OFFICE OF THE

CORRECTIONS OMBUDS

ANNUAL REPORT 2020

Prepared by

Joanna Carns, Director

Submitted on

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Message from the Director

2020 has been a challenging year, to say the least. I am tremendously proud of my staff and our work both during and in response to the COVID-19 pandemic. While managing the same impacts on our personal and professional lives as the rest of the state, OCO staff also pivoted to respond to the public health crisis through an impressive array of activities, including the following:

- Held weekly phone calls with the public to provide information and receive concerns regarding conditions of confinement for incarcerated individuals during the pandemic;

- Conducted 12 monitoring visits to DOC prisons with an associated report for each one, providing timely information on DOC's COVID-19 response and highlighting issues for DOC's corrective action;

- Organized a workgroup with family members of incarcerated individuals to develop overarching recommendations for DOC to improve the lives of people in prison during the pandemic, published in a report;

- Conducted a detailed review of DOC's compliance with the CDC's Interim Guidance on Management of COVID-19 for Correctional Facilities, with suggestions for improvement;

- Completed an investigation into the largest outbreak to date of COVID-19 at a DOC prison, with findings and recommendations for improvement;

- Reviewed the two deaths of incarcerated individuals due to COVID-19 to date;

- Received and responded to hundreds of calls and contacts from incarcerated individuals, family members, legislators, and concerned citizens regarding conditions of confinement for incarcerated individuals during the pandemic.

While achieving all of the above, OCO also responded to several thousand complaints, co-chaired a workgroup with DOC to make recommendations related to work release centers, published regular investigation reports, held public stakeholder meetings, communicated with legislators, and engaged in countless meetings with DOC staff to raise concerns and discuss solutions.

Despite the many challenges of this past year, there have also been positive signs of progress. OCO's collaborative work with DOC to reform its grievance procedure has continued with DOC staff carrying the work forward internally. DOC staff also continued to work to improve its policy process, which had been a previous cause of OCO's concern, including providing better opportunities for external stakeholder input. OCO

and DOC also worked together to provide better transparency and inclusion of family council members in decisions regarding the use of money in the Incarcerated Individual Betterment Fund. In hundreds of cases, OCO served the community by bringing forward substantiated concerns regarding incarcerated individuals and DOC staff resolved the issue.

However, some concerns are not so easily fixed. Health services as an entire department within DOC continues to be a primary focus of OCO's concern, not just due to the COVID-19 pandemic, but also our multiple published reports related to failures and delays in cancer treatment, and OCO's review of all suicides in custody that occurred in 2019 raised serious concerns. People with serious mental illness reported receiving infractions for behavior while they were in the midst of a mental health crisis, and experiencing barriers to completing programs mandated for their release. OCO is currently collecting complaints related to unfair discharges from therapeutic communities, and the use of restraints on persons engaging in self-harm. Continued focus on health services – medical, mental health, and substance use disorder treatment – is necessary to better serve the incarcerated population.

My vision for corrections in WA is in fact the healthcare model – when someone enters DOC's door, they are treated with the same concern, respect, and care as someone who enters a hospital. The mental, emotional, and addiction-based injuries that incarcerated people bear are not as visible as broken bones or open wounds, but they are just as real. Every action from every DOC staff who comes into contact with that person should be made through a trauma-informed lens, with the intention of helping that person heal. Every decision from an organizational standpoint should be made under the guiding principle of "how does this agency action help the person achieve wellness?" Ultimately, the goal should be to release people who are more well – physically, emotionally, and mentally – than they were when they entered.

2020 has also seen a surge of discussion related to law enforcement interactions with the community, particularly persons of color. Those same discussions and reforms should happen in the prison context as well. Truly achieving equity requires more than just annual trainings and words on paper; true equity—racial, gender, disability, or any other—would require a shift of the entire system.

DOC has begun to take steps toward this more therapeutic vision of treating persons in custody, but there is far to go. In the meantime, my staff and I work every day to catch the people who fall through the cracks, who are mistreated through individuals' actions, or for whom the grind of bureaucracy results in injustice.

Sincerely,

Joanna Carns

Joanna Carns, Director

Executive Summary

- In FY 2020, OCO opened **2,983 cases**, representing complaints from or regarding 1,982 incarcerated individuals. OCO was able to provide assistance or self-advocacy information in **40%** of the cases.

- Complaints related to a person's **medical care** continue to top OCO's categories of concern in FY 2020, as they have since OCO opened. Complaints range from failures to provide necessary accommodations and medical equipment, to missed appointments for health services, to allegations that a person's death was due to medical neglect. As the pandemic struck in late third quarter and all of the fourth quarter, **COVID-19** quickly became a top issue of concern reported to OCO.

- **Monroe Correctional Complex** and **Stafford Creek Corrections Center** have consistently topped OCO's list of the most frequent source of complaints to OCO. The **Washington Corrections Center for Women** was the third highest source of complaints when analyzing the rate of complaints.

- OCO was able to work with DOC to achieve positive resolutions for both individual and systemic cases. Systemic issues included reforms in DOC health services, the DOC internal grievance procedure reform, DOC's policy process, ADA access, DOC's COVID-19 testing and facility response, and inclusion of family member input and transparency of the Incarcerated Individual Betterment Fund.

- Due to the COVID-19 pandemic, DOC's response to OCO's recommendations and reports has been limited. Therefore, many of the recommendations in this annual report are similar to those submitted in last year's annual report or in larger systemic reports issued by OCO throughout the year, including the following:

1. DOC should continue working towards creating a rehabilitative environment that reduces trauma for incarcerated persons.

2. DOC should implement the recommendations OCO previously published in its report analyzing the five suicides that occurred in 2019.

3. DOC should implement the recommendations OCO published in its COVID-19 workgroup report.

4. DOC should implement the recommendations OCO previously published in its 2019 annual report related to health services.

5. DOC should ensure incarcerated individuals with a diagnosed mental health condition receive specialized consideration when involved in the internal DOC disciplinary system.

6. DOC should apply a trauma informed and gender responsive lens to programs, services, staff training, and conditions of confinement, particularly for women and LGBTQI individuals across facilities.

I. OCO Mission and Values

Mission

The mission of the Office of Corrections Ombuds is to reduce the likelihood of actions or inactions of DOC negatively impacting the health, safety, welfare, and rights of incarcerated individuals by intervening in individual cases and making public reports with recommendations for systemic improvement to the Governor, the Legislature, and agency officials.

Values

- **Dignity**: We recognize the dignity of all persons.
- **Impartiality**: We are neutral, independent, and unbiased in our work.
- **Confidentiality**: We respect and protect the information entrusted to us.
- **Integrity**: We are honest, ethical, and dedicated to our work.
- **Promoting Public Awareness**: We create systemic reform by publishing reports that influence change and outcomes.

