



Quarterly Meeting

1st Quarter: January – March 2025

April 18, 2025 | OCC
April 16, 2025 | VIRTUAL

OCO Community Meeting

April 16, 2025, 4:00 – 5:00pm

AGENDA

Welcome & Review Agenda	4:00-4:05pm (5 min)
OCO First Quarter 2025 Presentation	4:05-4:25pm (20 min)
Questions & Answers Session <ul style="list-style-type: none">• Community agreements• Live public comments & questions	4:25-4:55pm (30 min)
Closing	4:55-5:00pm (5 min)

OCO VISION

We envision a more humane and transparent Washington corrections system.

OCO MISSION

We provide opportunities for people impacted by incarceration to raise issues and resolve conflicts. We work to reduce harm in the Washington corrections system by negotiating outcomes, recommending positive change, and reporting individual and systemic concerns.

OCO CORE VALUES

INTEGRITY RESPECT COLLABORATION
EQUITY COURAGE

Our Purpose

Provide information

Promote public awareness & understanding

Ensure compliance with relevant statutes, rules, and policies

Identify system issues and responses for the governor and the legislature to act upon



OCO Data

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OCO Hotline

Free & Confidential

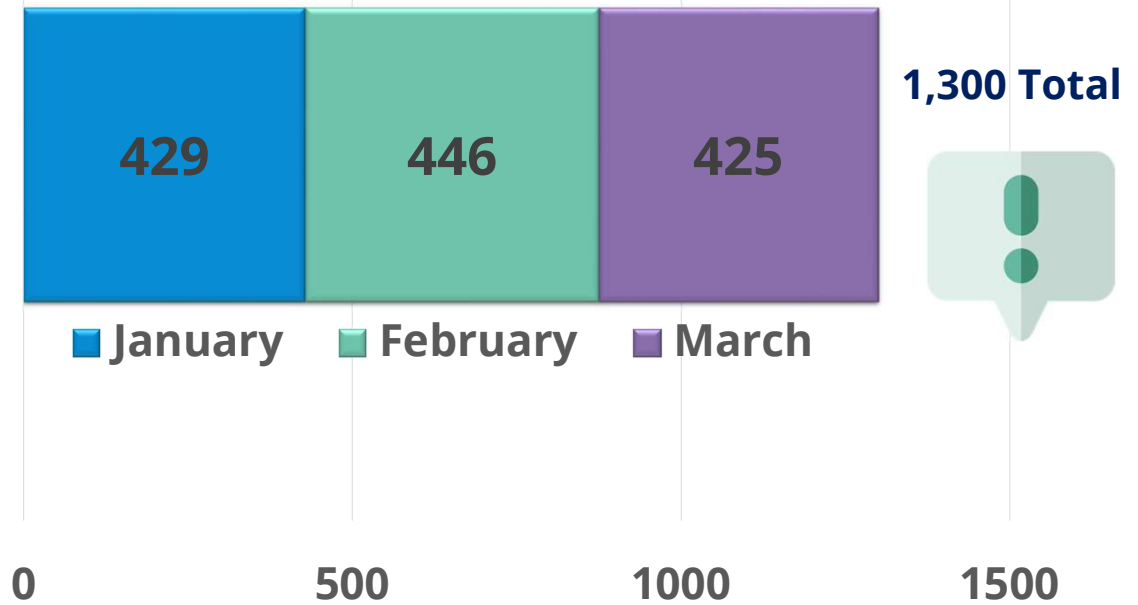
Average of

27

calls per day

Total Calls in the 1st Quarter

52% of calls were reporting new cases.



1070

OCO Complaints Received in 1st Quarter

Top 3 concerns statewide:

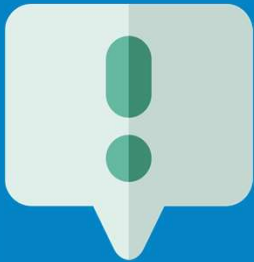
1. Appeals and Resolutions*
2. Staff Misconduct
3. Healthcare



*Includes all topics that may be appealed or grieved.

