 300.380. This office then spoke with DOC and requested that a staff member come and speak to the individual about the debriefing process and provide them with further information regarding their desire for assistance in removing themselves from any STG affiliation.
Negotiated Outcomes: After OCO outreach, DOC agreed to send a staff member to speak with the incarcerated individual about the debriefing process and to provide them further information on how to remove themselves from any STG affiliation.

Assistance Provided

Reported Concern: An incarcerated individual reported that essential oils for religious practices have been restricted due to only being able to order from Union Supply, who do not carry essential oils. The individual stated that the religious coordinators used to be able to order from any sources and that DOC is restricting their religious rights.
OCO Actions: The OCO reviewed the individual's resolutions request investigation, which was unsubstantiated by DOC headquarters. The OCO spoke with DOC staff to gather information and found that DOC violated policy when they restricted the ability to purchase essential oils. The OCO elevated this concern within this office and then spoke with DOC headquarters staff, who were aware of this concern and planning on drafting a memorandum.
Negotiated Outcomes: Upon OCO request and follow up with DOC headquarters, the OCO ensured that they released their memorandum, which stated that religious coordinators can once again purchase essential oils from trusted vendors other than Union Supply for group religious property.

Assistance Provided

Reported Concerns: Incarcerated individual reported that he needs new prescription glasses and treatment for his eye. The individual said he has filed resolution requests and kited medical but has not been able to get new glasses.
OCO Actions: The OCO reviewed DOC records and reached out to DOC staff, who confirmed that this individual was seen by optometry and is scheduled to receive treatment for his eye.
Negotiated Outcomes: After the OCO's outreach, DOC sent this individual a copy of his new prescription so he can order new glasses.

Assistance Provided

Reported Concerns: Incarcerated individual relayed concerns regarding an infraction that resulted from difficulties with a particular staff member.
OCO Actions: The OCO reviewed the infraction materials and found the individual was given a 607 infraction for refusing a urinary analysis (UA) as well as a 658 failure to comply for the same action. As a result, it appeared to be a double infraction for the same incident
Negotiated Outcomes: The OCO requested DOC dismiss the WAC 658, to which DOC agreed.

Unexpected Fatality Reviews

RCW 72.09.770 requires the Department of Corrections to convene an unexpected fatality review (UFR) committee to review any case in which the death of an incarcerated individual was unexpected, or in any case identified by the Office of the Corrections Ombuds (OCO) for review. The purpose of the unexpected fatality review is to develop recommendations for the DOC and the legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for incarcerated individuals in the DOC's custody.

UFR 24-007: The Unexpected Fatality Review Committee reviewed the unexpected death of a 29-year-old person in March 2024. The Unexpected Fatality Review Committee Report dated July 19, 2024 is a publicly available document. A Corrective Action Plan (CAP) was completed on July 29, 2024.

The Office of the Corrections Ombuds has included this UFR report at the end of this Monthly Outcome Report.

Monthly Outcome Report: July 2024

	Complaint Summary	Outcome Summary	Case Closure Reason
	Unexpected Fatality Reviews		
	Washington State Penitentiary		
1.	Incarcerated individual passed away while in DOC custody.	RCW 72.09.770 directs DOC to conduct an unexpected fatality review in any case in which the death of an incarcerated individual is unexpected, or any case identified by the OCO for review. The OCO conducted a review of records associated with this individual's death. This case was reviewed by the unexpected fatality review team, consisting of the OCO, DOC, Department of Health, and Health Care Authority. A report regarding UFR-24-007 was delivered to the Governor and state legislators this month. It is also publicly available on the DOC website. The following recommendations were included in the UFR report: 1. DOC should review and update their classification and health services support needs coding processes to better support individuals with developmental disabilities, and 2. DOC should continue to pursue an electronic health record when full legislative funding becomes available.	Unexpected Fatality Review
	Case Investigations		
	Airway Heights Corrections Center		
2.	Anonymous person reported that people in his unit are pressuring and extorting other people. It's been brought to DOC attention, and nothing has been done. He was informed that he would be in a dropout/safe harbor facility, but those people are shot calling on the unit.	OCO received this concern and brought it to facility leadership. AHCC did find that an individual was politicking, and he was removed and transferred to another facility.	Assistance Provided
3.	Incarcerated individual relayed concerns regarding difficulties with a particular staff member.	Based on the information the individual provided this office after being able to discuss this concern with this officer, the OCO closed this case without further investigation at the individual's request.	DOC Resolved
4.	Incarcerated individual relayed concerns regarding a delayed release date.	The OCO reviewed the individual's records and confirmed the individual has been released.	DOC Resolved
5.	Incarcerated individual shared concerns regarding releasing soon and not having housing to release to.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and saw that DOC staff ensured the individual's Release Plan (ORP) was completed and that they were accepted into housing pre-release.	DOC Resolved

6.	A loved one uplifted a public records request for an incarcerated individual.	The OCO provided information about this individual's current public records request with this office.	Information Provided
7.	Incarcerated individual relayed concerns regarding DOC taking away their tablet.	The OCO reviewed the individual's judgment and sentence (J&S) that lists community custody conditions that restrict computer and internet access. All community custody conditions are imposed while in DOC custody as well, thus the individual would not be allowed to have a tablet.	Information Provided
8.	The Clemency & Pardons Board voted to recommend to the Governor that this person be granted clemency. He and his attorneys requested that the OCO help accelerate the Governor's clemency and pardon process so that he may be eligible to release this summer.	The OCO provided information to the incarcerated individual and his attorneys on the Office of the Governor's clemency and pardon process and timeline.	Information Provided
9.	Incarcerated person reported concerns regarding the way he was treated during a random urinalysis (UA) test.	The OCO provided information about how to file a tort claim. The OCO spoke with DOC staff regarding the concern who agreed that the treatment of the person could have been improved. The staff at the facility were spoken with about this and they discussed improvements when presented with situations like the one the person experienced.	Information Provided
10.	Person reports having a terminal condition and is requesting Extraordinary Medical Placement.	The OCO provided information to the person regarding their Extraordinary Medical Placement request and the criteria for approval listed in DOC 350.270.	Information Provided
11.	Person reported that DOC rejected court-ordered video visits with his children, which are monitored by the Department of Children Youth and Families (DCYF).	The OCO provided information about how to properly appeal the visitation rejection and what information he needs to provide. The OCO spoke to DOC staff and reviewed the court order, which stated that he will have visits as the prison allows. DOC staff also confirmed that this individual has not appealed and needs to begin treatment programming and provide paperwork before he will be considered for approval. If an individual's children are under DCYF custody, their DCYF caseworker will need to file the visitation appeal and provide needed paperwork.	Information Provided
12.	Incarcerated individual reports concerns regarding rejected mail and requests OCO assistance in receiving this mail. The individual also reported concerns about DOC staff not assisting him in accessing services that he reports he should have more ability to access.	The OCO provided information regarding the rejected mail and how he can access the documents he was trying to receive. The OCO spoke with DOC staff who explained that the rejection was allowed per policy. The OCO shared options with the individual about how to access the documentation he was requiring. The OCO also confirmed that the individual has access to the services he is requesting, and that DOC staff are assisting him in receiving those services.	Information Provided

13.	Individual relayed concerns regarding water drainage onto sidewalk and how that poses a safety concern during winter months.	The OCO provided information regarding facility safety standards and the OCO reviewed DOC's records regarding the area in question and viewed the area. This office deemed the area safe for travel and DOC staff shared that with proper ice maintenance including applying salt in the area and shoveling snow, it will be safe for travel during the winter months. The OCO also shared that the individual can file another resolution request and the office can investigate the situation further.	Information Provided
14.	Incarcerated individual relayed concerns regarding their custody facility placement.	The OCO spoke to DOC regarding this concern and confirmed that the individual is not a documented member of any security threat group (STG) so that would not be considered in placement. The OCO informed the individual that if they have concerns about their placement due to STG concerns, they can write a letter stating the reasoning behind their appeal request to the Classification Administrator at DOC headquarters.	Information Provided
15.	Incarcerated individual relayed concerns regarding two infractions.	The OCO reviewed the individual's disciplinary record and confirmed that one infraction was dismissed and is no longer visible on the individual's disciplinary record and that the other infraction is substantiated based on the individual's behavior meeting the infraction elements.	Information Provided
16.	Incarcerated individual shared concerns regarding DOC taking an extended period of time to give an approval or denial for extended family visits (EFV) with their spouse.	The OCO provided information regarding the approval or denial of the EFV for this individual's spouse. This office also provided information regarding how to contact DOC headquarters for further EFV information.	Information Provided
17.	Incarcerated individual shared concerns regarding DOC not allowing incarcerated individuals to accrue interest in their savings accounts.	The OCO provided information to the individual regarding current WA DOC banking policy in relation to current law. *Dean v. Lehman* mandated that DOC pay out interest to incarcerated individuals. DOC complied with this and from 2001 to 2003 the department paid out all interest any interest-accruing account may have accumulated. During this time, and following this, DOC moved from interest-accruing accounts for incarcerated individuals to non-interest accruing accounts which is reflected in DOC 200.000 Trust Accounts for Individuals.	Information Provided
18.	Incarcerated individual shared concerns regarding the DOC mailroom losing property they have paid for.	The OCO provided information from the DOC mailroom that the delay was due to the outside vendor. This office substantiated that DOC provided their purchased property back after an extended period of time.	Information Provided
19.	Incarcerated individual shared concerns regarding DOC staff covering up a murder plot that puts their life in danger.	The OCO was unable to substantiate the concern due to insufficient evidence.	Insufficient Evidence to Substantiate