II. OCO Budget and Expenditures – FY 2020

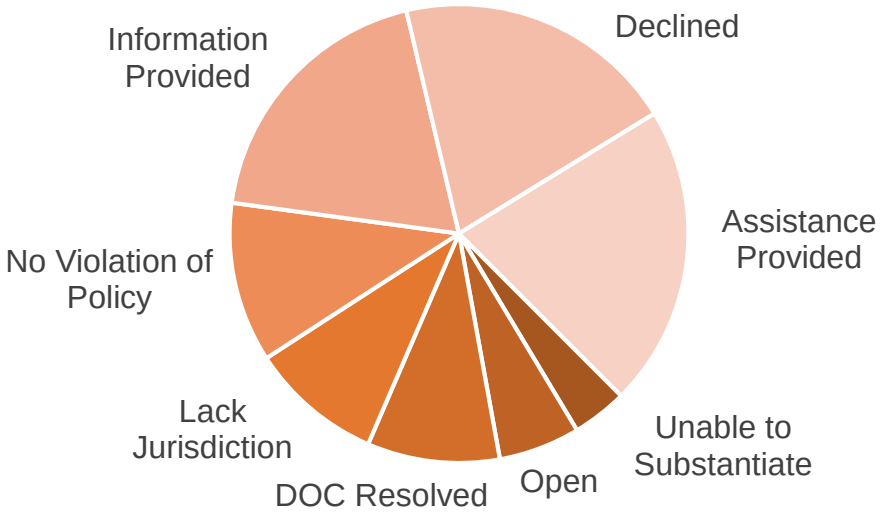
Category	Allotment	Expenditure
Salaries and Wages	707,250	673,605
Employee Benefits	250,237	265,903
Professional Service Contracts	0	17,641
Goods and Services	137,600	133,286
Travel	60,000	36,175*
Capital Outlays	0	2,438
Grants, Benefits, and Client Services	0	2,183
Total	**$1,155,087**	**$1,131,230**

*During the fourth quarter of the fiscal year, the state was under a stay-at-home order and all travel was halted.

III. OCO Complaint Stats

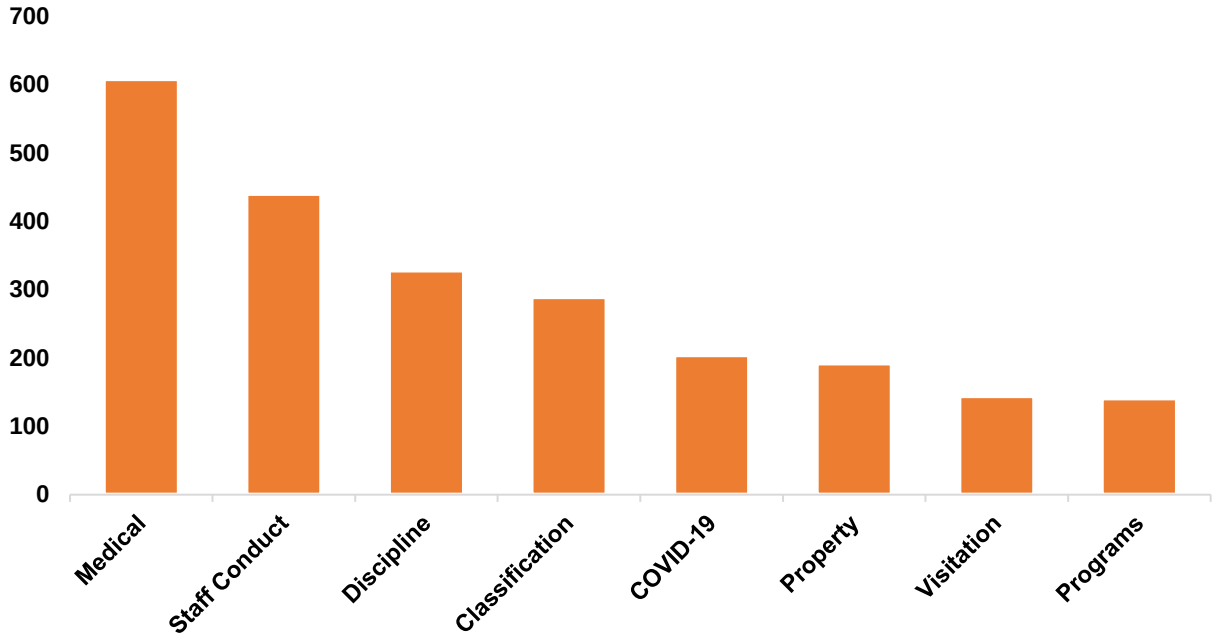
In FY 2020, OCO opened **2,983** cases, representing complaints from or regarding **1,982 incarcerated individuals**. In comparison with OCO's sister Ombuds agencies situated in the Governor's office, the Office of the Education Ombuds handled 617 cases in FY 2020, and in a calendar year, the Office of Family and Children Ombuds generally receives slightly under 1,000 cases.

Current Case Status for Cases Opened in FY 2020 (as of 9/29/20)