Men's Prison Division

Most Complaints Received in
1st Quarter 2025



Washington State Penitentiary: 279

Top concerns:

1. Appeals and Resolutions
2. Staff Conduct
3. Healthcare

Monroe Correctional Complex: 266

Top concerns:

1. Appeals and Resolutions
2. Healthcare
3. Staff Conduct

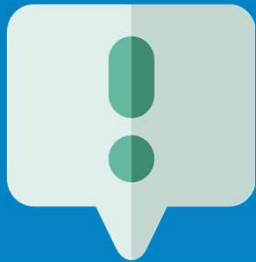
Airway Heights Corrections Center: 262

Top concerns:

1. Staff Conduct
2. Appeals and Resolutions
3. Healthcare

Women's Prison Division

Complaints Received in
1st Quarter 2025



Washington Corrections Center for Women: 77

Top concerns:

1. Appeals and Resolutions
2. Staff Conduct
3. Healthcare

Mission Creek Corrections Center for Women: 12

Top concerns:

1. Appeals and Resolutions
2. Staff Conduct
3. Healthcare

CASE INVESTIGATIONS: 507

Assistance Provided: 110
Information Provided: 215
DOC Resolved: 76
Insufficient Evidence to Substantiate: 22
No Violation of Policy: 79
Substantiated: 5

INTAKE INVESTIGATIONS: 398

Declined: 3
Lacked Jurisdiction: 23
Person Declined OCO Involvement: 55
Person Released from DOC Prior to OCO Action: 32
Technical Assistance Provided: 285

UNEXPECTED FATALITY REVIEWS: 5

Total Investigations Completed: **914**

Monthly Outcome Reports

January – March 2025

Assistance, Technical Assistance,
or Information Provided in

67%

of investigations completed

- UFR Committee Members are representatives from: OCO, DOH, HCA, and DOC
- OCO can request reviews of deaths not identified by the DOC as “unexpected”
- UFR Committee Members review incident reports, medical records, video, and other relevant documentation
- UFR Committee meets to discuss findings, questions, and recommendations

Unexpected Fatality Reviews (UFRs)

January – March 2025

Five fatality review meeting reports were published in Q1 2025. The deaths reviewed were attributed to:

- **suicide** (UFR# 24-011)
- **overdose** (UFR# 24-012)
- **neurological** (UFR# 24-019)
- **vascular disease** (UFR # 24-015 & 24-023)

The UFR Committee recommended:

- Remind custody staff of appropriate use and location of the ligature removal tool.
- Provide clarification to staff that the DNR request does not apply to self-harm events per Policy 620.010 Advance Directives.
- Direct staff to ensure cell windows are not fully covered.
- Update the identification badge DNR flag language to include “Does not apply in instances of self-harm.”



Investigation Examples

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Assistance Provided: Example 1

Reported Concerns: Person uses a wheelchair and cannot walk. Person said that DOC staff came to transfer him, but did not have a special wheelchair transport van as required by his HSR, so officers lifted him out of his wheelchair and carried him onto the chain bus. This occurred on two consecutive days. When they arrived at the new facility, staff refused to accept his transfer because the facility could not accommodate wheelchairs. The person was then served three infractions for refusing to get off the bus, despite the fact that it was the facility who refused the transfer, not the person.

OCO Actions: The OCO confirmed that this individual uses a wheelchair and requires special transport. The OCO reviewed the infractions and alerted DOC to these concerns. The OCO then asked DOC to dismiss and remove the infractions from his record.

Negotiated Outcomes: The DOC agreed and removed the infractions.



Assistance Provided: Example 2

Reported Concerns: Person reported that his religious group was not allowed to use candles during a ceremony, violating DOC policy and a previous OCO report.

OCO Actions: The OCO reviewed the individual's resolution requests and found that DOC acknowledged they were unaware of this information, and in the future, candles will be allowed during their ceremonies.

Negotiated Outcomes: The OCO contacted the facility and confirmed DOC staff will follow 560.200, allowing candles during religious ceremonies.



Assistance Provided: Example 3

Reported Concerns: Person reported they were given an infraction for possessing sexually explicit material in a tattoo book. This book is not on the list of banned books from DOC and is allowed at other facilities across the state.