20.	Person reports that his treatment for an infection was delayed and dismissed by medical staff.	The OCO was unable to substantiate the concern due to insufficient evidence. OCO staff reviewed the patient's records and noted that the patient was seen by multiple DOC health services staff and the community hospital. OCO staff also noted the patient did receive aftercare education appropriate to the reported issue.	Insufficient Evidence to Substantiate
21.	Incarcerated individual shared concerns regarding feeling targeted by DOC staff numerous times when returning from their work program.	The OCO was unable to substantiate a violation of policy by DOC. Due to the nature of the incarcerated individual's work program, being searched upon returning from that environment follows DOC 420.310 Searches of Incarcerated Individuals.	No Violation of Policy
22.	Person reports that he is not able to access the programming he needs because the assessment did not reflect his needs accurately.	The OCO was unable to substantiate a violation of policy by DOC. OCO staff reviewed the person's records and found that the program the person is requesting is in a unit that requires a lower custody level than that person is currently assigned. OCO reviewed the person's custody facility plan and determined the person's custody review was done in line with DOC 300.380.	No Violation of Policy
23.	Incarcerated individual shared concerns regarding being abruptly transferred from one facility to another.	The OCO was unable to substantiate a violation of policy by DOC. The OCO reviewed DOC records and determined that the individual did not follow specific treatment requirements and due to this, DOC transferred the individual to another facility so that the bed at the previous facility could become available to another individual. This reasoning complies with DOC 300.380 Classification and Custody Facility Plan Review as DOC can transfer individuals who are deemed noncompliant with programming requirements.	No Violation of Policy
Cedar Creek Corrections Center			
24.	Incarcerated individual relayed concerns regarding an infraction that resulted from difficulties with a particular staff member.	The OCO reviewed the infraction materials and found the individual was given a 607 infraction for refusing a urinary analysis (UA) as well as a 658 fail to comply for the same action. As a result, it appeared to be a double infraction for the same incident and the OCO requested DOC dismiss the WAC 658 to which DOC agreed.	Assistance Provided
25.	Incarcerated individual shared concerns regarding DOC blocking them from making outgoing calls to technical services at outside government agencies.	The OCO provided information regarding how incarcerated individuals can contact outside technical services. For incarcerated individuals, the best way to contact those agencies is by letter since those agencies do not take calls from DOC facilities.	Information Provided
26.	Incarcerated individual reports concerns regarding DOC staff conduct.	The OCO provided information regarding their recent transfer and verified DOC's action. The OCO verified DOC engaged in appropriate action related to the staff conduct. The OCO also verified that that the individual was transferred to another facility for an unrelated reason, and shared this information with the individual.	Information Provided

Clallam Bay Corrections Center			
27.	Loved one relayed concerns regarding an individual's placement in IMU and the incarcerated individual wanted assistance in removing themselves from any security threat group (STG) affiliation.	The OCO reviewed the individual's facility placement and found no violation of DOC policy 300.380. This office spoke with DOC and requested that a staff member come and speak to the individual about the debriefing process and provide them with further information regarding their desire for assistance in removing themselves from any STG affiliation, to which DOC agreed to do.	Assistance Provided
28.	Person reported that his resolution requests were not being picked up while he was in solitary confinement.	The OCO was unable to substantiate this concern due to insufficient evidence. The OCO reviewed DOC records and found evidence that this individual was able to file resolution requests and appeal them to higher levels of review while he was in solitary confinement.	Insufficient Evidence to Substantiate
29.	Person said that the COs are looking people up and telling people what individuals are incarcerated for.	The OCO reviewed this anonymous complaint but due to a lack of detail, the OCO was unable to further investigate the concern. The OCO will need names of staff to pursue a conversation with facility leadership.	Insufficient Evidence to Substantiate
30.	Incarcerated individual shared concerns regarding DOC property staff misplacing held legal documents.	The OCO was unable to substantiate the concern due to insufficient evidence. The DOC records the OCO reviewed indicated that DOC staff extensively investigated the claim and provided evidence consistent with the claim that DOC returned the individual's legal property.	Insufficient Evidence to Substantiate

Coyote Ridge Corrections Center			
31.	Person reported that essential oils for religious practices have been restricted due to only being able to order from Union Supply, who do not carry essential oils. Person stated that the religious coordinators used to be able to order from any sources and that DOC is restricting their religious rights.	The OCO provided assistance. The OCO reviewed this individual’s resolutions request investigation, which was unsubstantiated by DOC headquarters. The OCO spoke with DOC staff to gather information and found that DOC violated policy when they restricted the ability to purchase essential oils. The OCO elevated this concern within this office and then spoke with DOC headquarters staff, who were aware of this concern and planning on drafting a memorandum. This office followed up with DOC headquarters and ensured that they released their memorandum, which stated that religious coordinators can once again purchase essential oils from trusted vendors other than Union Supply for group religious property.	Assistance Provided
32.	Incarcerated individual shared complaints about having issues with accessing Securus services due to a technical issue in their file.	DOC staff resolved this concern prior to the OCO taking action on this complaint. DOC staff worked with Securus and was able to get the issue resolved for the incarcerated individual.	DOC Resolved
33.	Incarcerated individual relayed concerns regarding needing medical shoes.	DOC resolved this concern prior to OCO involvement. The OCO spoke to DOC and confirmed that the individual did receive the medical shoes as requested.	DOC Resolved

34.	Incarcerated individual shared concerns regarding DOC's reluctance to place them on a requested religious diet.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO found that DOC staff placed the individual on the requested diet.	DOC Resolved
35.	External person reported concerns about an incarcerated persons safety.	The OCO provided information to the incarcerated person directly about how to report safety concerns and gave information about DOCs protocol for safety concerns. The OCO also verified that there is not currently any evidence that the person's placement is an active safety threat to them.	Information Provided
36.	Incarcerated individual relayed concerns regarding concerns about being a target of certain security threat groups (STGs) that have resulted in them fearing for their safety related to their housing placement.	The OCO requested that DOC staff pull the individual out to discuss this concern. However, the individual informed DOC staff that they had no idea what the concern was about as they stated they are doing fine in the unit. Because they were unwilling to tell DOC about their safety concerns, there are no further steps this office can take to assist them in verifying the safety concerns or seeking more appropriate housing.	Information Provided
37.	A loved one made a concern on behalf of an incarcerated individual regarding a visitation approval.	The OCO provided information on how family members and loved ones can gain approval for extended family visits (EFV).	Information Provided
38.	Incarcerated person reported safety concerns if they are transferred to another facility. The person reports that they requested to speak with DOC staff about the concerns and has not heard back.	The OCO provided information to the incarcerated person directly about how to report safety concerns and gave information about DOCs protocol for safety concerns. The OCO verified that DOC staff did not speak to him about these safety concerns and this office also verified that there is not currently any evidence that the person's placement is an active safety threat to them.	Information Provided
39.	Incarcerated individual shared concerns about not being seen as often in health service needs despite requiring it.	The OCO provided information to the individual regarding the PULHES codes, which are meant to assist staff "in determining the best placement for living and working for incarcerated individuals" per WADOC PULHES Code Guidelines. Each letter represents a different healthcare need. When an incarcerated individual has been assessed by WADOC health services staff, the staff person then assigns a number to each letter. For more information regarding this assessment, the OCO has released the "Solitary Confinement Report I" which goes more into detail regarding this coding system. This office further provided information regarding how to request reassessment so they can potentially participate in more service opportunities.	Information Provided
40.	Person reports difficulty moving around his unit to use the restroom and is requesting to be assigned to a wet cell as an ADA accommodation.	The OCO provided information to the patient regarding the unit's process for assigning wet cells to patients who need them. OCO staff contacted DOC Health Services staff and were informed that the patient had recently been evaluated for his	Information Provided

		request and was found not to meet the criteria to be prioritized for a wet cell.	
41.	Incarcerated individual relayed concerns regarding a use of force in which they state they complied with orders, but officers still used OC spray.	The OCO reviewed the videos of the use of force, but because there is no audio and due to the camera angle, this office was unable to discern whether the two incarcerated individuals failed to follow officer directives to stop fighting before the OC was deployed or not. Thus, there was insufficient evidence to substantiate the concern.	Insufficient Evidence to Substantiate
GRE/CPA			
42.	External individual reports concerns regarding an incarcerated individual's termination from graduated reentry (GRE). The external individual reports concerns regarding staff behavior during the GRE termination process.	The OCO was unable to substantiate a violation of policy by the DOC. The OCO reviewed the GRE termination and found it to be in compliance with DOC 460.135 attachment 1 Disciplinary Sanction Table. Due to the type of infraction DOC issued and the individual admitted to in the hearing, the GRE termination as a sanction was appropriate. The OCO also reviewed documents and could not locate evidence to substantiate staff misconduct or retaliation that later led to a GRE termination. To substantiate retaliation, the OCO must be able to prove that a negative action from a DOC staff member is not only linked close in time to an incarcerated individual's protected action but there must be evidence of a clear relationship between the two acts.	No Violation of Policy
43.	Incarcerated individual shared concerns regarding being infracted due to DOC staff failing to update them on their schedule.	The OCO was unable to substantiate a violation of policy by DOC. The OCO found that DOC properly infracted the individual based on the processes outlined in DOC 460.135 Disciplinary Procedures for Work Release. DOC also held a proper hearing per DOC 460.140 Hearings and Appeals. Along with this information, the OCO also found out that the incarcerated individual admitted to committing the offenses they were sanctioned for.	No Violation of Policy
Mission Creek Corrections Center for Women			
44.	Incarcerated individual relayed concerns regarding having to participate in the therapeutic communities (TC) program.	The OCO spoke with DOC and confirmed that they must participate in a program in order to meet the court ordered (J&S) substance abuse treatment. DOC is working to come up with a solution for them to engage in treatment while addressing their safety concerns.	Information Provided
Monroe Correctional Complex			
45.	Incarcerated individual relayed concerns regarding needing medical care after an alleged use of force occurred.	The OCO reviewed the individual's grievance records and confirmed that two grievances were filed for this concern. One grievance duplicates the same concern as the first grievance filed, just with the addition of medical care not being provided after the alleged use of force. To establish a medical need, DOC must first establish if the use of force occurred. As a result, the duplicative grievance will need to remain not accepted as a duplicate at this	Assistance Provided

