



**SLIDES FOR
OCO QUARTERLY
MEETINGS**

JANUARY 2024

OFFICE OF THE CORRECTIONS OMBUDS

QUARTERLY MEETING

JANUARY 19, 2024: MISSION CREEK CORRECTIONS CENTER FOR WOMEN

JANUARY 26, 2024: ZOOM



PURPOSE OF THE OCO

- Provide information
- Promote public awareness & understanding
- Ensure compliance with relevant statutes, rules, & policies
- Identify system issues and responses for the governor & the legislature to act upon

OCO VISION

The OCO envisions a more humane and transparent Washington Corrections System.

MISSION

The OCO is on a mission to 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.

CORE VALUES

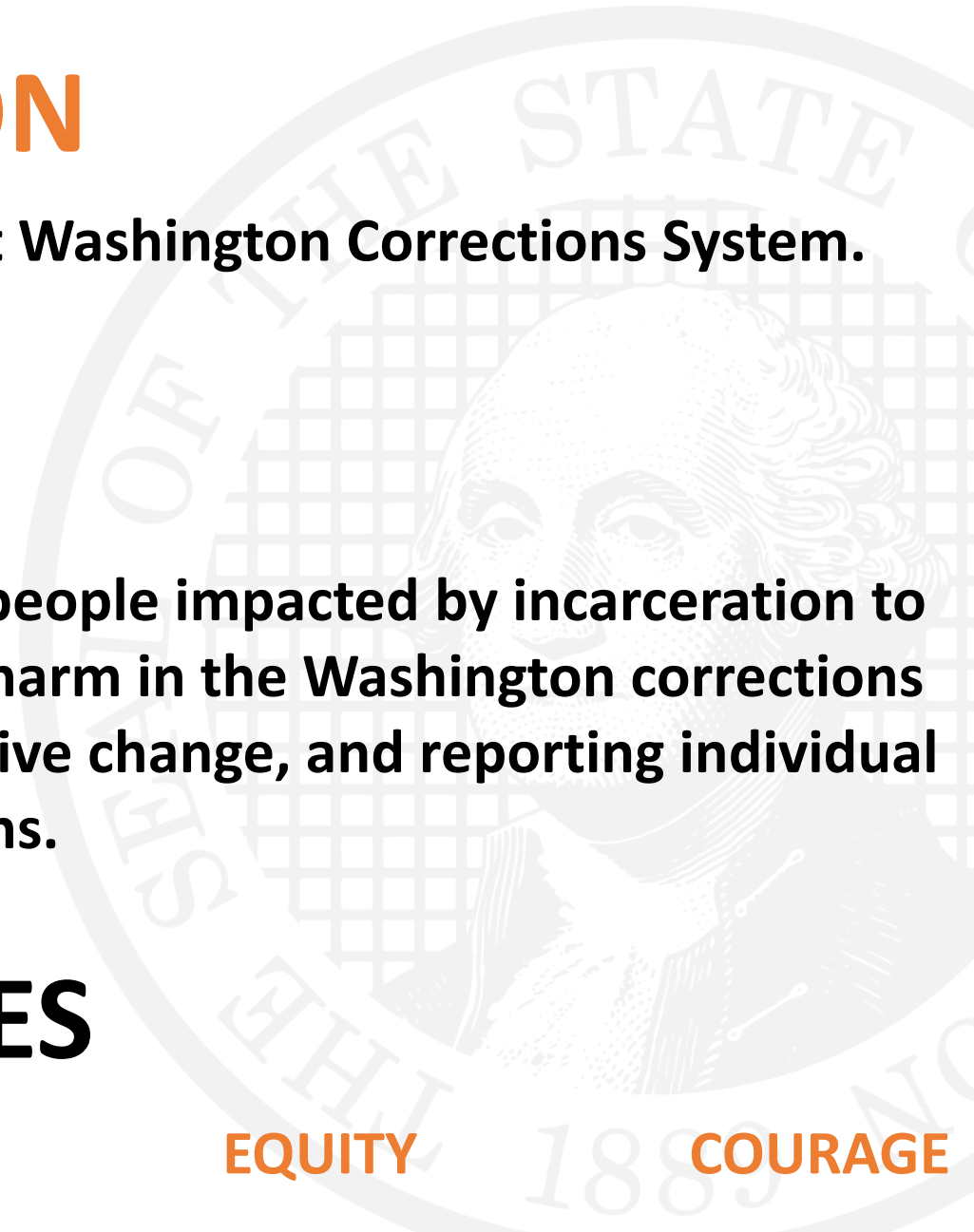
INTEGRITY

RESPECT

COLLABORATION

EQUITY

COURAGE

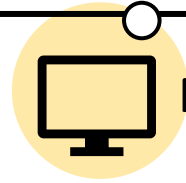


PHASES OF A COMPLAINT



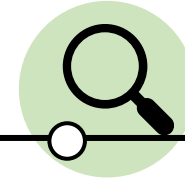
PHASE 1: INTAKE

Complaints can be reported via hotline, mail, or webform.



PHASE 2: TRIAGE SCREENING

Complaints are screened for OCO jurisdictional requirements and resource availability.



PHASE 3: DETERMINE INVESTIGATION TYPE

The case holder determines the investigation type.



PHASE 4: DOCUMENTATION & EVIDENCE REVIEW

The case holder reviews documentation and evidence related to the complaint.



PHASE 5: FINDINGS & NEGOTIATION

Once documentation and evidence is reviewed the case holder will contact the DOC to negotiate a possible resolution.



PHASE 6: OUTCOMES & CASE CLOSING

Once an outcome is determined, the case holder will close the case and notify the incarcerated individual by mail of the findings and outcome.



OCO DATA

4th Quarter

October – December 2023

MONTHLY OUTCOME REPORT NUMBERS

Q4: OCTOBER - DECEMBER 2023

CASE INVESTIGATIONS: 647

Assistance Provided: 102
Information Provided: 293
DOC Resolved: 84
Insufficient Evidence to Substantiate: 50
No Violation of Policy: 117
Substantiated: 1

INTAKE INVESTIGATIONS: 300

Administrative Remedies Not Pursued: 205
Declined: 43
Lacked Jurisdiction: 16
Person Declined OCO Involvement: 25
Person Left DOC Custody Prior to OCO Action: 11