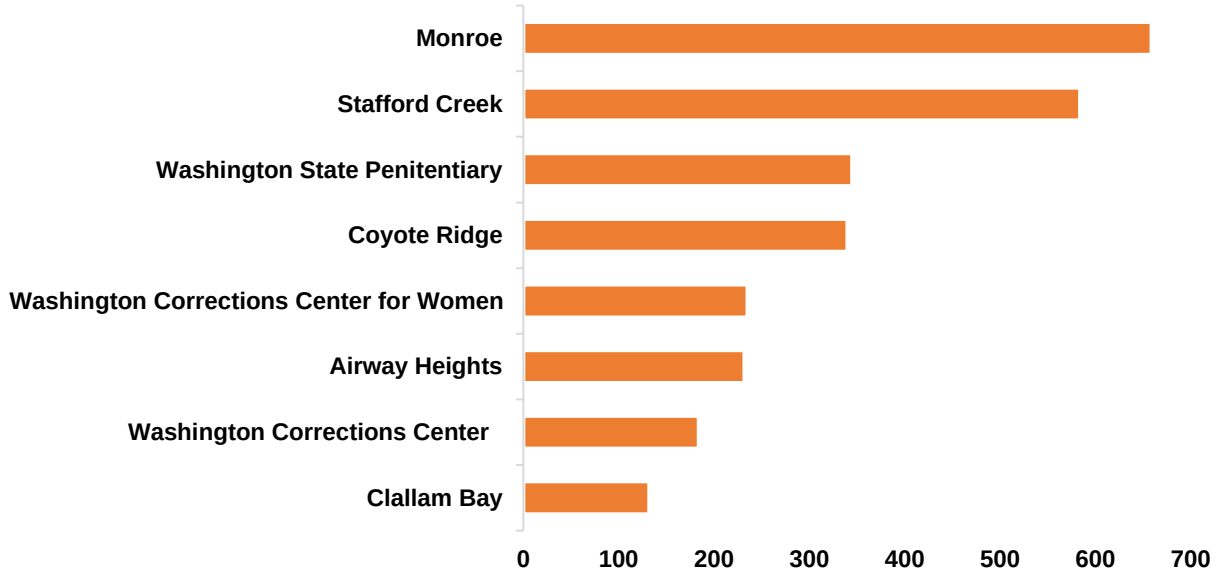
Case Status	Explanation
Assistance Provided	OCO, through outreach to DOC staff, was able to achieve full or partial resolution of the person's complaint.
Declined	Status from OCO's old database that is no longer used in favor of one of the more descriptive labels. Cases in this category could have been closed for any of the rationales given in the other labels.
DOC Resolved	Case resolved by action of DOC staff prior to OCO involvement.
Information Provided	OCO provides self-advocacy information
Lack Jurisdiction	Complaint does not meet OCO's jurisdictional requirements (not about an incarcerated individual, not about a DOC action, or person did not reasonably pursue grievance/appellate procedure)
No Violation of Policy	After reviewing all relevant documents and DOC policy, OCO staff determine that DOC policy was not violated.
Open	Case is still active in OCO's caseload
Unable to Substantiate	Insufficient evidence exists to support the complainant's allegation.

Complaints by Top Categories of Concern - FY 2020

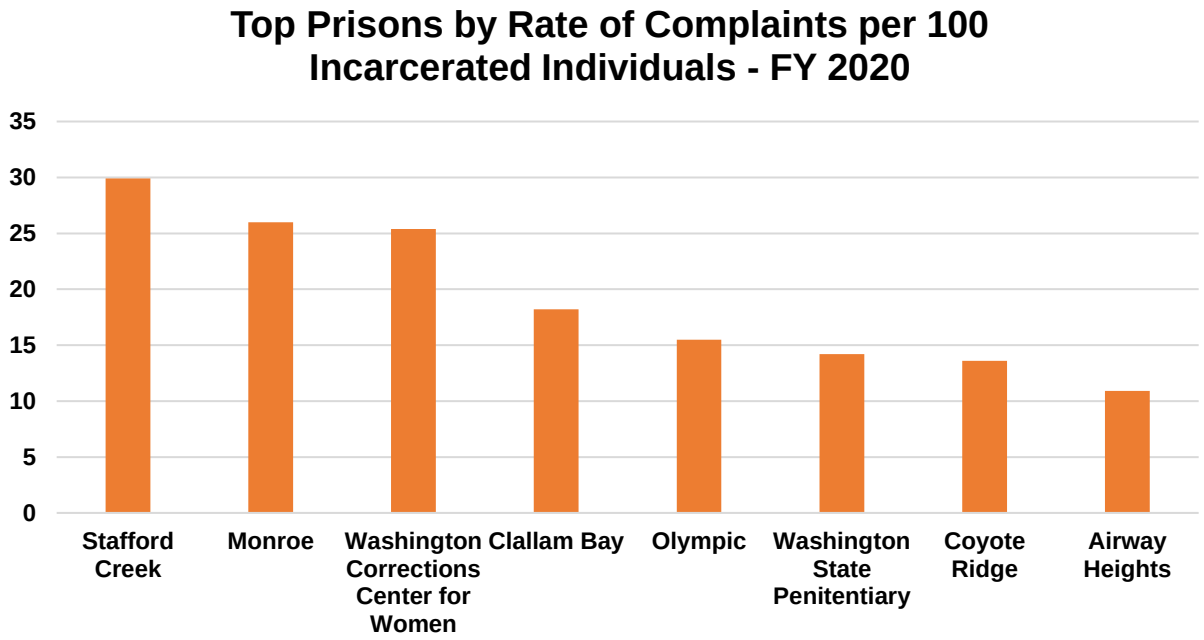


Complaints related to a person's **medical** care continue to top OCO's categories of concern in FY 2020, as they have since OCO opened. Complaints range from failures to provide necessary accommodations and medical equipment, to missed appointments for health services, to allegations that a person's death was due to medical neglect. As the pandemic struck in late third quarter and all of the fourth quarter, **COVID-19** quickly became a top issue of concern reported to OCO.

Top Prisons by Total Complaints - FY 2020



Monroe Correctional Complex and **Stafford Creek Corrections Center** have consistently topped OCO's list of the most frequent source of complaints to OCO. OCO notes that Monroe houses both a higher percentage of persons with serious medical needs and also a higher population of persons with serious mental illness, in addition to housing one of the larger populations in the state; it was also the site of the first large outbreak of COVID-19. For Stafford Creek, both medical and disciplinary issues have been frequent causes of complaints.



Washington Corrections Center for Women is the third highest source of complaints when analyzing the rate of complaints to OCO compared to the population. OCO is particularly concerned regarding conditions of confinement for transgender persons at WCCW, staff misconduct and general treatment of incarcerated individuals, and the disciplinary process.

IV. Selected Individual Case Summaries – FY 2020

The following case summaries are examples of times when OCO staff felt that their work made a direct, positive impact on an incarcerated person's health, safety, welfare, and rights. This list is by no means exhaustive, but are representative of OCO's work.

Institution	Concern	Outcome
AHCC	Family of the incarcerated person had paid off his child support debt. DOC was still taking payment out of his spendable account and the family could not resolve through contacts to DOC.	DOC refunded money taken.
CCCC	Complainant was denied both work release and GRE due to undefined "community concerns."	DOC approved him for work release.
CRCC	Complainant's urinalysis positive for benzos and spice. A few weeks later he was tested again and it came back clean. DOC refused to overturn the first infraction saying that the second one didn't prove he was clean for the first one. OCO reached out to Headquarters and requested all information and further review.	DOC overturned infraction.
CRCC	Complainant has IBS; HSR for a specialized diet was removed, causing a flair up in symptoms.	DOC renewed HSR for specialized diet.
CRCC	Patient fell out of wheelchair during transport and sustained injuries.	DOC provided treatment. COs retrained on securing wheelchairs.
MCC	Complainant disclosed transgender status and was not given the preference form within the 10 days outlined in the new DOC transgender policy.	DOC provided the form.
MCC	Complainant reported delays in cancer care treatment and a need for more medical information following recent tests.	OCO confirmed cancer care appointments had been scheduled and additional testing occurred, and that results were shared with individual.
MCC	Person received several infractions due to failures to program. Upon review, his mental health condition was impeding his participation.	DOC overturned the infraction.