		time. However, upon OCO request, DOC did agree to reopen the first grievance and it will be sent to level 1 for review regarding the possible use of force. The OCO informed the individual that DOC must investigate whether or not the use of force occurred in the grievance first in order to determine medical need. Based on the outcome of the grievance investigation, the OCO informed the individual they can contact this office to either request a new case be opened about the use of force or a new case be opened about the medical need.	
46.	Person reported that she was threatened with an infraction for refusing a strip search from a staff member of a different gender and had to refuse a medical trip.	The OCO provided assistance. The OCO extensively reviewed this concern and multiple similar concerns at the facility, including reviewing DOC records and resolutions requests, and met with facility leadership multiple times. DOC released a staff memorandum on February 26, 2024 stating when a staff member changes their gender identity, they must receive approval from the Superintendent to conduct strip searches of individual's matching their new gender identity. The OCO confirmed with facility leadership that appropriate action was taken regarding this staff member.	Assistance Provided
47.	Incarcerated individual relayed concerns regarding being limited to indigent hygiene items due to a loss of store sanction but having allergies to the available products.	The OCO spoke with DOC and confirmed that when a loss of store sanction is given, individuals are limited to the ability to order hygiene items from the indigent list only. This office then reached out to DOC regarding the allergy concern and DOC has placed the individual on the medical callout to be seen to address this concern.	Assistance Provided
48.	Person reported that the treatments he has received from Health Services are not working, and that Health Services are refusing his request to see a specialist.	The OCO provided assistance. The OCO reviewed DOC records and reached out to DOC staff and substantiated that there was a delay in care and that his request for a specialist was never reviewed by the Care Review Committee (CRC). The OCO found that the consult was submitted at CRC request and denied by the Facility Medical Director (FMD), who has authority over clinical decisions that are elevated to the CRC per the WA DOC Health Plan. After OCO outreach, this individual was approved for seeing the specialist, and this office verified that an appointment with the specialist was scheduled. If incarcerated individuals are denied CRC review by the FMD, they can file a Health Services resolutions request and request CRC review.	Assistance Provided
49.	Person reported concern about a DOC staff member of a different gender than her strip searching her.	The OCO provided assistance. The OCO extensively reviewed this concern and multiple similar concerns at the facility, including reviewing DOC records and resolutions requests, and met with facility leadership multiple times. DOC released a staff memorandum on February 26, 2024, stating when a staff member changes their gender identity, they	Assistance Provided

		must receive approval from the Superintendent to conduct strip searches of individual's matching their new gender identity. The OCO confirmed with facility leadership that appropriate action was taken regarding this staff member.	
50.	Incarcerated individual expressed concerns about an infraction.	The OCO confirmed that the infraction was dismissed by DOC on appeal and is no longer visible on the individual's disciplinary record.	DOC Resolved
51.	Incarcerated individual relayed concerns regarding being on a medication that they are allergic to.	DOC resolved this concern prior to OCO involvement. The OCO spoke with DOC and confirmed that the individual is no longer taking the medication they expressed concerns about and has been scheduled to see their primary care provider to address any lingering concerns.	DOC Resolved
52.	Incarcerated individual relayed concerns regarding being placed on involuntary medication that they believe they are allergic to.	DOC resolved this concern prior to OCO involvement. The OCO spoke with DOC and confirmed that the individual has been switched from the medication of concern to an alternative medication.	DOC Resolved
53.	Incarcerated individual expressed concerns about an infraction.	The OCO confirmed the infraction was dismissed on appeal and is no longer visible on the individual's disciplinary record.	DOC Resolved
54.	Person reported that he is writing a book that has been sent in and out of the facility several times for editing. Person said that DOC Headquarters rejected his manuscript from being mailed in because it was too long.	The OCO provided information on how to notify DOC Headquarters before receiving a manuscript in the mail, so that it does not get rejected by the mailroom. The OCO reviewed the mail rejection and found that it did not violate DOC 450.100 Mail for Individuals in Prison.	Information Provided
55.	Incarcerated individual relayed concerns regarding there being black mold in the kitchen.	The OCO spoke with multiple DOC staff concerning this issue including facility leadership and confirmed that on-site testing was done throughout the kitchen area and the only place where black mold was found was in the staff office. This area was sealed off and a professional company is coming to conduct mold mitigation. Additional testing was done throughout the kitchen including the areas the OCO expressed concerns about (dish pit and coolers) and while other mold was found, it was determined to be non-toxic. Testing revealed that just because it looks black, does not necessarily mean that it is black mold or toxic mold. An evening crew has been established to deep clean the kitchen when it is clear of work crews. Safety equipment including eye protection is available for staff, CI and incarcerated workers. To remove the current mold and prevent future mold, better cleaning techniques are being implemented along with aggressive testing and treating non-toxigenic mold to prevent spreading. DOC informed the OCO that they are on the lookout for new growth and will test new areas of concern at they arise.	Information Provided

56.	Person reported that after filing a resolution request, DOC took away his Health Services Report (HSR) for a nutritional supplement. Person expressed concern that he was being retaliated against.	The OCO provided information about the criteria for nutritional supplements. The OCO reviewed this individual's resolution request and found that this individual met with DOC staff about his medical condition, and that staff found he no longer meets the criteria for that nutritional supplement, per 610.240 Therapeutic Diets and the Diet Supplement Protocol. The OCO could not substantiate that the removal of this individual's HSR was in retaliation for filing a resolution request.	Information Provided
57.	Person reports being denied treatment for a mental health issue. The person states that a provider is refusing to submit his request to the Care Review Committee.	OCO staff provided information to the person regarding their treatment plan and Care Review Committee consult request. OCO staff reviewed the patient's records and found that the patient had been started on an alternative medication for that issue. OCO staff also provided information to the patient regarding the DOC Formulary and Pharmaceutical Management manual.	Information Provided
58.	Incarcerated person reported concerns about accessing their property used for an Americans with Disabilities Act (ADA) accommodation. The person also reported concerns about accessing medical appointments.	The OCO provided information to the individual about how to access the property items. The OCO found that currently the person is not engaged in programming that would require this property, which was issued by DOC. The OCO shared that DOC staff are willing to resubmit the ADA accommodation in the future if the person is active in programming that requires the items. The OCO asks for people to attempt to file a resolution request about the medical concern prior to OCO involvement, the OCO could not find records to show that the person attempted to file a resolution request about the access issue.	Information Provided
59.	Person reports he had a Health Status Report (HSR) over a year ago that his current provider is not willing to renew. He also reported that the Care Review Committee denied a requested item.	The OCO provided information to the patient regarding the steps he will need to take to get the Health Status Report (HSR) reordered. The ordering of HSRs is a clinical decision to be made by the care provider and must be reviewed for proof of continued need. If a patient does not agree with their provider's decision, they can request the Facility medical director review their request or contact the Health Services Manager to initiate the Patient Paid Healthcare process to self-pay for a second opinion outside of DOC medical.	Information Provided
60.	Incarcerated individual shared concerns about losing property upon return from administrative segregation. Also shared concerns about facility maintenance not fixing the hot water.	This person was released prior to the OCO taking action on the complaint. The OCO also provided information relating to tort claims and how to file those claims.	Information Provided
61.	Incarcerated individual relayed concerns regarding an infraction where they state their mental health provider	The OCO reviewed the infraction materials and contacted the staff member named by the individual, but that staff member was not present	Information Provided

	stated they would provide them with a statement on the individual's behalf.	during the incident that led to the infraction and thus was unable to provide a statement.	
62.	Incarcerated individual relayed concerns regarding black mold in the kitchen.	The OCO spoke with multiple DOC staff concerning this issue including facility leadership. The OCO confirmed that on-site testing had been done throughout the kitchen area and the only place where black mold was found was in the staff office. This area was sealed off and a professional company is coming to conduct mold mitigation. Additional testing was done throughout the kitchen including the areas the OCO expressed concerns about (dish pit and coolers) and while other mold was found, it was determined to be non-toxic. Although the mold looks black, testing revealed that it is not black mold or toxic mold. An evening crew has been established to deep clean the kitchen when it is clear of work crews. Safety equipment including eye protection is available for staff, CI and incarcerated workers. To remove the current mold and prevent future mold, better cleaning techniques are being implemented along with aggressive testing and treating non-toxigenic mold to prevent spreading. DOC informed the OCO that they are on the lookout for new growth and will test new areas of concern at they arise.	Information Provided
63.	Incarcerated individual shared concerns regarding their disagreement with their Washington ONE (WA ONE) assessment, which is a dynamic risk assessment tool utilized by DOC that determines an individual's likelihood of reoffending, program referrals, and helps decide if an individual needs informal intervention strategies.	The OCO provided information on how to properly appeal WA ONE assessments and the importance of participating in the assessment process.	Information Provided
64.	Incarcerated individual shared concerns regarding wanting to take part in programming for their long-term safety.	The OCO provided information regarding DOC programming requirements and how earned release date (ERD) play into those programming approval or denial.	Information Provided
65.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and requested DOC dismiss the infraction at two different levels of leadership, but DOC was unwilling to dismiss the infraction as they state the infraction elements have been met.	Information Provided
66.	An incarcerated individual reports that he was unfairly fired from a job without being infracted or written up.	The OCO provided information about how this individual may regain employment. This office contacted DOC staff who verified why the individual was terminated from their job and how she could appeal the facility risk management team (FRMT)	Information Provided

		decision. The individual needs to be placed on the appropriate referral list for available positions, if she would like to be employed again. The OCO encouraged this person to contact their counselor if they want to be added to this list.	
67.	Incarcerated individual shared concerns regarding a hearing in community custody and requested the OCO attend the community custody hearing.	The OCO provided information regarding the OCO's jurisdiction via hotline. Per the OCO's RCW the OCO is not allowed to directly advocate for incarcerated individuals.	Information Provided
68.	Incarcerated individual shared concerns regarding being transferred and not receiving their legal property.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. The OCO also provided information on how to properly resolve issues regarding legal property within DOC before OCO involvement.	Information Provided
69.	Incarcerated individual reports concerns about receiving his property after transferring.	The OCO provided the individual with information about how to appeal resolution requests to the DOC headquarters level. The OCO also provided the individual with information about how to file a tort claim and the tort claim process.	Information Provided
70.	Incarcerated individual shared a concern regarding not hearing back about a request for accommodations.	The OCO provided information regarding the response the incarcerated individual requested about their accommodation request and how they can request future accommodations.	Information Provided
71.	The OCO relayed concerns regarding the heat mitigation plan for the facility due to the high temperatures.	The OCO spoke with DOC and confirmed if a patient has a heat related illness/symptoms, they are managed on a case by case basis after a clinical assessment. The OCO also reviewed the MCC population heat mitigation plan and confirmed that it includes availability of ice in unit, cooling stations, authorization of clothing to include shorts, t-shirts, and sandals outside of the unit from May 1, 2024, to November 1, 2024 except for certain areas, hydration stations, misting stations, sunblock and cooling towels.	Information Provided
72.	Incarcerated individual relayed concerns regarding staff conduct including not having grievances turned in, being harassed by staff, having a cage around their door, not being out of their room in over a week, not eating regularly and having a dirty cell.	The OCO came to the facility to visit the individual in person to verify each of the concerns raised. The OCO confirmed that the individual did have an additional shield placed in front of their door due to having thrown liquids out of the cell that landed on staff previously. The OCO spoke with staff and confirmed that the individual had been placed on a 72 hour cell restriction but, besides that, has had the opportunity to get out of their cell regularly for yard and showers. The OCO also saw that the cell was clean and they were given meals regularly as this office confirmed they were given a meal while this office was visiting with them. The OCO	Information Provided