UNEXPECTED FATALITY REVIEWS: 9

TOTAL RESOLVED INVESTIGATIONS

956

WITH ASSISTANCE OR INFORMATION
PROVIDED IN

61%

OF CASE INVESTIGATIONS

OCO COMPLAINTS

WOMEN'S PRISON DIVISION

Washington Corrections Center for Women: 25

Top 3 concerns: Healthcare, Staff Conduct, & Resolution Program

Mission Creek Corrections Center for Women: 1

Concern was about: Healthcare

OCO COMPLAINTS

MEN'S PRISON DIVISION

TOP 3 FACILITIES WITH MOST COMPLAINTS

Monroe Correctional Complex : 153

Top 3 concerns: Healthcare, Staff Conduct, & Discipline

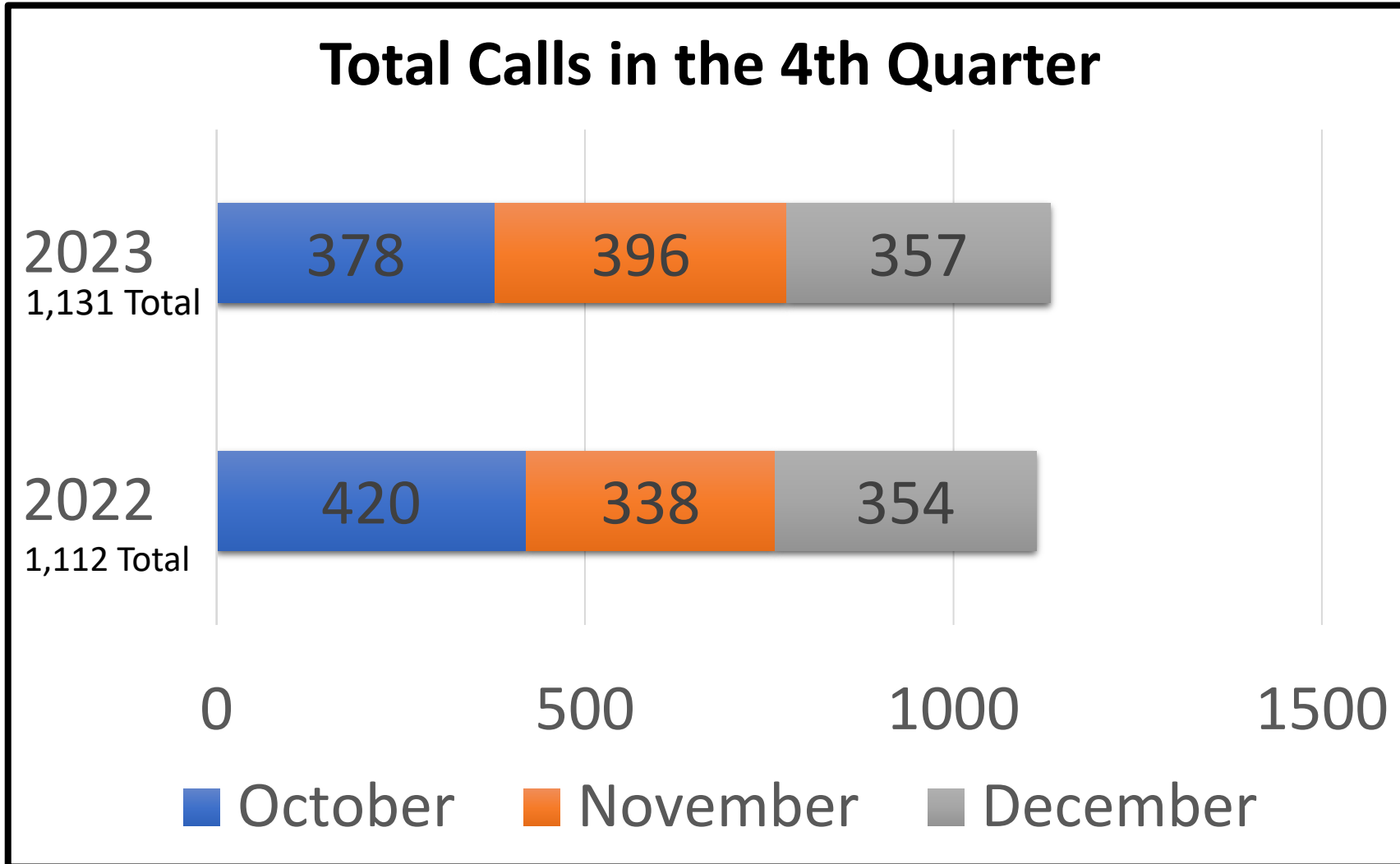
Airway Heights Corrections Center: 133

Top 3 concerns: Classification, Discipline, & Staff Conduct

Stafford Creek Corrections Center: 104

Top 3 concerns: Healthcare, Staff Conduct, & Discipline

OCO ACTION – CONFIDENTIAL HOTLINE



Average of

22

calls per day

Of the 1,131 calls received in Q4 2023, only 517 were reporting new cases.



CASE EXAMPLES

4th Quarter
October – December 2023

OCO ACTION – CUSTODY

Example 1: Resolution Request Denial

Reported Concerns: Person reported concerns about a DOC officer's misconduct. She reported that she has filed resolution requests, but nothing has changed.

OCO Actions

- Reviewed the resolution requests and reasons for re-write/denial.
- Met with DOC HQ Resolutions Staff to discuss resolution request denial.

Negotiated Outcomes

- DOC Resolutions staff contacted the resolutions specialist at the facility to ensure that resolutions are accepted, even if an infraction was involved.
- DOC agreed that the individual could appeal the resolution request which had been denied, even though it was now past the timeframes.

OCO ACTION – CUSTODY

Example 2: DOC Staff Conduct

Reported Concerns: An anonymous individual reported that two DOC staff members were creating a hostile living in environment in their unit. The OCO has received multiple complaints regarding the staff members named in this concern.

OCO Actions

- The OCO contacted facility leadership and asked for a resolution to the problem.

Negotiated Outcome

- DOC reassigned one of the two staff members to a different unit.