Institution	Concern	Outcome
MCC	Complainant reported many issues with a lack of medical care. His toe was amputated and he fractured his foot twice because he had not received any physical therapy. He also lost an eye, was told the surgery went well, but months later is now blind.	OCO ensured he was scheduled for podiatrist, ophthalmologist, and referral for vascular surgery scheduled. His ADA needs were better documented.
MCC	Complainant reported being transported to an off-site appointment on his side in the back of a Charger with no seatbelt, which was causing him pain, in addition to delays in his cancer care treatment.	OCO confirmed that follow up appointments are occurring. DOC issued an HSR for ADA transport.
MCC	Complainant reported bleeding, extreme swelling and sinus conditions that were not being fully treated over the span of about a year.	DOC scheduled him for pre-op, surgery, post-op, and a follow-up appointment.
MCC	Complainant reported that their medical appointment had been canceled and never rescheduled. Upon follow-up, OCO learned that the PA had been out sick on one day, and none of the appointments originally scheduled for that day had been rescheduled.	DOC rescheduled all of the patients to be seen by medical staff.
MCC	Complainant reported he was fired due to retaliation and with the false statement that he stole nuggets from the kitchen. The only person who reviewed the actual video was the person he believed was retaliating against him.	Video viewed and DOC concurred the video did not show what the staff said it did. Complainant vindicated.
MCC	Person placed in IMU at AHCC then transferred to MCC. Once he got to MCC, infracted for library books in his property packup from AHCC.	DOC overturned the infraction.
SCCC	DOC defined complainant's daughter as a victim as she witnessed the crime against her mother, even though the court did not file any charges or see her as having been a victim of the crime. The daughter had been trying to visit since 2012; DOC put a prohibited contact on her in 2014.	DOC began allowing video visits as a pathway toward restoring regular visitation.

Institution	Concern	Outcome
SCCC	Complainant approved for early release as part of DOC COVID-19 Rapid Reentry, but was blocked from release due to medical hold.	DOC removed medical hold and released complainant to community. He shared later that he was able to access medical care for his skin cancer once released that he had not received for 9 months prior.
SCCC	DOC was unable to provide complainant with a properly fitting knee brace before his release date and told him he would not be released with his wheelchair.	OCO confirmed that wheelchair would be provided upon release.
SCCC	Complainant reported not receiving medical care for severe hemorrhoids for over 6 months. Declared 5 medical emergencies, and each time was told to sign up for sick call. Signed up for sick call and now has a $25 debt and still has not been treated. He was prescribed a hemorrhoid cream and still hasn't received it 4 months later. He has kited medical, verbally asked nurses and continues to be told to sign up for sick call.	OCO ensured medications were provided and appropriate testing and follow-up appointment scheduled.
WCC	When WCC is working on replacing their power grid, the power goes down at night and depends on backup generators. These generators aren't connected to the cell plug ins. This creates an issue for folks who rely on CPAP machines at night.	OCO alerted ADA Compliance Manager and Facility HSM3 of concerns and documented plan of action, to include moving individuals to better housing.
WCC	OCO received a complaint regarding the lack of emergency preparedness at WCC -- specifically that some staff members had not been trained or practiced evacuation of individuals with disabilities.	OCO alerted the ADA Compliance Manager who worked with WCC administration to resolve this issue.
WCCW	Complainant did not receive gate money. OCO verified through OMNI and WCCW banking records.	DOC sent a check.

Institution	Concern	Outcome
WCCW	Terminated from TC and infracted for failure to program. Person identifies as Transgender. He said TC was not transgender responsive and exacerbated his mental health issues which was documented in mental health records.	DOC overturned the infraction.
WCCW	Removed from GRE approval for receiving a cell tag infraction for extra blankets and clothes in the common area of her cell. She was removed from the program before she had a hearing. She had already paid rent at the recovery home she was moving into. She was found not guilty at the hearing and was still denied for GRE.	DOC reinstated GRE.
WCCW	Complainant charged with a staff assault infraction, which OCO did not believe qualified as a staff assault. Person identifies as Transgender. OCO emailed the Superintendent to let her know our concerns.	DOC found person not guilty of the infraction and moved from TEC Acute to close custody.
WCCW	Complainant stated that she had been suspended from her job as a recreation photographer at WCCW pending investigation because she witnessed a PREA allegation between staff and another incarcerated person.	DOC returned her to her original job and staff were informed that they cannot suspend someone due to a PREA investigation.
WCCW	Person needed gender affirming bottom surgery and repeatedly delayed.	DOC scheduled surgery.
WCCW	Six women had been sent to the Yakima Jail Therapeutic Community – one who had medical needs and five who had no TC or substance related needs.	All six were returned to WCCW and Headquarters took back responsibility for the screening of individuals rather than facility staff.
WCCW	Complainant infracted for failure to produce a urine sample for a urinalysis, even though she had an accommodation on record to allow her extra time to produce the sample.	DOC overturned the infraction.

V. Significant Systemic/Investigative Outcomes

Concern	Outcome
Last year, OCO raised concerns regarding cancer care, organization and appeals of the Care Review Committee, poor tracking and monitoring of medical concerns via grievances for systemic improvement, and tracking of off-site visits cancelled due to insufficient medical transport staff.	DOC implemented a system to pull weekly data from OMNI to better ensure cancer care treatment is provided timely; created a grievance tracking log to identify trends; implemented a tracking system for off-site visits to ensure that cancelled visits are rescheduled; changed the structure of the Care Review Committee; and, created a new process for CRC appeals.
In 2019, OCO co-chaired a workgroup with DOC to develop recommendations for reforms related to the internal grievance procedure. The workgroup produced a report with recommendations in January 2020.	DOC has continued the reform work internally to implement the recommendations of the workgroup, including increased oversight, better data review, improved survey of the incarcerated for better feedback, increased training for Grievance Coordinators, a revised training manual, and a new grievance form that better captures the information needed to successfully investigate and resolve a grievance.
Following several concerns and an investigation report related to retaliation at a work release center, DOC agreed to co-chair a workgroup involving a cross-section of internal and external stakeholders to develop recommendations to improve work release conditions, the disciplinary program, and access to programs, among others.	The workgroup was paused due to the COVID-19 pandemic, but it restarted and still hopes to produce a final report with recommendations by the end of 2020.
OCO conducted a systemic review of concerns related to access to programs, services, and activities for individuals with disabilities in DOC custody. Staff reviewed all disability-related complaints received by OCO, interviewed the ADA Compliance Manager, facility ADA Coordinators, and stakeholders, researched best practices, and published an extensive report with recommendations.	DOC agreed to create an appeal process for accommodation denials, clarify the role of access assistants, conduct routine checks on law library assistive technology, enhance disability screenings, collect data on the rates of access to camp and work release for individuals with disabilities, and conduct numerous staff trainings related to disability and mental health awareness.