		reviewed the grievances and confirmed that over a dozen grievances had been filed and responded to from April to June 2024, thus there is insufficient evidence to show their grievances are not being turned in. Regarding the staff conduct, because no grievances regarding staff conduct were pursued beyond a level 2, there was insufficient evidence for this office to review. This office also confirmed that in order to mitigate the staff conduct concerns that were occurring, the individual was moved facilities.	
73.	Person reported that he was denied his Passover meal because no sign-up sheets were put up in the unit.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed this individual's resolution request and found that staff confirmed that Passover sign-up was posted in the unit and stated that the DOC staff met with him regarding this concern. The OCO has not received other concerns from individuals in this facility regarding the sign-up for Passover not being posted in the unit.	Insufficient Evidence to Substantiate
74.	Person reported concern that a DOC staff member is racially discriminating against him and that he has been targeted because of filing resolutions requests against staff.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed this individual's Resolutions Request about this staff member, which claimed he was fired from his job by this staff as discriminatory retaliation. The OCO reviewed a Behavioral Observation Entry (BOE) that stated this individual attempted to leave work before the scheduled end of his shift, and that his hours had been a consistent issue. This office reviewed this individual's concerns about systemic racial discrimination at the facility in a separate case.	Insufficient Evidence to Substantiate
75.	An incarcerated individual reports that staff refused to serve him sanction paperwork after receiving an infraction and denied him the ability to purchase hygiene products from commissary.	The OCO was unable to substantiate the concern due to insufficient evidence. This office contacted DOC staff about this issue and staff confirmed that the person was given sanction paperwork. DOC staff reported he was upset about the sanction and unit staff encouraged him to kite facility leadership with his concerns. Ultimately, the sanction was reduced. The OCO verified that individuals are only allowed to purchase indigent deodorant instead of regular deodorant from commissary when they are serving a sanction and have lost their privileges.	Insufficient Evidence to Substantiate
76.	An individual reports that DOC staff gave a false narrative while documenting a behavior observation entry (BOE) and accused him of threatening DOC staff. The individual is adamant that he did not threaten anyone, and was not given fair consideration in his BOE appeal or resolution request	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed this individual's resolution request that was documented with his concern. The resolution request was unsubstantiated at the facility and headquarters level. The DOC found that staff did not intentionally treat him differently based on race. Additionally, this office reviewed the narrative of the BOE and appeal information. The OCO determined that DOC was within policy 300.100 and followed the procedures outlined in the directive. This office is reviewing other concerns for this	Insufficient Evidence to Substantiate

	regarding this concern and racial discrimination.	individual and will continue to monitor allegations of racial bias at this facility.	
77.	Person reported that he is being retaliated against by a DOC staff that he filed a Prison Rape Elimination Act (PREA) complaint against. Person said that he has received many infractions and urinalysis tests as retaliation.	The OCO was unable to substantiate the concern due to insufficient evidence. The OCO reviewed DOC records regarding this individual's infractions and found that they did not involve the staff this individual filed a PREA complaint against. The OCO also could not substantiate that this individual is being subjected to an abnormal number of urinalysis tests. This office reviewed this PREA concern in an earlier case and is currently reviewing this individual's infractions in a new case.	Insufficient Evidence to Substantiate
78.	Incarcerated Individual expressed concerns about the mailroom rejecting his pictures as a form of harassment because he has advocated for sexually explicit material to be approved.	The OCO independently reviewed the rejected materials and found no violation of DOC policy 450.100 Mail for Individuals in Prison. In addition, the OCO found that one of the previously rejected photographs was approved by DOC staff after the incarcerated individual appealed the rejection and prior to OCO's involvement.	No Violation of Policy
79.	Incarcerated individual relayed concerns regarding an infraction hearing that occurred without them waiving their appearance.	The OCO found no violation of DOC policy 460.000 as the individual signed the appearance waiver form.	No Violation of Policy
80.	Incarcerated individual expressed concerns about an infraction they received.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
Olympic Corrections Center			
81.	External person reported concerns about retaliation from DOC towards incarcerated people in a cultural group.	The OCO provided information to the incarcerated person about options to continue to report concerns as they arise, even after their release. The OCO spoke with the facility Superintendent about the concerns reported and will continue to have conversations with facility leadership around the treatment of incarcerated people. The superintendent reviewed the concerns and took appropriate action.	Information Provided
82.	Incarcerated individual shared concerns regarding DOC's lack of proper accommodations.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process. The OCO also found that DOC staff removed this individual from their work program until their medical needs are met. The OCO also provided the individual with a resolution flyer with specific information about the resolution program.	Information Provided
83.	Incarcerated person reported DOC staff infracted him as	The OCO was unable to substantiate this concern due to insufficient evidence. The OCO reviewed the previously reported issue and the infraction and	Insufficient Evidence to Substantiate

	retaliation for him reporting a previous issue.	could not identify a direct link between the two. The infraction was issued, and the hearing was completed per DOC protocol, using the "some" evidence standard. The OCO was unable to verify any other negative action inflicted on the person that could be substantiated as retaliation.	
Other			
84.	External person reported that an officer told members of the community she was married to an incarcerated person and due to this information, the owner of a service she utilized terminated her membership.	The OCO reviewed this concern and contacted the facility. The facility leadership had determined that they did not have evidence to substantiate that the officer shared this information.	Information Provided
85.	External individual reports concerns about a state employee trying to find information about them.	The OCO provided information about how to report concerns about state employees to the agency that employs them. The OCO spoke with the external individual and found the person is not employed at DOC and the concern is not related to an incarcerated individual. The OCO shared how to contact the agency and report the concern for further review.	Information Provided
86.	Family member called on behalf of an incarcerated individual asking questions about DOC healthcare providers.	The OCO provided information to the family member regarding how to contact DOC to obtain more information about DOC healthcare providers.	Information Provided
87.	External person reported concerns about her friend's community custody and had concerns about a police department harassing her friend.	The OCO provided information about where to report concerns related to the police department named. The OCO also shared how to report concerns related to community custody to the DOC directly as they had not been reported to them.	Information Provided
88.	Incarcerated individual shared concerns regarding DOC utilizing the restraint bed, giving them involuntary medication, and how that negatively affected them.	The OCO was unable to substantiate the concern due to insufficient evidence. The individual didn't share their name or any other pertinent information, due to this we were unable to investigate further.	Insufficient Evidence to Substantiate
Stafford Creek Corrections Center			
89.	External person has been requesting permission to fund two persons' commissary accounts: one person is a family member and she was appointed as a financial guardian by a court for the other person. The external person has provided the court order four times to DOC. DOC	The OCO contacted the facility leadership and asked for this issue to be resolved. DOC resolved the issue and the facility notified the external reporter.	Assistance Provided

	is still withholding commissary funds.		
90.	Person reported that he needs new prescription glasses and treatment for his eye. Person said he has filed resolution requests and kited medical but has not been able to get new glasses.	The OCO provided assistance. The OCO reviewed DOC records and reached out to DOC staff, who confirmed that this individual was seen by optometry and is scheduled to receive treatment for his eye. After the OCO's outreach, DOC sent this individual a copy of his new prescription so he can order new glasses.	Assistance Provided
91.	Person reports he did not receive adequate treatment for an injury he sustained over a year ago. The patient is requesting to be seen by a specialist to have the issue corrected.	The OCO provided assistance. OCO staff reviewed the patient's consultations and noted that the requested consult had been approved and not scheduled. OCO staff contacted DOC health services staff and requested for the approved specialist appointment to be scheduled. DOC staff agreed to get the appointment scheduled.	Assistance Provided
92.	Incarcerated individual shares concerns regarding a sanitation concern within facility laundry.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO found that DOC staff provided the individual with information relating to sheet discoloration that happens during washing over the lifetime of a sheet.	DOC Resolved
93.	Person reported concerns with leg pain, and that the last time he went to Health Services he never received a diagnosis. Person also reported concerns about his medical shoes not fitting properly.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed DOC records and reached out to DOC staff, who confirmed that this individual has seen Health Services multiple times and has received a diagnosis for his leg pain and has a treatment plan going forward. DOC staff also stated that this individual is working with Health Services and property to address his concerns with his medical shoes.	DOC Resolved
94.	The individual reports concerns regarding his Passover meals and the DOC not following policy and allowing him to take his food back to his cell. The person also reported that staff told him they do not care about his religion and are not going to accommodate his religious beliefs.	The OCO provided information about Passover meals. This office made contact with the religious coordinator and followed up on the current protocols for Passover. The DOC staff member confirmed there is a separate mealtime for Passover participants. However, incarcerated individuals are allowed to bring their Matza crackers and macarons back to their cells. The DOC religious coordinator agreed to resend the Passover mealtime protocols to the officers and shift lieutenant.	Information Provided
95.	Incarcerated individual shared concerns about DOC's lack of ADA jobs at facilities.	The OCO provided information regarding Class III jobs, DOC's compliance with DOC 690.400 Individuals with Disabilities by providing the individual with adequate accommodations, and how this individual can try to obtain an ADA accommodation. The position falls within Class III, which has an employment expiration date and requires re-selection. In this case, the individual was not selected to fill the position again due to the DOC's job priority selection process. This process includes viewing an individual's need for work	Information Provided