OCO ACTION – INFRACTION

Example: Cell Tag Dismissed

Reported Concerns: Person reported they received a cell tag infraction but provided evidence that it belonged to their cellmate instead.

OCO Actions

- The OCO saw that infraction packet included a statement from the cellmate who claims responsibility for the contraband that was the basis of the infraction.
- The OCO contacted the facility and requested the DOC dismiss the infraction since the individual was able to provide a witness statement that another individual claimed possession of the contraband.

Negotiated Outcome

- The DOC confirmed the individual met the WAC requirements laid out in WAC 137-96-100 that establishes a lack of involvement in the infraction.
- The DOC agreed to dismiss the infraction.

OCO ACTION – TRIAGE

Example: Securus Phone Access

Reported Concerns: Multiple people reported not being allowed to use the Securus phone app during count while higher custody levels are allowed to do so.

OCO Actions

- Contacted DOC staff and inquired about the concern.
- Recommended DOC allow all custody levels to access Securus during count.

Negotiated Outcomes

- The Superintendent changed the protocol to allow individuals in MI3 to use the Securus phone app during count.

OCO ACTION – HEALTH SERVICES

Example: Medical Appointment & Interpreter

Reported Concerns: Person reports he was transferred to a new institution and has not been seen by a medical provider. The person was scheduled multiple times, and each appointment was cancelled.

OCO Actions & Negotiated Outcomes

- OCO staff reviewed the patient's appointments and noted that an interpreter flag was not used to indicate the provider would need interpretation.
- OCO confirmed multiple delays in the patient receiving a physical assessment due to language barrier.
- OCO contacted Health Services management and requested that an appointment be made with a note to prepare for interpretation services. The OCO also requested staff be reminded to use the "interpretation needed" flag when scheduling patients who speak a language other than English.

UNEXPECTED FATALITY REVIEWS (UFRs)

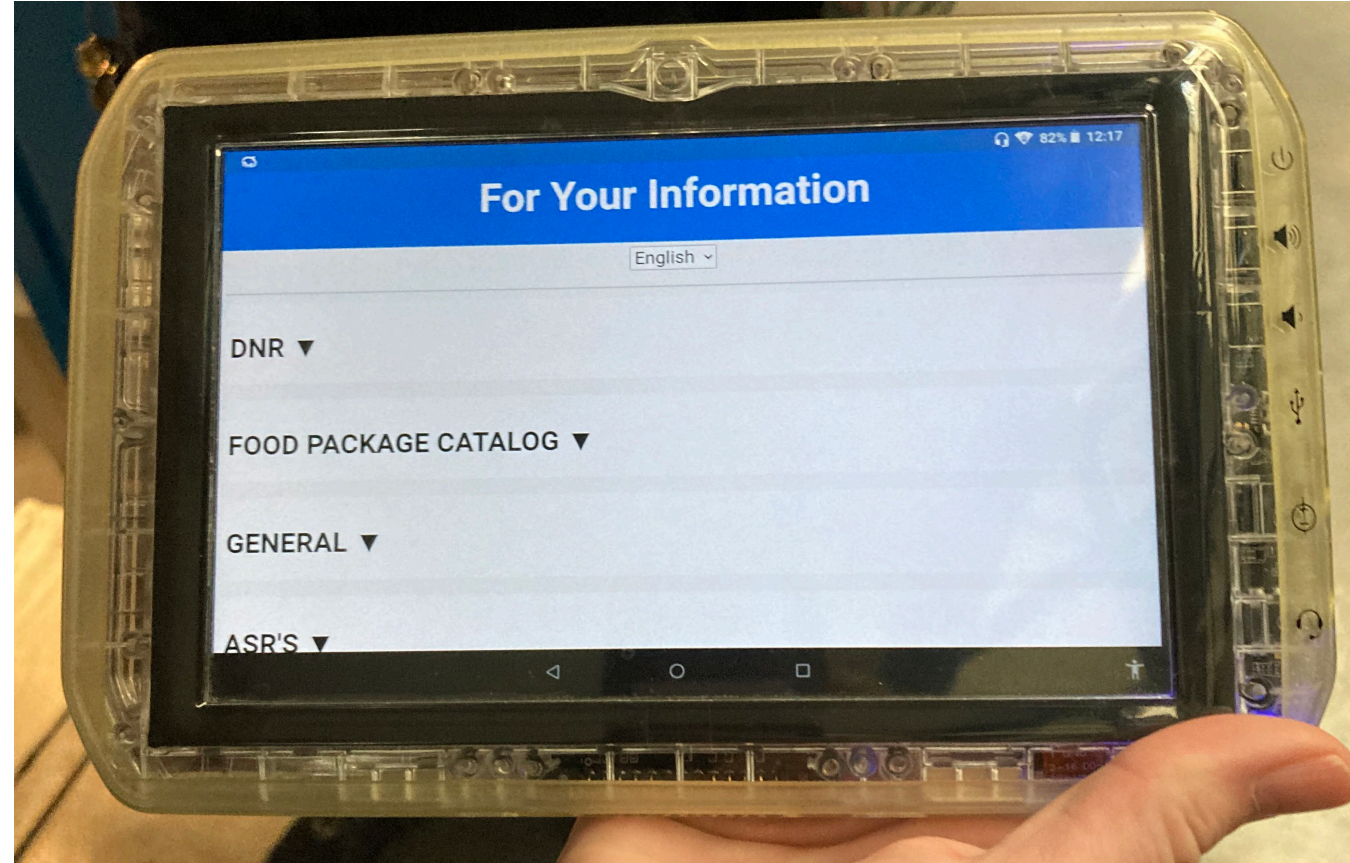
Seven (7) fatality review meeting reports were published in Q4 2023.