Concern	Outcome
OCO published an investigation report related to a person who had sat in IMU/segregation for many months waiting on a court appearance that he never received a summons for and then the court hearing was cancelled without him or DOC being aware that they should move him back to his parent facility and out of IMU.	DOC implemented a requirement that all facilities should have a written plan for the service of all court documents. DOC confirmed process to ensure timely communication with outside courts to ensure up-to-date information related to hearings dates.
OCO advocated for several months for the increased and expanded COVID-19 testing of both staff and incarcerated individuals.	Mass testing was conducted at the site of DOC's largest outbreak to date – Coyote Ridge Corrections Center – and serial testing of staff is occurring at several facilities.
OCO conducted a number of visits to DOC facilities to monitor the DOC response to the COVID-19 pandemic.	OCO was able to obtain quick corrective action for a number of concerns, including very limited out of cell time at Coyote Ridge, lack of telephone access in the Monroe isolation unit, immediate improvements to the first Monroe isolation unit, better cleaning equipment at WCCW, and more.
Family members raised concerns regarding the "Offender Betterment Fund," including a lack of transparency and a lack of inclusion of family members, whose money predominately funds the account, in decisionmaking.	DOC changed the policy for the fund (now called the "Incarcerated Individual Betterment Fund") to include two Statewide Family Council members to provide input and also the financial report for the fund will be updated and posted quarterly on the DOC website.
In OCO's 2019 annual report, OCO noted that "DOC's efforts at policy change are directly impeded by its policy office, which is at best sclerotic, with policy changes sometimes taking over a year and some policies not having been updated for a decade."	DOC has engaged in a massive policy office improvement exercise, including researching other agencies' policy processes, mapping its current process and identifying barriers, developing a new system to expedite policy changes, and improving collection of external stakeholder feedback.

**In 2019, community stakeholders selected five systemic issues for OCO to work on in 2020: mattresses, property loss, the disciplinary program, mental health access/treatment/services, and educational access/options. OCO has engaged in significant work on all of these issues; reports are being finalized and the outcomes will be included in next year's annual report.

VI. Recommendations

1. DOC should continue working towards creating a rehabilitative environment that reduces trauma for incarcerated persons.

DOC has taken action to re-orient itself toward a more rehabilitative model, including integrating its new "Values" (including respectful and inclusive interactions, positivity in words and actions, and supporting people's success) into employee performance reviews and partnering with Amend to increase its knowledge of humane correctional best practices currently employed by global correctional practice leaders such as Norway. OCO recognizes and applauds these moves. However, OCO also continues to receive complaints – both large and small – in which individual employees' actions did not reflect this larger organizational goal. Thus, while acknowledging that large organizational change takes time, OCO urges for both continued and greater actions to reinforce DOC's shift towards a rehabilitative model.

Case Examples: Rehabilitative Environment

Ms. A, a 56 year old white female, wrote the following to OCO: "I got here to Washington Corrections Center for Women on 6-27-2019. I have been complaining that there was something wrong with me. I had pain and an odor. I was finally treated last week for a urinary track [sic] infection. 4 month it took to get treated. I was having dreams of being raped as a 6 year old. This infection has caused me fights with several roommates because of noises made in my sleep caused by the discomfort of a urinary track [sic] infection. My last roommate came from a meeting with staff telling me I could be charged with PREA for making noises at night while sleeping crying out. Now I have been abused as a child and my whole life do [sic] to drug addiction do [sic] to child trauma in my life and instead of staff trying to help me I'm accussed [sic] of being the problem. What kind of rebilitation [sic] program is this place where a woman with a urinary track [sic] infection is left for 4 months and accussed [sic] of PREA by staff." OCO confirmed that a month after her reception, Ms. A was transferred to the segregation unit for personal safety concerns; she was soon thereafter placed in the Therapeutic Community. Her mental health concerns resulted in behavioral infractions, at which point she was removed from the program and her DOSA was terminated. Since this time, her mental health concerns have been addressed and her behavior has regulated, but neither her DOSA nor her substance use disorder programming has been reinstated.

Mr. B, a white male serving an eight year sentence, was a former gang dropout and also experienced behavioral and medical concerns. Since entering prison in 2016,

he spent the majority of his time in Intensive Management Units around the state due to a combination of personal safety and disciplinary issues, moving from WCC IMU to MCC IMU to AHCC main compound back to WCC IMU to SCC IMU back to WCC IMU back to AHCC back to MCC IMU, etc. During one of his brief stints out on AHCC main compound, he initiated a hunger strike reportedly due to DOC's loss of his property during the transfers. He was placed back in segregation. After missing 19 meals, the Facility Medical Director (FMD) decided to obtain a blood draw to monitor his health against his wishes. Mr. B was strapped into an Emergency Restraint Chair (ERC) for almost four hours. Medical staff attempted four times to insert an IV and were unsuccessful. The FMD called in the Airway Heights Fire Department to initiate the IV, who had to reposition Mr. B's arm in the ERC to secure an IV line. While the IV is inserted, not only was a blood draw conducted, but two liters of fluid were also administered without his consent. Mr. B is currently in WSP's IMU.

2. DOC should implement the recommendations OCO previously published in its report analyzing the five suicides that occurred in 2019.

The following recommendations were provided in a previously published OCO report. Incarcerated individuals frequently have histories of trauma, mental health diagnoses, or substance abuse. These issues, combined with confinement and social exclusion, can result in feelings of hopelessness and a desire to end what may feel like inescapable pain. Because of this, suicide remains one of the leading causes of death in the U.S. prison population. In 2019, DOC experienced five suicides, an increase of 250% over the prior year. OCO initiated a review of all five of the suicides and developed a series of recommendations based on those reviews, which include, but are not limited to the following:

- DOC should convene a multi-disciplinary, cross-departmental workgroup to review the 2019 suicides (and moving forward, on an annual basis) to evaluate any trends and consider developing any necessary additional processes to prevent suicides in the future. OCO should be included in those workgroups.