		programming and selects individuals who score high in that necessity.	
96.	Incarcerated individual shared concerns regarding their lack of access to legal supplies.	The OCO provided information relating to access to legal material in DOC facility as well as information shared by DOC staff regarding the Restricted Housing Unit Handbook. DOC staff shared that the individual has access to legal material and the aforementioned handbook provides information on how to acquire all necessary items.	Information Provided
97.	Incarcerated individual shared concerns about wanting DOC to place them into a more appropriate reentry setting before community integration.	The OCO met with DOC graduated reentry (GRE) staff and spoke with them regarding this individual's desired reentry pathway. DOC staff shared that this individual's requested pathway is unfeasible due to the amount of time each individual step would take in comparison to their earned release date (ERD). The amount of time elapsed within the programs desired would exceed that of their ERD. Along with this, DOC is unable to relinquish incarcerated individuals to a contractual setting (in-patient treatment, etc.) and receive them back in a DOC setting.	Information Provided
98.	Incarcerated individual relayed concerns regarding an infraction that has resulted in a demotion and probable transfer.	The OCO reviewed the individual's custody facility plan (CFP) and confirmed that DOC is properly addressing their concerns in accordance with DOC policy 300.380. The OCO informed the individual that the infraction has not been appealed, and that they will need to appeal it and get the appeal response before this office is able to investigate.	Information Provided
99.	An incarcerated individual relayed concerns regarding not having access to the (medically assisted treatment) MAT program and heavy sanctions due to drug-related infractions. He states the new policy results in exorbitant sanctions that do not seem to be in alignment with recovery goals.	The OCO provided information about how to access a 12-step program via mail. This office reviewed the person's discipline record and compared the sanctions he received to DOC 460.050 attachment two. All of the sanctions are within policy and the individual is not eligible for the MAT program or chemical dependency programming because he is too far from his release date. The OCO provided a flyer with contact information for a 12-step program that could assist with his recovery goals and a mailing address to the DOC Correspondence Unit for future policy revision suggestions.	Information Provided
100.	An incarcerated individual reports issues with getting a compatible therapy aide.	The OCO reviewed the individual's electronic file and determined the individual was moved to another facility. The OCO provided information explaining how to request a new therapy aide once moved to their permanent housing unit.	Information Provided
101.	Incarcerated individual shared concerns about DOC staff blocking their ability to utilize the resolution program.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO was able to confirm that DOC is allowing the incarcerated individual to write resolution request about concerns as they arise per the DOC Resolution Program Manual.	No Violation of Policy
102.	Incarcerated individual relayed concerns regarding	The OCO reviewed the individual's custody facility plan (CFP) and see that DOC states they are to	No Violation of Policy

	not being able to progress beyond a level 2.	maintain IMU level 2 only due to being an influential member of a security threat group in accordance with DOC policy 320.250.	
Washington Corrections Center			
103.	Incarcerated individual shared concerns regarding DOC retaliating against him and losing his property purposely through the mail.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO found that DOC staff shipped the property in question properly and gave the tracking information to the individual to verify.	DOC Resolved
104.	Incarcerated individual relayed concerns regarding a delayed release date.	The OCO reviewed the individual's record and confirmed the individual has been released.	DOC Resolved
105.	Incarcerated individual relayed concerns regarding a delayed release date.	The OCO reviewed the individual's record and confirmed the individual has been released.	DOC Resolved
106.	Incarcerated individual relayed concerns regarding needing a threader to floss their bridge but this not being available to them due to your facility placement.	The OCO reviewed the associated grievance response in which DOC has substantiated the concern that threaders cannot be added to the commissary list, but informed the individual that they can go through the patient paid healthcare option by submitting DOC form 13-461 and DOC is willing to work with them to obtain threaders. The OCO informed the individual that at their next custody facility plan (CFP) they can bring up their desire to transfer.	Information Provided
107.	An incarcerated person asked for help with a property concern and reported a concern related to a urinalysis.	The OCO provided information related to the role of the OCO and what steps an incarcerated person can pursue to resolve the issue. The OCO verified the person was not infracted for the urinalysis result.	Information Provided
108.	Incarcerated individual shared concerns regarding being unsure if their property could be transferred although DOC said they would take care of it.	The OCO provided information shared by DOC property staff relating to cost of shipment for property from facility to facility, current status of this individual's property, and the next steps they can take.	Information Provided
109.	Incarcerated individual shared concerns regarding DOC blocking their ability to get married.	The OCO provided information relating to properly completing the full marriage process outlined in DOC 590.200 Marriages and State Registered Domestic Partnerships by completing the forms provided by DOC. Upon reviewing DOC records, the OCO was unable to locate any documents indicating that the individual pursued the marriage in accordance with policy.	Information Provided
110.	Incarcerated person reported concerns about a medical diagnosis.	The OCO provided information about how to navigate the DOC healthcare system and self-advocate through information about internal processes. The OCO shared how to file a complaint about a medical professional. The OCO also provided self-advocacy information about how to file a resolution request to address this issue prior to OCO involvement.	Information Provided

111.	Incarcerated individual shared concerns about being held in receiving due to DOC being unable to classify them.	The OCO provided information to the individual regarding why DOC held them in receiving for an extended period of time. This office also verified that the individual was held in receiving for an extended time due to technical issues and they were transferred to a suitable facility. This office also shared this information as well as self-advocacy information if this issue happens again in the future.	Information Provided
112.	Incarcerated individual shared concerns regarding DOC staff wrongfully searching their room and taking their items.	The OCO provided information to the incarcerated individual regarding how to file tort claims and resolve property complaints.	Information Provided
113.	Incarcerated individual reported concerns regarding DOC staff not providing them healthcare after purposely hurting them.	The incarcerated person has not pursued internal resolution of this concern. Per RCW 43.06C(2)(b), the OCO cannot investigate a complaint until the incarcerated person has reasonably attempted to resolve it through the DOC internal grievance process, administrative, or appellate process.	Information Provided
114.	Person reported that the battery on his Securus tablet is dying, and he is not getting help.	The OCO provided information about how to request a meeting with a Securus representative. The OCO is actively monitoring the transition to Securus and is still gathering information. The OCO does not have jurisdiction over Securus but is in discussion with DOC regarding their contract with Securus and is bringing issues and concerns from incarcerated individuals to DOC's attention. The OCO made Securus and DOC aware of this issue at the Securus Quarterly meeting.	Information Provided
Washington Corrections Center for Women			
115.	Incarcerated individual relayed concerns regarding a use of force.	The OCO reviewed all records including use of force packets and video of the incident report management system (IMRS) documents the individual was involved in in 2024. However, the documented IMRS were related to another incident, not uses of force. Thus, there were no records indicative of a use of force in 2024. There was insufficient evidence for the OCO to substantiate that a use of force occurred.	Insufficient Evidence to Substantiate
116.	Incarcerated individual relayed concerns regarding an infraction.	The OCO reviewed the infraction materials and found no violation of DOC policy 460.000 as the individual's behavior met the infraction elements.	No Violation of Policy
Washington State Penitentiary			
117.	Anonymous person reported a planned riot in one of the close custody units.	The OCO contacted the facility and shared the detailed information reported.	Assistance Provided
118.	Incarcerated individual reported safety concerns and requested the OCO assist him with accessing a confidential space to share these concerns.	The OCO provided assistance. The OCO spoke with DOC staff who facilitated a confidential space to express their concerns. This office shared information about how incarcerated individuals can remain active in their custody facility planning to report safety issues at their planned review.	Assistance Provided

119.	Individual reported on-going power outages in their unit.	The OCO contacted the facility regarding this issue. The DOC stated that they were having a difficult time getting the outage fixed, however after the OCO reached out it was fixed shortly after.	Assistance Provided
120.	A loved one reports that an incarcerated individual was accused of participating in an event that led to someone's death. The individual reports that they had nothing to do with the incident, and the internal investigation found that the allegations were unfounded. Despite the investigation, the DOC has infracted him and will not allow any of his supporting evidence.	DOC staff resolved this concern prior to the OCO taking action on this complaint. The OCO reviewed the incarcerated individual's electronic file and determined the DOC overturned the infractions and are promoting him to close custody before he is transferred to another facility.	DOC Resolved
121.	Incarcerated individual relayed concerns about a delayed release.	The OCO reviewed the individual's records and confirmed the individual has been released from prison.	DOC Resolved
122.	Incarcerated individual expressed concerns about a delayed transfer.	DOC resolved this concern prior to OCO involvement. The OCO confirmed that the individual's transfer has been completed.	DOC Resolved
123.	Incarcerated individual relayed concerns regarding not being able to order store.	The OCO reviewed the individual's disciplinary records and confirmed that they have an infraction sanction for loss of store and informed the individual that that is the reason why they are unable to order store.	Information Provided
124.	Incarcerated individual relayed concerns regarding good conduct time restoration.	The OCO spoke with DOC and confirmed that due to the individual's resentencing and the amount of good conduct time they have lost, the maximum amount of time that could be restored was restored.	Information Provided
125.	Incarcerated individual shared concerns regarding Securus blocking them from making outgoing calls.	The OCO provided information shared by DOC staff regarding a DOC Securus liaison assisting the incarcerated individual to resolve the issue. This office also encourages the individual to reach back out to the OCO if the issue persists and we will investigate further.	Information Provided
126.	Incarcerated individual reports concerns regarding their sentence, classification and infractions they received. The individual requests that we review these items for policy compliance.	The OCO provided information about who to reach out to regarding their conviction. This office also reviewed the individual’s recent infractions and found they meet the "some" evidence standard used to support infractions. The OCO also reviewed the individual’s classification, including his custody level, and found it to comply with DOC 300.380 Classification and Custody Facility Plan Review. The OCO shared information with the individual about how to promote custody levels and request classification reviews as policy allows.	Information Provided