The deaths reviewed were attributed to suicide and overdose.

- Multiple state agencies participate:
OCO, DOH, HCA, and DOC
- OCO can request reviews of deaths not identified by the DOC as “unexpected”
- Committee members review incident reports, medical records, video, and other relevant documentation
- Committee meets to discuss findings, questions, and recommendations

REPORTS & PUBLICATIONS

4th Quarter
October – December 2023



AVAILABLE ON THE FYI APP ON YOUR SECURUS TABLET

OFFICE OF THE
CORRECTIONS OMBUDS
MONTHLY NEWSLETTER

DEC. 2023

The OCO Newsletter

Includes updates about projects, reports, ways you can be involved, and a monthly message from our Director.

What's new with the OCO?

Unexpected Fatality Review Annual Report

The OCO published its first standalone annual report on Unexpected Fatality Reviews (UFR). RCW 72.09.770 directs the Department of Corrections to convene an Unexpected Fatality Review Committee when the death of an incarcerated individual is unexpected, or for any case identified by the OCO for review. The DOC, the OCO, and the Department of Health all must participate. OCO's report covers the unexpected fatality recommendations and reports published by DOC in Fiscal Year 2023 (July 1, 2022 to June 30, 2023).

Last fiscal year, there were **54** total deaths in DOC Custody; **29** of those deaths were unexpected due to:

10 – Overdose	1 – Homicide
6 – Vascular Disease	1 – Respiratory
6 – Suicide	1 – Accident
3 – Infection	1 – Medication Complications