- DOC should review the overall therapeutic environment for all patients, particularly those at risk for suicide. Suicidal patients need to be surrounded by caring, empathetic staff who respond in a trauma-informed manner. DOC should consider using other incarcerated individuals as peer support to help with feelings of isolation. Providing books, a tablet, or other mentally-distracting activities may assist in redirecting a person's thoughts.

- Promote continuity of care by developing policies and processes unique to the violator population.

- DOC should work with local jail administrators to re-work its form to better facilitate the communication of critical mental health and suicide risk information for all individuals transferred to DOC.

- Strengthen the processes for identifying those at risk of self-harm. Existing intake forms should be reviewed and updated to include multiple ways of eliciting mental health histories, intellectual disabilities, and feelings of depression or suicidality. In addition, staff should be required to ask suicide screening questions each time they come in contact with an incarcerated individual on the violator unit, rather than only on intake.

- Adopt a collaborative care approach for patients with medical and mental health diagnoses.

Concerning Case Examples: Suicide Review

In FY 2020, OCO investigated a suicide that occurred in March 2019 at Monroe Correctional Complex. Mr. C, a white male, reported that he had recently attempted suicide prior to incarceration, that he had attempted suicide even the prior night while at the facility, and was in extreme pain. DOC staff performed a perfunctory assessment, told Mr. C that he would be charged a copay if he did not stop complaining, and when he continued to pull the emergency cord to set off an alarm for staff, staff chose to turn down the volume rather than immediately respond. Staff later found that Mr. C had hung himself from the cord. DOC took the corrective action of changing the unit's post orders so that DOC staff would have to respond in person at any point that the emergency alarm cord is pulled rather than turning the down the volume. However, although this occurred in March 2019, it is unclear what else has changed at the facility to create a more therapeutic environment.

Mr. D, a 74 year old white male, died by suicide in October of 2019 at Monroe Correctional Complex. He had multiple significant chronic medical conditions, including Parkinson's disease and a cardiac pacemaker implantation. DOC records for the last year of his life relay an escalating series of events and many attempts at self-harm. Despite this, there are multiple failures on DOC staff's part to perform necessary suicide risk assessments and to provide care for his medical and mental health conditions. The reported "last straw" for him was staff taking Mr. D's walker from him because he did not have an HSR for it.

3. DOC should implement the recommendations OCO published in its COVID-19 workgroup report.

Versions of the following recommendations were published in OCO's COVID-19 workgroup report. The COVID-19 pandemic, the worst public health crisis to impact the United States in decades, poses a particular risk to people incarcerated within correctional facilities due to confined living spaces, overcrowded populations, and group movements. Further, incarcerated persons tend to have greater underlying health conditions and comorbidities, making them especially susceptible to complications arising from COVID-19. As of September 22, 2020, there were 454 confirmed cases of COVID-19 in the incarcerated population, and 172 confirmed cases amongst staff. Two incarcerated persons and one staff have died due to COVID-19.

OCO gathered a workgroup of family members of the incarcerated with a healthcare background and based on their insight and the hundreds of complaints submitted to OCO related to COVID-19, issued a report with overarching recommendations. The following is a summary of the outstanding concerns:

- Full compliance with all of the CDC Interim Guidance on Management of COVID-19 in Correctional Facilities.
- Assessment of capacity requirements at each facility to better inform any necessary legislative or gubernatorial action.
- Better mental health support for the entire population, but particularly those who are in medical isolation due to COVID-19, which will have the dual benefit of better promoting self-reporting of symptoms by incarcerated individuals for earlier identification of illness.
- Encouraging greater communication with incarcerated individuals' loved ones, including reopening visitation with protections as soon as possible.
- More rigorous screening and testing, particularly once a positive test is identified.
- Better infection prevention measures, including additional face coverings.
- Improved communication with the population regarding the current status of positive cases of both incarcerated and staff, and continuous communication regarding infection prevention, as personal prevention measures may become lax over time.

COVID-19 Concerns

While WA DOC thankfully has not experienced the sheer volume of numbers of both infected persons and deaths, the COVID-19 pandemic has still had a severely negative impact on the incarcerated population. In-person visitation with loved ones has been completely halted, most in-person programs have stopped, volunteers have been restricted, many medical appointments have been postponed, dental care still has not returned to the previous service level, and incarcerated individuals have reported tension in the prison environment—and that is for persons who have not been diagnosed with COVID-19. Symptomatic individuals are moved to segregation cells made slightly better through the provision of televisions and puzzles, but depending on the facility, conditions can be grim. As the state's understanding of COVID-19 prevention and treatment improves, it is hoped that prison operations will return to normal as much as possible with appropriate testing, screening, and preventative protection measures in place.

Starting in May 2020, Coyote Ridge Corrections Center experienced an outbreak of COVID-19. On June 12, 2020, OCO staff conducted a monitoring visit to the facility due to concerns from the community about restrictive lockdown measures and reports that incarcerated individuals were not able to use the restroom and were resorting to using containers in their cells. OCO staff reported that the overall atmosphere of the incarcerated population was extremely stressed, emotionally and mentally. In every unit OCO staff visited, there was talk of rioting, something "brewing," and "push back." One incarcerated person noted, "I've been on lockdown for over a month, I know I'm strong and encourage others to do the right thing regardless of what they do to us, but I'm breaking mentally and if they don't do something quick, those still small voices will fade." There were other concerns shared about lack of legal access, needing cultural and religious practices, communication, and food quality. Following the OCO monitoring visit, positive changes were made by DOC staff, including an increase in the out-of-cell time.

4. DOC should implement the recommendations OCO previously published in its 2019 annual report related to health services.

Versions of the following recommendations were published in OCO's 2019 annual report. OCO's largest area of concern continues to be health services, as it is consistently the number one area of complaint reported to OCO. While DOC provided a response to OCO's last annual report, much of the work that was planned had to be halted with the department's shift toward the COVID-19 pandemic response. Thus, these concerns and recommendations remain mostly the same from the prior year.

DOC did report some improvements via creating a new grievance tracking system, an off-site medical visit tracking system, and a weekly data pull of current cancer cases to better monitor for any delays in treatment.

- Create an improved quality assurance feedback loop so that health services administrators are made aware of medical error incidents, whether reported via grievances, medication error reports, or any other format.

- Strengthen the internal audit process for health services based on a broad review of comparable audits of healthcare facilities and ensure better accountability for failure to pass the audits.

- Pursue external accreditation by a nationally recognized accrediting body for correctional health services.

- Ensure each facility holds regular CQI meetings, per policy, and that the information from those meetings is communicated to HQ staff with action taken when needed.

- Develop an established process that includes both qualitative and quantitative data for HQ Health Services Administrators to become proactively aware of concerning trends or actions at each facility.