OCO Actions: The OCO reviewed the infraction and asked the facility to reconsider, as this book is not on the statewide list of banned books and there is no evidence to suggest the individual was using it inappropriately.

Negotiated Outcomes: As a result of OCO outreach, the facility agreed to overturn the infraction.



Assistance Provided: Example 4

Reported Concerns: An anonymous person reported a concern about UW Harborview Medical Center attempting to transfer a patient back to a DOC facility which would not have been able to provide the level of care needed.

OCO Actions: OCO staff elevated this concern to the DOC Chief Medical Officer who communicated with the hospital.

Negotiated Outcomes: The patient was kept at the hospital so he could continue receiving the level of care he needed.



OCO Actions

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OCO UFR Annual Report

Published January 2025

The top causes of unexpected deaths in DOC were overdoses and suicides. OCO continues to urge DOC to implement: (1) meaningful, and universally available, substance use disorder treatment and (2) statewide access to 988 Suicide and Crisis Lifeline services inside prisons.

Of the 89 recommendations from the UFR Committee, DOC created CAPs for 29% and chose to designate 71% of the recommendations as Consultative Remarks for DOC to consider.

After negotiations, DOC agreed to three recommendations made by the OCO in this report:

- Recommendation 1: **Convene quarterly Unexpected Fatality Review Committee process meetings.**
- Recommendation 2: **Track, assign, and respond to Unexpected Fatality Review Committee “Consultative Remarks.”**
- Recommendation 3: **Prioritize access to the 988 Suicide and Crisis Lifeline inside WADOC prisons.**

Total Deaths in WADOC Custody:

46

UFR Reports:

26

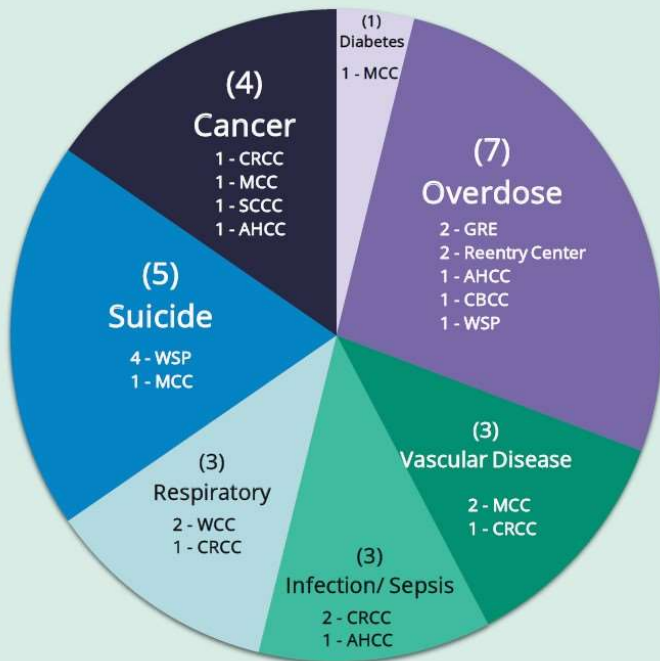
UFRs with CAPs:

13

UFRs without CAPs:

13

WADOC UFR Reports by Cause of Death and by Location in Fiscal Year 2024



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Patients can find the
 OCO Spotlight and
 more information on
 the FYI App

OCO Spotlight



Addressing Dental Care Delays in DOC Prisons

After addressing complaints from incarcerated patients regarding delayed access to dental care statewide, the OCO has effectively negotiated a resolution with DOC. This agreement aims to tackle dental appointment backlogs and enhance the timeliness of services.