127.	Individual wants to move to a different prison, he is currently in a restrictive housing unit.	The OCO met with this individual in-person and over the phone. The DOC wants to place him in general population, however this individual refuses housing in the general population. The DOC is unwilling to move him to a different restrictive housing unit. This office informed the individual that DOC does not intend to transfer him to his desired prison, but that he still has the option of accepting a general population housing placement..	Information Provided
128.	Individual reported that DOC staff misquoted his statement in a report which caused many people to be taken to restrictive housing and have their tablets taken.	The OCO reviewed this concern and cannot comment on why other individuals were taken to restrictive housing. The DOC did recently identify multiple individuals involved in a highly violent security threat group that have participated in violence within DOC facilities. Per 320.250 electronic devices can be withheld if placement in restricted housing is for violence outside of a one-on-one fight.	Information Provided
129.	Person reports that a hold placed by DOC staff is preventing them from accessing Graduated Reentry (GRE). The person is requesting the hold be lifted so he can be approved for GRE.	The OCO provided information to the person regarding their Graduated Reentry (GRE) screening. OCO staff contacted the DOC staff who shared that per policy revocations will not be accepted to GRE due to the language in the sentencing alternative statute.	Information Provided
130.	Incarcerated individual relayed concerns regarding wanting to move to a facility located on the West side of the state.	The OCO reviewed the individual's custody facility plan and confirmed the individual requested to stay at their current facility. Thus, DOC did as the individual requested. The OCO informed the individual that if they have a desire to transfer to another facility, they will need to discuss this during their next custody facility plan.	Information Provided
131.	Person reported multiple medical concerns and said that Health Services is not seeing him. Person said that his medical concerns have prevented him from being able to eat.	The OCO provided information. The OCO reviewed this individual's health records and confirmed that he has regularly been seen by medical for multiple concerns, including chronic care. This individual has also been released and is no longer in total confinement. The OCO provided information about seeking healthcare in the community.	Information Provided
132.	Incarcerated individual relayed concerns regarding wanting OCO help to make sure their attorney is present when meeting with DOC staff.	The OCO spoke to DOC and confirmed that the individual is offered yard for three hours every day and can make a call to their attorney during that time, their attorney can contact the legal liaison to request a time and day for the phone call, counselors do rounds every week and the individual can verbally request a call be set up, and the individual can also maintain good behavior and comply with DOC requirements to earn a tablet and make calls from their cell.	Information Provided
133.	An anonymous incarcerated individual wrote to the OCO with reported concerns about	OCO staff reviewed the concerns, and will continue to monitor the TC programs state-wide.	Information Provided

	therapeutic community (TC) program.		
134.	Incarcerated individual shared concerns regarding releasing into reentry center (previously work release).	The OCO provided information regarding the custody level requirements before going into a reentry center. The OCO verified the individual was not within the correct custody level to transfer into a reentry setting. This office provided this information to the incarcerated individual.	Information Provided
135.	An external person reported that a certain officer was harassing their loved one.	The OCO could not find a pattern of harassment from the officer in question. The office found that the officer had written one infraction that was dismissed and no negative BOES.	Insufficient Evidence to Substantiate
136.	Incarcerated individual shared a concern on behalf of another individual regarding staff misconduct.	The OCO was unable to substantiate the concern due to insufficient evidence. The anonymous individual did not share any names and shared that there were no grievances filed pertaining to this issue. Due to the reasons listed, the OCO was unable to substantiate any evidence to investigate.	Insufficient Evidence to Substantiate
137.	Incarcerated individual relayed concerns regarding placement in IMU.	The OCO reviewed the individual's custody facility plan (CFP) and found no violation of DOC policy 300.380 as the individual was placed on a MAX program due to persistent infraction behavior.	No Violation of Policy

Intake Investigations

Airway Heights Corrections Center

138.	Loved one expressed concerns about an incarcerated individual's sentence.	The OCO has declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
139.	Loved one relayed concerns regarding difficulties an incarcerated individual is having with certain staff members.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
140.	Loved one relayed concerns regarding an incarcerated individual's facility placement.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
141.	Loved one relayed concerns regarding facility placement.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a	Person Declined OCO Assistance

		result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	
142.	Loved one relayed concerns regarding staff conduct.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
143.	Incarcerated individual relayed concerns regarding a delay in getting books approved.	The OCO confirmed the individual has been released prior to OCO involvement in this concern.	Person Released from DOC Prior to OCO Action
144.	Incarcerated individual shared concern regarding DOC staff targeting them.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
145.	Incarcerated individual shared concerns regarding DOC denying them graduated reentry (GRE) and making them do programming that they don't need to do.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
146.	Incarcerated person reports concerns with a DOC staff after they were terminated from a program.	The OCO provided technical assistance by providing self-advocacy information about how to file a resolution request to address this issue prior to OCO involvement. The OCO could not find any evidence the individual attempted to resolve this issue internally.	Technical Assistance Provided
147.	Incarcerated individual contacted the OCO requesting whether or not to utilize the DOC resolution program.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
148.	Incarcerated person reported concerns about a banking issue.	The OCO provided technical assistance by providing self-advocacy information about how to file a resolution request and appeal the issue to the next level of review to address this issue prior to OCO involvement.	Technical Assistance Provided
149.	Incarcerated individual shared concerns regarding DOC staff mistreating them and threatening to infract them.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
150.	Incarcerated person report a delay in passing out	The OCO provided technical assistance by providing self-advocacy information about how to file a resolution request to address this issue prior to OCO	Technical Assistance Provided

	commissary due to an event in the facility.	involvement. The OCO could not find any evidence the individual attempted to resolve this issue internally.	
151.	Incarcerated individual shared concerns regarding being denied for graduated reentry (GRE) for an infraction they were found not guilty of.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
152.	Incarcerated individual reported concerns with their recent past cellmate. The individual requested OCO assistance to ensure they were assigned a cellmate they get along with better.	The OCO provided the individual with self-advocacy information about how to report safety concerns and how to request a cell move. The OCO also provided information about how to file a resolution request to address this issue prior to OCO involvement.	Technical Assistance Provided
153.	Incarcerated individual shared concerns regarding DOC HQ embezzling money from checks they are receiving.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
154.	Incarcerated person reported property was taken during a cell search.	The OCO provided technical assistance to the individual by sharing information about how to file a tort claim and information about the tort claim process. The OCO verified the items were thrown out by DOC staff.	Technical Assistance Provided
155.	An incarcerated person reports they are missing a piece of mail that an external person has verified they sent.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
156.	Incarcerated person reported concerns about DOC staff.	The OCO was not provided enough details to investigate the reports. The OCO provided self-advocacy information about how to file a resolution request to address this issue prior to OCO involvement.	Technical Assistance Provided
157.	Incarcerated individual reports missing property and requests assistance in getting their property returned.	The OCO provided technical assistance to the individual by sharing information about how to file a tort claim and information about the tort claim process. The OCO verified the individuals items were lost.	Technical Assistance Provided
158.	Incarcerated individual shared concerns regarding their family being denied visitation.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
159.	An incarcerated person requested assistance with a property concern.	The OCO provided information about how to advocate for themselves internally with DOC prior to reaching out to the OCO. The OCO also shared information with the person about how to file a tort claim and information about the tort claim process.	Technical Assistance Provided
160.	Individual shared concerns regarding DOC delaying fixing facility bathrooms.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided

161.	Incarcerated person shares DOC lost all of their property during a transfer.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
Cedar Creek Corrections Center			
162.	Loved one relayed concerns regarding a work release denial.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
163.	Loved one relayed concerns regarding a denial of an extended family visit.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
Clallam Bay Corrections Center			
164.	Loved one relayed concerns regarding incarcerated individual's placement in the IMU.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
165.	Loved one relayed concerns regarding Securus outages.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
166.	Incarcerated person reported concerns about accessing a commissary refund.	The OCO provided technical assistance by providing self-advocacy information about how to file a resolution request and appeal the response to the next level to address this issue prior to OCO involvement. The OCO verified the person received information regarding their refund from DOC.	Technical Assistance Provided
167.	Incarcerated person reports an incident with DOC staff they felt was unfair.	The OCO also provided self-advocacy information about how to file a resolution request and appeal to the next level to address this issue prior to OCO involvement. The OCO verified the person withdrew their resolution requests.	Technical Assistance Provided

168.	An incarcerated person reports they want to be moved to a specific other unit.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
169.	Incarcerated person reports concerns regarding DOC staff moving him without conducting a Facility Risk Management Team (FRMT) meeting.	The OCO verified the person was moved for safety reasons and the DOC conducted a FRMT meeting shortly after moving the person. The OCO shared information about safety concerns and how to report them to DOC and how DOC responds to safety concerns. The OCO also provided self-advocacy information about how to file a resolution request to address this issue prior to OCO involvement.	Technical Assistance Provided
170.	Incarcerated person reported concern about issue with payment for outgoing mail the person was sending.	The OCO provided information about the mail process and rates. The OCO also provided self-advocacy information about how to file a resolution request to address this issue prior to OCO involvement.	Technical Assistance Provided
Coyote Ridge Corrections Center			
171.	A loved one of an incarcerated person reported that their family member is experiencing difficulty accessing hygiene items. A consent form was sent to the incarcerated person and not returned.	The incarcerated individual did not respond to the OCO's request to provide additional information within 30 days. The OCO encouraged this person to contact this office if they would like to request assistance.	Person Declined OCO Assistance
172.	Loved one relayed concerns regarding an incarcerated individual's mental health and safety concerns not being taken seriously.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
173.	Loved one relayed concerns regarding staff searching hobby and religious items and the two being mixed.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
174.	Loved one relayed concerns regarding a denial of an extended family visit.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in	Person Declined OCO Assistance

		error, to please contact this office to open a new case.	
175.	Loved one relayed concerns regarding an incarcerated individual needing certain programming before being eligible to release.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
176.	Incarcerated individual shared concerns regarding DOC staff taking their religious property and requested tort claim information.	The OCO provided technical assistance to the individual including tort claim information.	Technical Assistance Provided
177.	Incarcerated person reported concerns about their time calculation.	The OCO also provided self-advocacy information about how to file a resolution request and appeal the response to address this issue prior to OCO involvement. The OCO verified the individual received information about their time calculation.	Technical Assistance Provided
178.	Incarcerated person reports concerns regarding another person living in the same unit.	The OCO provided the individual with self advocacy information. The OCO Shared how to report concerns related to other people in the living unit through the resolution process and other investigation methods provided through DOC.	Technical Assistance Provided
179.	Incarcerated individual shared concerns regarding DOC withholding their funds.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
180.	Incarcerated person reported concerns about a potential investigation and wanted records related to it.	The OCO provided technical assistance by sharing how to file a DOC records request. The OCO also shared information about how to utilize the resolution program.	Technical Assistance Provided
181.	An incarcerated person reported an issue with inmate banking.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
182.	An incarcerated person reports DOC staff lost their property at a recent move.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
183.	Incarcerated person reported concerns with their cell.	The OCO also provided self-advocacy information about how to file a resolution request to address this issue prior to OCO involvement. The OCO could not find any evidence the individual attempted to resolve this issue internally.	Technical Assistance Provided
184.	Incarcerated individual shared concerns regarding DOC not responding to their infraction appeal and fearing it may affect their graduated reentry (GRE).	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided

Monroe Correctional Complex			
185.	Loved one relayed concerns regarding an incarcerated individual's placement in IMU.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
186.	Loved one relayed concerns regarding an incarcerated individual's placement in IMU after facial feminization surgery.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
187.	Loved one relayed concerns regarding an incarcerated individual being removed from SOTAP programming.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
188.	Loved one relayed concerns regarding an infraction.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
189.	Loved one relayed concerns regarding infractions.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
190.	An incarcerated person reports their property was lost by DOC at their most recent facility transfer.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
191.	Incarcerated individual reported concerns regarding religious services.	The OCO provided information about how to advocate for themselves internally with DOC prior	Technical Assistance Provided

		to reaching out to the OCO. The OCO provided this information to the individual over the OCO Hotline.	
192.	Person reports their property has been lost by DOC.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
193.	Incarcerated individual reports concerns regarding refunds for cost of supervision.	The OCO provided self advocacy information about how to file a resolution request to address this issue prior to OCO involvement. The OCO also shared information with the person about how to file a tort claim and information about the tort claim process.	Technical Assistance Provided
194.	Incarcerated person reported concerns about a religious service.	The OCO provided self-advocacy information about how to file a resolution request to address this issue prior to OCO involvement. The OCO could not find any evidence the individual attempted to resolve this issue internally.	Technical Assistance Provided
195.	Incarcerated person reports concerns regarding a past sentence.	The OCO provided technical assistance by providing self-advocacy information about how to file a resolution request to address this issue prior to OCO involvement. The OCO could not find any evidence the individual attempted to resolve this issue internally. The OCO also provided information about how to file a DOC public records request to review their records.	Technical Assistance Provided
196.	Incarcerated individual shared concerns regarding DOC staff mistreating them.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
197.	Incarcerated individual shared concerns regarding a facility chaplain not allowing them to have a medicine bag.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
198.	Incarcerated person reported concerns about the quality of their television service.	The OCO verified the facility is working with DOC headquarters to secure funding to resolve the issue. The OCO provided the person with technical assistance by sharing how to appeal resolution requests to the next level if they believe the response was inadequate.	Technical Assistance Provided
199.	An incarcerated person asked for information on how to access documents through DOC's Public Records process.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
200.	Incarcerated individual reports concerns about obtaining video footage and requested information about how to obtain footage. The individual reported concerns regarding contraband being planted in his cell.	The OCO provided information about how to request footage they are wanting and have it sent to an outside person. The OCO also provided self advocacy information about how to file a resolution request to address this issue prior to OCO involvement.	Technical Assistance Provided
Olympic Corrections Center			

201.	Loved one relayed concerns regarding an incarcerated individual's dental needs not being met.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
202.	Incarcerated individual shared concerns regarding DOC staff retaliating against them.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
203.	Incarcerated individual reports concerns regarding the amount of gratuity paid out, and reports that he is not being paid correctly.	The OCO provided information about how to appeal resolution requests if they believe response they receive is not adequate. We also reviewed the resolution request, and found the DOC provided the individual with information about his pay scale. The OCO verified the individual is being paid per policy.	Technical Assistance Provided
Other			
204.	Loved one expressed concerns regarding their loved one's placement in a jail facility.	The OCO declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
205.	Loved one expressed concerns about an individual who is in a jail facility.	The OCO has declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
206.	Loved one expressed concerns about a community corrections officer's conduct.	The OCO has declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
207.	Loved one expressed concerns about an individual who is in a jail facility.	The OCO has declined to move the complaint beyond the intake investigation phase per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
208.	Individual relayed concerns regarding several cruel and unusual punishments while incarcerated at Pierce County Jail.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
209.	Individual expressed concerns about conduct while in a jail facility.	The OCO declined to investigate this concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
210.	Individual relayed concerns regarding concerns while at Grays Harbor County Jail.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
211.	Individual relayed concerns regarding medical concerns while at Snohomish County Jail.	The OCO declined to investigate the concern per WAC 138-10-040(3)(a) as the ombuds lacks jurisdiction over the complaint.	Lacked Jurisdiction
Stafford Creek Corrections Center			

212.	Individual states DOC has not signed him up for healthcare.	Individual released before the OCO reviewed the concern.	Person Released from DOC Prior to OCO Action
213.	Incarcerated individual shared concerns regarding not receiving their property post transfer.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
214.	Incarcerated individual shared concerns regarding DOC taking their purchased property.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
215.	An incarcerated person reports an issue with their LFO deductions.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
216.	Incarcerated individual reported concerns about an interaction they had with DOC staff.	The OCO provided information about how to advocate for themselves internally with DOC prior to reaching out to the OCO. The OCO reviewed the individuals file and could not locate any negative impacts as a result of the reported incident.	Technical Assistance Provided
217.	Incarcerated individual reports concerns regarding their cellmate and unit placement.	The OCO provided information about how to make a cell move request. The OCO also shared information about how to utilize the DOC resolution process to address these concerns prior to OCO involvement.	Technical Assistance Provided
218.	Incarcerated person reported concerns with their Community Corrections Officer prior to being incarcerated. The person also shared concerns about their recent conviction.	The OCO cannot review a person underlying conviction, however this office provided the person with legal resources available. This office also shared how to report concerns related to Community Corrections Officers. The OCO also provided information about the resolution program and how to access it.	Technical Assistance Provided
219.	Incarcerated person reports concerns about how DOC staff are handling their mail.	The OCO also provided self-advocacy information about how to appeal a resolution request to the next level prior to OCO involvement.	Technical Assistance Provided
220.	Incarcerated individual shared concerns regarding DOC taking their money.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
221.	An incarcerated person expressed frustration with the lack of information about the status of a visitation application with their child.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
Washington Corrections Center			
222.	Loved one relayed concerns regarding an EFV application delay.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated	Person Declined OCO Assistance

		individual that if they believe the case was closed in error, to please contact this office to open a new case.	
223.	Loved one relayed concerns regarding an infraction.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
224.	Loved one relayed concerns regarding an incarcerated individual not getting on the medical assisted treatment (MAT) program.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
225.	Incarcerated person reported concerns about access to their tablet and had questions about how to have the tablet returned.	The OCO provided the person with information and resources about how to be re-issued a tablet and report SecurUs concerns. The OCO also provided self-advocacy information about how to file a resolution request to address this issue prior to OCO involvement.	Technical Assistance Provided
226.	An incarcerated person reports they are not able to access their media on their tablet.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
227.	Incarcerated individual reported concerns regarding their time calculation and shared they wish to transfer to graduated reentry(GRE) or a reentry center.	The OCO provided information about how to advocate for themselves internally with DOC prior to reaching out to the OCO. The OCO also shared information about GRE and reentry center eligibility and access.	Technical Assistance Provided
228.	An incarcerated person reports they have concerns about the facility they are going to be moved to.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
Washington Corrections Center for Women			
229.	Loved one relayed concerns regarding an infraction.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance

230.	Incarcerated individual reports concerns related to DOC staff conduct.	The OCO also provided self-advocacy information about how to file a resolution request and appeal the response if it is not adequate to address this issue prior to OCO involvement.	Technical Assistance Provided
Washington State Penitentiary			
231.	Loved one relayed concerns regarding a power outage in the cell.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
232.	Loved one relayed concerns regarding an incarcerated individual needing access to glasses that were sent in and proper orthopedic shoes.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
233.	Loved one relayed concerns regarding an incarcerated individual being harassed by a certain staff member.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
234.	Loved one relayed concerns regarding an incarcerated individual needing to be seen by medical.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
235.	Loved one relayed concerns regarding an infraction.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	Person Declined OCO Assistance
236.	Loved one relayed concerns regarding facility placement.	The OCO sent the incarcerated individual an ombuds review request form to ensure that this was a concern that they consented to having	Person Declined OCO Assistance

		investigated but never received the form back. As a result, this concern was closed without further investigation. The OCO informed the incarcerated individual that if they believe the case was closed in error, to please contact this office to open a new case.	
237.	An incarcerated person requested information related to their Earned Release Date (ERD). They reported they had not yet requested information from their counselor.	This person was released prior to the OCO taking action on the complaint.	Person Released from DOC Prior to OCO Action
238.	Incarcerated individual shared concerns regarding their attorney not returning their legal documents despite the individual requesting them back.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
239.	An incarcerated person reports they are not able to access their media and old emails on their tablet.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided
240.	Incarcerated individual reported concerns about access to their commissary order.	The OCO verified the individual was set to receive their commissary unless the facility hearing department had disciplinary reason to remove the access. The OCO also provided self-advocacy information about how to file a resolution request to address this issue if it persists prior to OCO involvement.	Technical Assistance Provided
241.	An incarcerated person asked for a copy of an LFO summary.	The OCO provided technical assistance to the incarcerated person so they can advocate for themselves.	Technical Assistance Provided

Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-007

Report to the Legislature

As required by RCW 72.09.770

July 19, 2024

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

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Unexpected Fatality Review Committee Report

UFR-24-007 Report to the Legislature–600-SR001

Legislative Directive and Governance

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

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

This report describes the results of one such review and presents recommendations. Within ten days of the publication of this report, DOC must publish an associated corrective action plan. DOC will then have 120 days to implement that plan.

Disclosure of Protected Health Information

RCW 72.09.770 requires DOC to disclose protected health information - including mental health and sexually transmitted disease records - to UFR committee members. 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 June 12, 2024:

DOC Health Services
- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Ryan Quirk, Director – Mental Health
- Dr. Bhinna Park, Chief of Psychiatry
- Dr. Zainab Ghazal, Administrator
- Dr. Rae Simpson, Director – Quality Systems
- Mark Eliason, Deputy Assistant Secretary
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division
- James Key, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Program Manager
- Rochelle Stephens, Men's Prisons project Manager

DOC Risk Mitigation
- Mick Pettersen, Director

Office of the Corrections Ombuds (OCO)
- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Deputy Director
- EV Webb, Assistant Corrections Ombuds – Investigations
- Madison Vinson, Assistant Corrections Ombuds - Policy

Department of Health (DOH)
- Brittany Tybo, Deputy Director, Office of Nutrition Services

Health Care Authority (HCA)
- Dr. Heather Schultz, Associate Medical Director

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

Fatality Summary

Year of Birth: 1994 (29-years-old)

Date of Incarceration: May 2022

Date of Death: March 2024

At the time of his death, this incarcerated individual was housed in a DOC prison facility.