After every unexpected death, the DOC is required to

November

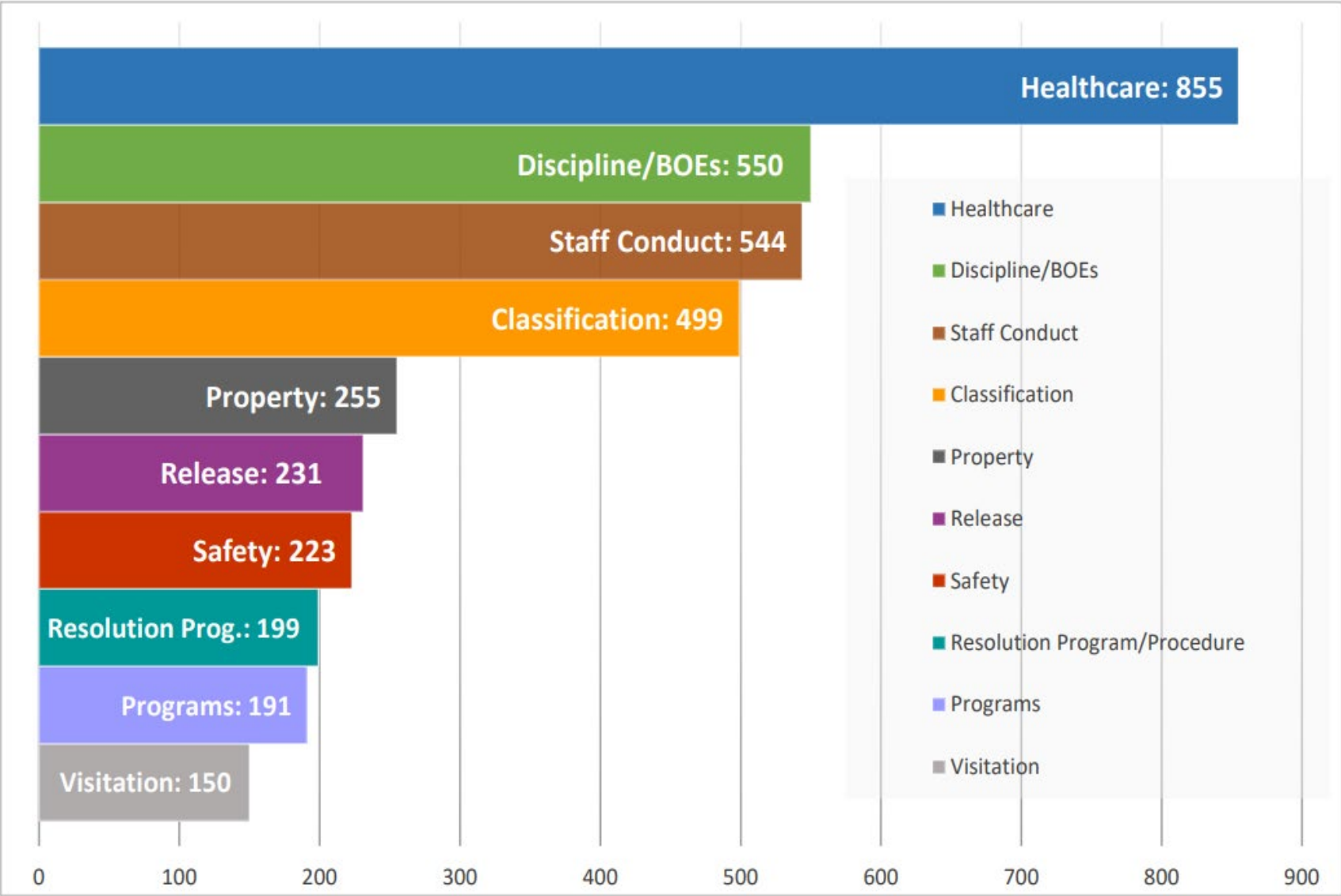
11.3.23 WSP – OCO staff met with Health Services, UFR and Facility Leadership to discuss the facility; and spoke with individuals housed in various living units.

11.4.23 MCC – OCO staff attended the Harvest event and met with DOC staff to discuss incarcerated individuals and their families.

11.14.23 SCC – OCO staff met with individuals in the IMU units. They also met with the Superintendent prior to their departure.