- Conduct a review of current scheduling practices at each facility and determine better measures to ensure medical appointments are scheduled, held, and rescheduled if needed.

- Conduct a review and create a process for greater consistency in decisions made by health services staff across DOC, as well as by the Care Review Committee. Implement standardized criteria for treatment decisions and make this criteria transparent.

- Conduct a review and determine how to provide greater transparency and criteria for DOC staff's decision to not follow an outside specialist's recommendations.

- From the point that medical staff identify that cancer is a possible cause for concern for a patient, there needs to be an expedited track for biopsy, diagnosis, and a specialist visit with an oncologist, followed by whatever treatment is determined by that specialist to be necessary. Delays in treatment need to be immediately addressed.

- Continue to provide training for medical staff on transgender health care.

- DOC Health Services should evaluate its current use of a non-board certified physician to make the vast majority of orthopedic recommendations.

- DOC should be required to produce an annual public report on deaths in custody that provides an explanation of cause of death and any findings/recommendations developed by the Department of Health review and/or Critical Incident Review.

Concerning Case Examples – Health Services

Mr. E, a 31 year old black male, sustained a knee injury in November 2019. He was diagnosed with a probable ACL tear and treated with crutches, ibuprofen/ Tylenol, and physical therapy. He reported that his knee was "locking up" and he requested multiple times for an MRI to be performed. The DOC orthopedic specialist said that an MRI was not medically necessary because it would not change the treatment plan. The Care Review Committee then denied the patient's request for an MRI based on this opinion. The case was presented to CRC two additional times, but an MRI continued to be denied. Mr. E sustained two additional injuries to the knee because of falls. After eight months, an MRI was finally approved by a Facility Medical Director outside of CRC. The MRI identified a large bucket-handle tear of the medial meniscus, requiring surgical repair.

In January 2019, Mr. F, a white male, reported severe pain related to his dilated biliary duct. He requested narcotic pain management and reportedly was denied this due to providers' feeling that he was "drug seeking." He was provided Tramadol, but he reported that it was not effective in his pain management. He filed a number of grievances and kites, and declared medical emergencies. Staff note regular medical visits, but by May of 2019, the communication had become such that he was placed in IMU for alleged threatening of medical staff. He was threatened with a transfer. An infraction was not written for a month, which was subsequently dropped altogether, and he was released from IMU back to the facility after spending two and a half months in IMU, but only after OCO intervention. His severe pain continued in the meantime and he developed other medical issues. He had a CT of his abdomen conducted in November 2019, which demonstrated cirrhosis and cancer. He was not notified of these results for another month. OCO continues to follow this case.

5. DOC should ensure incarcerated individuals with a diagnosed mental health condition receive specialized consideration when involved in the internal DOC disciplinary system.

Versions of the below recommendations were previously published in OCO's 2019 annual report. OCO recognizes that DOC has been actively engaged in collaboration with the Vera Institute to reduce its use of solitary confinement, particularly for those with mental health concerns. However, OCO continues to receive complaints from persons with behavioral or mental health issues who receive infraction after infraction with associated sanctions due to failures to comply with DOC's rules. It is unclear how this negative cycle positively impacts either the person nor gains greater compliance with the rules. Similar to movements in the greater realm of sentencing reform, DOC should move from a strict behavior and rules-based disciplinary system, to an individualized system that takes into account the person before them, their needs, their reasons for engaging in the behavior, and establishes an appropriate plan that both supports the person's health and promotes institutional security.

- DOC should ensure that those on the mental health caseload receive an expedited investigation, review, and hearing to reduce the total time in restrictive housing.

- DOC should ensure that disciplinary hearings officers receive specialized mental health training related to various symptoms and manifestations of mental illness as it relates to behavior and the impact of restrictive housing on mental health.

- DOC should ensure that all individuals diagnosed as having a serious mental health condition or who are assigned a PULHESDXTR code of S-2 or above are offered assistance from a department advisor throughout the disciplinary process. All department advisers should receive specialized mental health training.

- DOC should reform the disciplinary structure in the residential treatment units. Decisions related to issuing in fractions, hearing participation, and sanctions should be made with mental health stuff involved on the front end in a formalized process rather than as a secondary consideration.

Concerning Case Examples – Disciplinary Hearings and Sanctions

Mr. G lives in the Special Offender Unit (SOU) at Monroe and has been identified as "seriously mentally ill" by DOC. His PULHESDXTR code is S-4, indicating "significant active symptoms that cause serious impairment in functioning." DOC job screening documents indicate that he experiences command hallucinations, anxiety, and paranoia. He also has limited English speaking skills. Mr. G received eight infractions during 2019, including four serious infractions. He was not offered assistance from a department advisor for any hearing in 2019. One infraction was

for failure to program; he had been terminated from the Sex Offender Treatment Program because his mental health precluded his participation and was infracted for it. DOC agreed to overturn this infraction. However, DOC declined to amend the remaining infractions (for failure to work and failure to abide by a sanction) or the sanctions that resulted from them. This is true despite Mr. G informing the hearing officer that voices had instructed him to engage in the behaviors and actions that he was infracted for. Among other reasons, DOC indicated that "[m]andating that a Department Advisor be appointed based exclusively on an S-code would be an unwise use of State resources."

Staff responded to Mr. H who was engaging in self-harm in the Close Observation Unit in SOU. Staff responded to the self-harm incident by attempting to restrain Mr. H in the five point Emergency Restraint Chair (ERC). Mr. H backed up to the cuff port to allow his hands to be restrained, but when the cuff port was opened, he kicked the door and attempted to grab staff. Staff disseminated a short burst of OC spray. Mr. H then submitted to restraints, but as staff attempted to secure his ankles into the ERC, he started kicking. Staff attempted to place a spit hood over Mr. H's head, at which point he started moving his head rapidly side to side. He also spit at the officers and head-butted staff. For an incident that began with his mental health crisis and self-harm, he was ultimately infracted with a staff assault, placed in IMU, and lost custody points and good time.

6. DOC should apply a trauma-informed and gender-responsive lens to programs, services, staff training, and conditions of confinement, particularly for women and LGBTQI individuals across facilities.

Versions of the following recommendations were previously published in OCO's 2019 annual report. Due to the COVID-19 pandemic, work that was planned by DOC to address these recommendations was predominately halted. DOC did report positive progress on the 2019 recommendations related to the transgender population; they have therefore been removed from this report, but OCO is planning to publish a separate report in 2021 specific to the concerns of the transgender population that have been communicated to OCO. OCO recommends the restart of forward progress to implement gender-responsive, trauma-informed practices for incarcerated women.