His cause of death was severe traumatic brain injury. The manner of his death was homicide.

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

<table>
<tr><th colspan="2">Days Prior to Death</th><th>Event</th></tr>
<tr><td rowspan="4">7 days prior</td><td>2016 hours</td><td>• After incident review of security video, showed the incarcerated individual walking with a second incarcerated individual into the unit recreation yard.</td></tr>
<tr><td>2032 hours - 2040 hours</td><td>• The recreation period ends, and the yard began to clear.
• Custody staff observed the second incarcerated individual with blood on clothing as he was exiting the yard, and he was detained for questioning.
• Custody staff began searching the yard for anyone that may be injured.</td></tr>
<tr><td>2044 hours</td><td>• The incarcerated individual was found unresponsive.
• Medical emergency response was requested, and first aid provided.</td></tr>
<tr><td>2049 hours - 2122 hours</td><td>• Facility medical staff arrived and rendered aid.
• Community Emergency Medical Services (EMS) were requested.
• EMS arrived, assumed care, and transported him to the hospital.</td></tr>
<tr><td>6 days prior</td><td>0732 hours</td><td>• He was placed on DOC seriously ill status.</td></tr>
<tr><th colspan="2">Day of Death</th><th>Event</th></tr>
<tr><td>Day 0</td><td>0234 hours</td><td>• He was pronounced deceased by the community hospital.</td></tr>
</table>

UFR Committee Discussion

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

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

   1. The committee found:

      a. The medical emergency response was appropriate.

      b. He was diagnosed with autism spectrum disorder with attention deficit hyperactivity disorder. Neuro-psychological testing documented an approximate IQ of 81.

      c. He was coded correctly in the DOC electronic case management system for developmental disability support needs based on the current criteria.

   2. The committee recommended:

      a. Referring to the UFR committee for review.

      b. Exploring updating the Health Services coding to accurately reflect the definition of developmental disability in accordance with RCW 71A.10.020.

      c. Exploring opportunities for Health Services to actively engage in housing/placement decisions for incarcerated individuals with identified intellectual and developmental disabilities.

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

   1. The CIR found:

      a. Custody staff were not present in the recreation yard at the time of the incident.

      b. There was limited visibility in the corner of the recreation yard where the incident took place.

      c. Staff experienced limited and broken radio communication during the incident response.

   2. The CIR recommended:

a. Increase recreation yard walkthroughs and visibility of custody staff.

b. Install additional lighting to assist with visibility in the recreation yard.

c. Implement planned upgrades to the radio system to ensure access is adequate for daily and emergency operations.

C. The committee reviewed the unexpected fatality, and the following topics were discussed.

1. Housing decisions and classification levels.

The committee discussed whether the diagnosis of an intellectual or developmental disability would have impacted this incarcerated individual's housing placement and custody level. DOC stated that if an individual had a diagnosis of developmental disability this may have triggered heightened case management and may have impacted the adjudication of infractions he received. The committee discussed the resources available in close custody or more restrictive settings for individuals needing skill building supports including the Sky River Unit at Monroe Correctional Center and the Specialized Housing units at the Washington State Penitentiary.

The committee discussed the classification review which triggered the move of this individual to a general close custody housing unit rather than being placed in protective custody or other specialized housing unit. The Ombuds expressed concerns about safety related to the incarcerated individual's placement in a general close custody unit with known violence. DOC indicated that staff members had interviewed him on multiple occasions, and he stated he was okay living there.

2. Structural and equipment issues.

The committee discussed the technical issues related to the incident, specifically focusing on the radio system, lighting, and cameras. DOC shared that updates are currently underway for each of these systems. Specifically:

a. Radio system updates: The radio system upgrade was funded in 2023. The project was initiated in May of 2023 and installation of new equipment and shelter initiated on April 23, 2024. The new radio system went live on June 29th, 2024. This was a major upgrade to the system requiring extensive multi-year planning and implementation.

b. Additional lighting: A capital project was initiated in the 19-21 biennium budget. However, the agency is allocated limited funding for capital projects as designated through legislative process. Typically, priority requests are usually more urgent deferred maintenance issues as compared to new programmatic requests. This would be categorized and prioritized as a new programmatic request.

c. The initial lighting in the area was designed and installed per contractor specifications. On the Northeast corner of the recreation yard, there were two additional cobra heads lights installed on the rack to provide lighting. The light models initially installed per the contract's specifications were within specifications of the city's permitting

requirements regulating the amount of light emitted to prevent light pollution.

On the Northeast side of the cemetery, 2 additional cobra head lights were installed. The additional new installation does enhance the field of view for surveillance area wide. New lights have also been installed to enhance visibility in other locations. On the south side of a unit, facility staff installed two additional flood lights that are aimed at the three tables that were near the incident site.

d. Camera adjustments: The existing cameras have been adjusted to cover specific areas of the yard. In the NE corner of the yard. There were blind spots in the cameras view. Those cameras have been adjusted minimizing the blind spots.

e. Capital project: There is a capital project underway to install new cameras and construct an additional tower to improve overall security and surveillance to enhance monitoring capabilities. This request is subject to the agency and legislative prioritization and approval process.

3. Monitoring of the yard.

   The committee discussed safety protocols for custody staff. DOC is piloting changes to yard patrols, assigning four (4) officers to patrol the yard twice during each recreation period. These updated patrols aim to enhance security and will be reviewed to evaluate effectiveness.

Committee Findings

The incarcerated individual died as a result of severe traumatic brain injury. The manner of death was homicide.

Committee Recommendations

Table 1 presents the UFR Committee's recommendations to prevent similar fatalities and further strengthen safety and health protections for incarcerated individuals. As required, the DOC will develop, publish, and implement an associated corrective action plan within 10 days following the publishing of this report.

Table 1. ***UFR Committee Recommendations***
1. DOC should review and update their classification and health services support needs coding processes to better support individuals with developmental disabilities.

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 continue to pursue an electronic health record when full legislative funding becomes available.

Unexpected Fatality Review
DOC Corrective Action Plan

Unexpected Fatality UFR-24-007

Report to the Legislature

As required by RCW 72.09.770

July 29, 2024

DOC Corrective Action, Publication Number 600-PL001

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

Unexpected Fatality Review DOC Corrective Action Plan

DOC Corrective Action Publication Number 600-PL001

Legislative Directive

Engrossed Substitute Senate Bill 5119 (2021)

Unexpected Fatality Review Governance

RCW 72.09.770 requires the Department of Corrections (DOC) to convene an Unexpected Fatality Review (UFR) committee and meeting in any case "in which the death of an incarcerated individual is unexpected, or any case identified by the Office of the Corrections Ombuds." The department is also required to issue a report on the results of the review within 120 days of the fatality and, within 10 days of completion of the review, develop an associated corrective action plan to implement any recommendations made by the review team. The statute took effect July 25, 2021.

The "primary purpose of the unexpected fatality review shall be the development of recommendations to the department and legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for prisoners in the custody of the department."

"'Unexpected fatality review' means a review of any death that was not the result of a diagnosed or documented terminal illness or other debilitating or deteriorating illness or condition where the death was anticipated and includes the death of any person under the jurisdiction of the department, regardless of where the death actually occurred. A review must include an analysis of the root cause or causes of the unexpected fatality, and an associated corrective action plan for the department to address identified root causes and recommendations made by the unexpected fatality review team under this section."

Unexpected Fatality Review Committee Report

The department issued the UFR committee report #24-007 on July 19, 2024 (DOC publication 600-SR001). This document includes the required corrective action plan. The department is required to implement the corrective actions within 120 days from the corrective action plan publication.

Corrective Action Plan

CAP ID Number:	UFR-24-007-1
Finding:	The current DOC system of classification and the Health Services support needs coding tool did not identify that this incarcerated individual, diagnosed with autism, required additional staff support and had need for accommodation.
Root Cause:	The current DOC processes for identifying, case managing, and housing individuals with developmental disabilities during incarceration are not standardized.
Recommendations:	DOC should review and update their classification and health services support needs coding processes to better support individuals with developmental disabilities.
Corrective Action:	DOC Health Services will recommend to the Executive Leadership Team the establishment of a workgroup to review current DOC practice, identify gaps, and make recommendations for improvement to standardize processes and protocols for identifying, coding, classifying and appropriately housing incarcerated individuals with intellectual and developmental disabilities, including autism.
Expected Outcome:	Standardized processes will better support incarcerated individuals and staff.

The Office of the Corrections Ombuds (OCO) investigates complaints regarding any Department of Corrections' (DOC) actions or inactions that adversely affect the health, safety, welfare, and rights of incarcerated individuals. RCW 43.06C.040. RCW 43.06C.040(2)(k) directs the ombuds to render a public decision on the merits of each complaint at the conclusion an investigation. All cases opened by the OCO are considered investigations for the purposes of the statute. As of March 15, 2022, the OCO opens an investigation for every complaint received by this office. The following pages serve as the public decisions required by RCW 43.06C.040(2)(k).

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

All published monthly outcome reports are available at https://oco.wa.gov/reports-publications/reports/monthly-outcome-reports.

Abbreviations & Glossary

ADA: Americans with Disabilities Act

AHCC: Airway Heights Corrections Center

ASR: Accommodation Status Report

BOE: Behavioral Observation Entry

CBCC: Clallam Bay Corrections Center

CCCC: Cedar Creek Corrections Center

CI: Correctional Industries

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

CO: Correctional Officer

CRC: Care Review Committee

CRCC: Coyote Ridge Corrections Center

CUS: Correctional Unit Supervisor

DES: Department of Enterprise Services

DOSA: Drug Offender Sentencing Alternative

EFV: Extended Family Visit

ERD: Earned Release Date

GRE: Graduated Reentry

HCSC: Headquarters Community Screening Committee

HSR: Health Status Report

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

J&S: Judgment and Sentence

MCC: Monroe Correctional Complex

MCCCW: Mission Creek Corrections Center for Women

OCC: Olympic Corrections Center

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

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

SCCC: Stafford Creek Corrections Center

SOTAP: Sex Offender Treatment and Assessment Program

SVP: Sexually Violent Predator

TC: Therapeutic Community

WaONE: Washington ONE ("Offender Needs Evaluation")

WCC: Washington Corrections Center

WCCW: Washington Corrections Center for Women

WSP: Washington State Penitentiary