2023 OCO ANNUAL REPORT

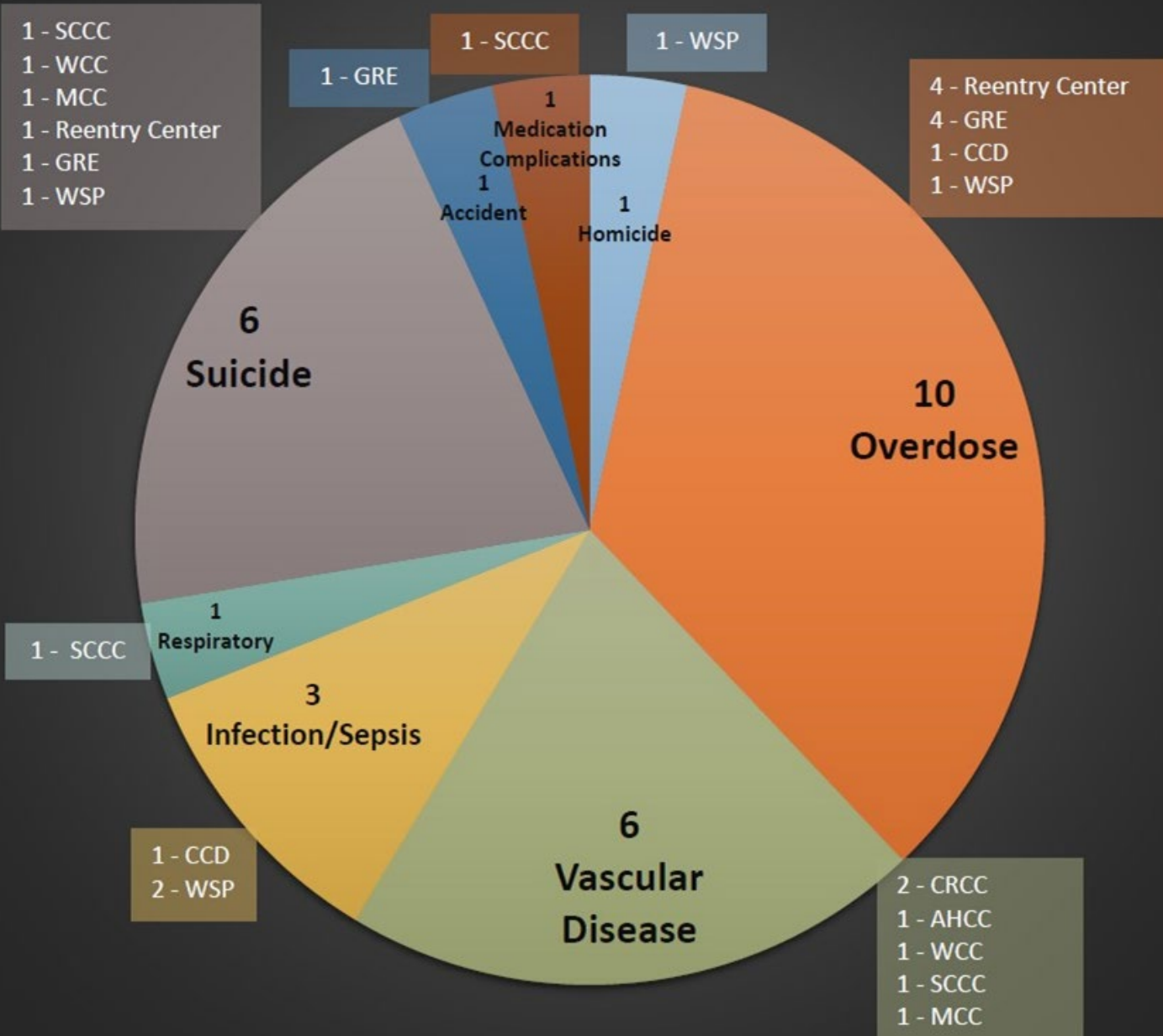
TOP TEN INVESTIGATIVE CASE FACTORS IN FY 2023



FY 2023 Published UFR Reports by Cause of Death and by Location

OCO UFR ANNUAL REPORT

FISCAL YEAR 2023
(JULY 2022-JUNE 2023)