- DOC should implement the Gender Informed Practices Assessment (GIPA) and ensure that it addresses the needs of the transgender and gender-nonconforming population in addition to women.

- DOC should implement a gender responsive classification tool.

- DOC should implement trauma-informed disciplinary processes to address aggressive and other antisocial behaviors instead of using restrictive housing. DOC should also find alternative safe housing arrangements for alleged victims of sexual assault and harassment other than segregation to ensure minimal disruption to programming, education, and well-being.

- DOC should ensure Pathways and Perspectives trainings for staff working with female inmates is re-implemented and ongoing training provided. All staff at all facilities should receive training on gender and sexuality, race, and disability.

- DOC should conduct a review of disciplinary infractions and sanctions that involve the LGBTIQ population, particularly the transgender population, to determine whether there is a disparate impact.

- DOC should continue to grow and strengthen existing peer support programs within the prisons for the LGBTIQ population.

Concerning Case Examples – Gender Equity

Ms. I, a woman of mixed race, filed a grievance stating that she was approached by another incarcerated person who made several racial slurs about her and another incarcerated individual. She reported that she attempted to contact the Custody Unit Supervisor to report the racial slurs and he reportedly refused to see her. The grievance was returned to her for a rewrite, requesting additional information. It is not clear that further staff action was taken to investigate or resolve the situation. The two incarcerated individuals engaged in a physical altercation. Ms. I, who had tried to report concerns to staff, was then charged with an assault infraction and placed on Max Custody. She appealed the disciplinary decision and it was denied. She then requested a review by HQ staff as the administrator who had heard the disciplinary appeal allegedly was the one who told staff to write the assault infraction in the first place; that review also upheld the disciplinary decision, stating, “The Superintendent/designee is not required to be an impartial person to review the infraction and/or appeal.”

Ms. J, a Native American woman, reported during her suicide risk assessment subsequent to a self-harm attempt that she had had “issues with my roommate to the breaking point. She yells at me at night, she says the TV is radiating heat when it isn’t on, and she does a lot of weird stuff. I spoke to Sergeant [redacted] and [other correctional staff] about it and they did nothing. I eventually said, ‘f*ck it,’

took out the rest of my pills (31 Lexapro), took them, and said goodbye to my friend."

VII. Community Outreach and Input

In the pandemic era, community outreach has shifted from the personal to the virtual. In some ways, this has likely decreased the public's feeling of a personal connection with the office; on the other hand, OCO's weekly public phone calls have engaged a range of people across the state who may not usually have had the opportunity to speak directly to OCO in a public forum.

OCO further engaged with non-incarcerated stakeholders and the community through a variety of methods, including:

- Quarterly public stakeholder meetings, required per RCW 43.06C.040:

12/7/19	Tacoma, WA
3/20/20	Online
6/25/20	Online
10/1/20	Online

  Presentations and/or notes are available on oco.wa.gov/public-meetings

- Attending almost all DOC Statewide Family Council Meeting (including the biweekly COVID Statewide Family Council calls).

- Attending almost all local family council calls (which occur weekly during the pandemic).

- Per RCW 43.06C.040, Director Carns gathered stakeholder input into OCO's activities for the prior year. The responses are provided below:

  - Your investigative reports have been game changers. Please include them in some way.
  - responding to [how many] individual concerns and getting resolution or not. conveying concerns to the people who have authority to make change dismissive or rote responses by the DOC shocking misbehavior and neglect in face of health crises--individual and pandemic related. the importance of having frequent open phone calls to make sure people feel heard. inconsistencies between what DOC says and what your research has shown to be true--and some indication of how careful that process is. how diverse and responsive your staff is.
  - I am just really impressed with the OCO's effectiveness this year, and with the OCO's coordination with other entities (DRW, legislators,

Seattle Times, etc.) to engage and educate the public. I appreciate that OCO has facilitated so many working groups with the Statewide Family Council and DOC. These are effective and powerful, and set a good precedent for both our WA DOC and DOCs in other jurisdictions, making Washington a leader in competent prison policy and public engagement in public safety policy. For 2021, I would like to see OCO advocate for the establishment of an independent policy review board that would review all DOC policies for potential systemic harms BEFORE the policies are finalized and implemented. This review board should include the following types of board members, to be appointed by the Governor or the OCO: A person formerly incarcerated for longer than five years in the WA DOC system (preferably someone who also spent at least a year in WA DOC community corrections after release to provide insight on how DOC prison policies affect reentry success), a well-educated SFC rep (meaning well-educated and competent on state and DOC policies and legislative processes), a UW Law Societies & Justice professor, a non-DOC reentry expert, an OCO staff person, a social worker with expertise on how incarceration affects both the individual and the family, a legislator from one of the law and justice committees in the house or senate, a county prosecutor, and a DRW staff person. A current prisoner should also be able to serve as a board member or board advisor via phone or video meeting and should have meaningful opportunity to participate in policy oversight process. No DOC policy should be finalized until it has such a board's stamp of approval. This board should be made permanent through legislation or an Executive Order. Thank you for your fantastic work this year!

- I submitted two separate complaints about my husband's continued medical neglect through the OCO - and never got a response. Because the issue was not resolved, my husband's spinal surgery was delayed, causing further complications, more neglect, and ultimately an infraction resulting in an unwanted move from honor housing to a wing that has so many people he has to wait in line often for the phone - so that he has also lost regular contact with me, his wife. Everything that happened with and to him, was a direct result of the lack of medical care that both medical and the OCO refused to help with. He finally got his surgery 9 months after his injury, and because of the delay he is facing permanent damage to his spine and major muscle groups. We thought the Ombuds would help us, and were very disappointed that no one even responded.[1]

[1] OCO Director Carns followed up with this person and ascertained that the response to the concerns had been sent to the incarcerated husband. OCO resent the letter to the husband and also sent a confidentiality waiver form to be able to communicate the findings directly to the wife.

- The OCO's model of operation, which is one of quick response to what appear to be DOC irregularities/departure from safe and humane care during incarceration, is an example of "how to do" this independent (as much as possible) form of oversight of a process or organization - Speaking truth to power takes bravery, fortitude and courage of one's convictions. I think this organization's leadership and visibility in it's operation is the best I've seen in my research of the ombuds process.
- They have a difficult job, and this year has been challenging, yet they have accomplished so much. We have all learned a lot of the ombudsman's job and their office's responsibilities. I find comfort in how they do their job, the reports/investigations they have completed, and keeping us all informed.
- We are grateful for the existence of the Office Of Corrections Ombuds. This is an important and in our opinion, a necessary office in Washington state government.