OCO Actions & Outcomes

In Fall 2024, the OCO urged DOC Health Services leadership to create a plan to address the long backlog of dental appointments that were put on hold when COVID began. COVID safety protocols had been updated and patients could once again see dental for routine and urgent care needs; however, patients still reported delayed access to dental care and the backlog continued to grow. After OCO meetings with DOC Health Services leadership, DOC assigned project managers to assist with accurately tracking and addressing the dental backlog. **The DOC Assistant Secretary of Health Services agreed to continue monthly meetings with the OCO to provide updates about dental services across the state.**

The OCO identified that DOC dentists were handling their own scheduling and taking fewer than five patients a day. **After lengthy negotiations, the DOC agreed to ensure dental appointments are set by the scheduling specialists with a goal of increasing the number of appointments.** DOC created a scheduling tool that outlines the typical timelines needed for different procedures so that schedulers can build schedules that match community standards. **DOC also moved forward with staffing and preparing the traveling dental clinic.**

As the OCO continues to receive dental concerns from incarcerated patients, the office will review and attempt to resolve individual cases while also tracking systemic issues and improvements.

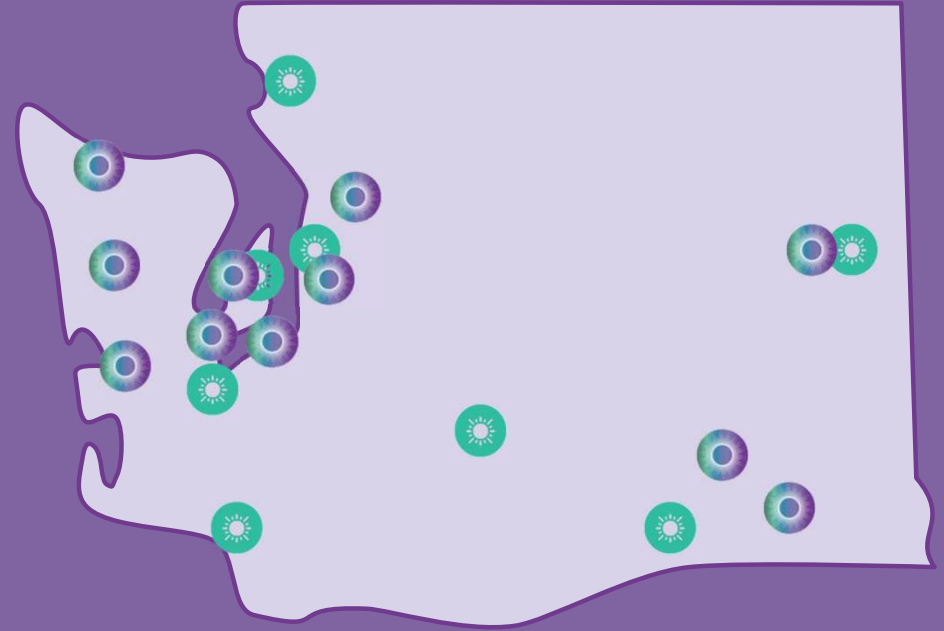
Monitoring Visits January – March 2025

43

Prison & Reentry Centers

OCO staff also attend special events and group meetings in facilities whenever possible. This quarter included:

- CLO Meeting Presentation at MCC
- Alliances Community Gathering at MCC
- BPC Meetings at SCCC & WCC
- LGBTQ Meetings at SCCC
- New Freedom Group at MCC
- PEAR-CAT at WCCW



“The way to right wrongs is to turn the light of truth upon them.”

Ida B. Wells, 1892

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Submit a Complaint



Confidential Hotline:
(360) 664-4749

Mon: 1:00 – 3:00 PM

Tues: 1:00 – 3:00 PM & 4:00 – 6:00 PM

Wed: 1:00 – 3:00 PM & 4:00 – 6:00 PM

Thur: 1:00 – 3:00 PM

Mailing Address:

PO Box 40009
Olympia, WA 98504

SUBMIT

Online:

oco.wa.gov/submit-complaint



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Comments, Questions & Answers Session



The OCO is committed to creating and maintaining respectful and courteous conversations at our public meetings. We expect all participants to refrain from engaging in hostile, intimidating, and offensive activities or behaviors that may amount to discrimination, harassment, sexual harassment, or bullying.

- Provide space for other voices to be heard.
- Be open to topics brought forth by others.
- Please feel welcome to raise your hand to ask a question or offer a comment, or type your question using the Q&A function.