Prison-Initiated Disciplinary Process Recommendations

October 30, 2023

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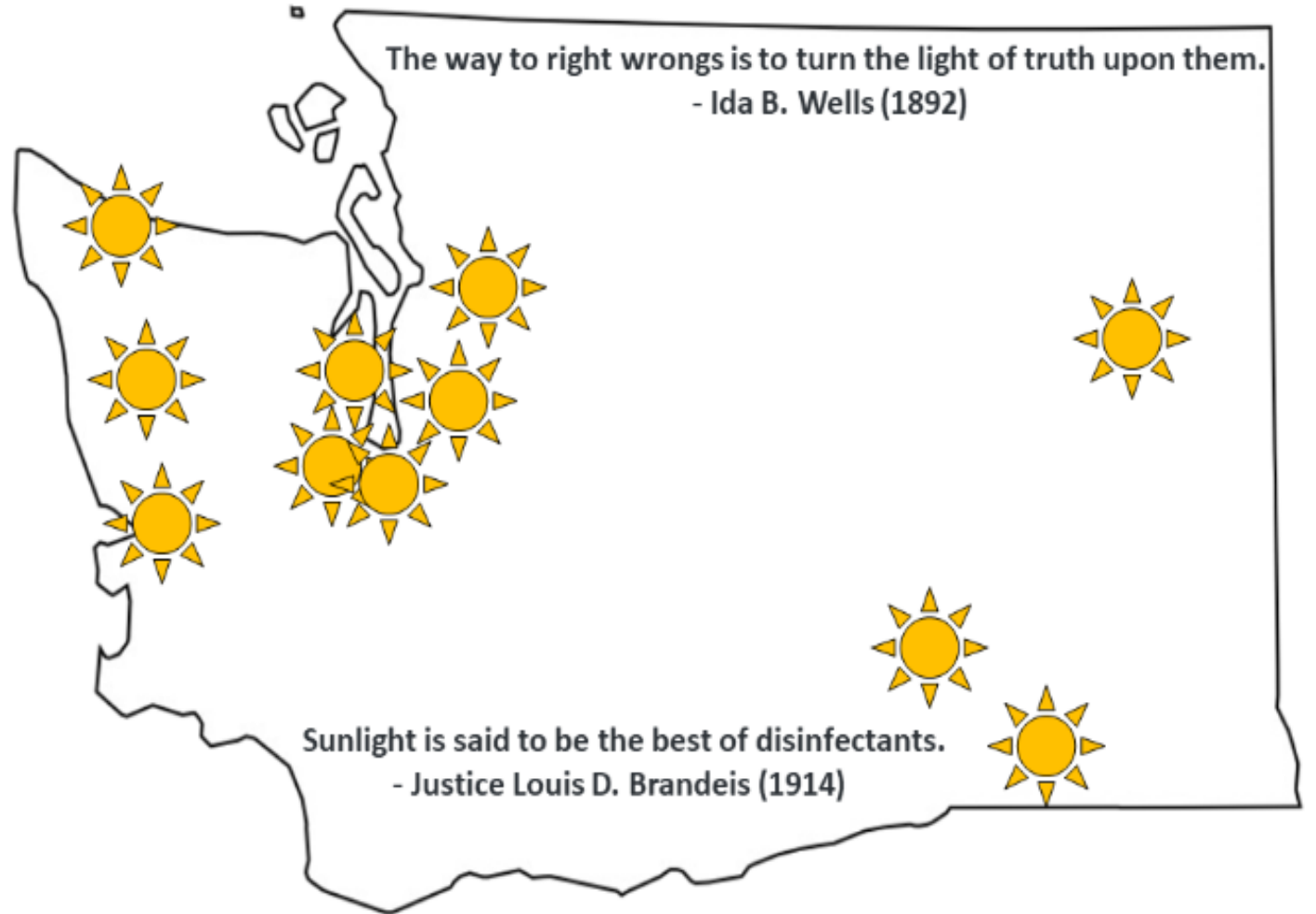
FACILITY MONITORING

4th Quarter

October – December 2023

18

Facility Monitoring Visits Oct - Dec 2023



OCO Facility Monitoring Visits: The practice of routinely inspecting all correctional institutions to assess and report on the facility conditions and treatment of people who are incarcerated. All facilities are inspected, not just those with known problems. Monitoring is critical for ensuring the safety of all people inside. It is a proactive process meant to provide early identification of concerns about conditions and ill-treatment.

2023 OCO QUARTERLY MEETINGS INSIDE PRISONS

January 6 : WCC

April 26 : MCC

July 7 : WSP

October 6 : CBCC

2024 OCO QUARTERLY MEETINGS INSIDE PRISONS

January : MCCCW

April : SCCC*

July : AHCC & CRCC*

October : CCCC*

*Subject to change

OFFICE OF THE CORRECTIONS OMBUDS

CONFIDENTIAL

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Olympia, WA 98504

Online: www.oco.wa.gov/submit-complaint

