STATE OF WASHINGTON

OFFICE OF THE CORRECTIONS OMBUDS

2700 Evergreen Parkway NW • Olympia, WA 98505 • (360) 664-4749

November 12, 2020

Steve Sinclair, Secretary
Department of Corrections (DOC)

Office of the Corrections Ombuds (OCO) Investigative Report

Attached is the official report regarding OCO's investigation into the recent death of a person incarcerated at Airway Heights Corrections Center. We appreciate the opportunity to work collaboratively with DOC to amend current policies and practices to better ensure that the safety of all incarcerated persons is protected while they are within state confinement.

Any member of the public who wishes to report a concern to OCO is welcome to contact the office at (360) 664-4749 or at the address above. All concerns are logged into the OCO database and used as part of its overall reporting to policymakers and analysis of issues within DOC.

Sincerely,

Joanna Carns

Joanna Carns
Director

cc: Governor Inslee

OCO INVESTIGATION AND REPORT
BY CAITLIN ROBERTSON, ASSISTANT OMBUDS – EASTERN DIVISION

Summary of Complaint/Concern

On June 5, 2020, a white, 70 year-old man under the jurisdiction of DOC (the deceased) died at Sacred Heart Medical Center after sustaining life-threatening injuries while being violently attacked by another Incarcerated Individual (the accused) in Nora Unit, B Pod at Airway Heights Corrections Center (AHCC) on June 2, 2020. The victims of the deceased, for which he was serving his prison sentence, includes a minor family member of the accused.

Note: There is an ongoing criminal court case related to this homicide in which the accused has been charged with first degree murder. In light of the ongoing court case, the scope of OCO's investigation is very narrow: what can DOC do to prevent a similar bed/cell assignment from happening in the future. OCO did not review this complaint with a goal of determining issues of liability or culpability of the homicide and no inference of such should be made from this report.

OCO Statutory Authority

- Per RCW 43.06C.005, OCO was created to assist in strengthening procedures and practices that lessen the possibility of actions occurring within DOC that may adversely impact the health, safety, welfare, and rehabilitation of incarcerated individuals, and that will effectively reduce the exposure of DOC to litigation.

- Per RCW 43.06C.040, OCO has the authority to receive, investigate, and resolve complaints related to incarcerated individuals' health, safety, welfare, and rights.

OCO Investigative Process

As part of this investigation, OCO:

- Reviewed DOC policies and procedures, video evidence, and internal DOC staff correspondence
- Reviewed DOC's Critical Incident Review and Washington State Patrol's Report of the incident
- Interviewed relevant DOC staff
- Interviewed the Nora Unit, B Pod Tier Representative
- Interviewed the accused

Timeline of Key Events

The Deceased

12/30/2019 First admission to prison

2/13/2020	Initial Facility Plan created
	Assigned to medium custody with a transfer plan to AHCC
3/4/2020	Transferred from WCC to AHCC
3/4/2020	Assigned to bed NB10L

The Accused

10/20/2017	Readmission to prison (current incarceration)
10/20/2017	Initial Facility Plan created
	Assigned to close custody with a transfer plan to WSP Main
1/24/2018	Transferred from WCC-IMU to WSP Main
1/2018-6/2019	Numerous transfers, because of custody changes, to various facilities throughout the state
6/13/2019	Demoted to Intensive Management Status (IMS) / maximum custody
4/25/2020	Transferred from MCC-IMU to WSP-IMU to provide for COVID-19 preventative cleaning and physical spacing at MCC
5/13/2020	DOC Facility Risk Management Team (FRMT) at WSP met and recommended: maintain maximum custody until all facility plan and Behavior and Programming Plan (BPP) expectations are met
5/21/2020	DOC Headquarters MAX Custody Committee met and recommended: promotion to medium custody with a transfer plan to AHCC
6/2/2020	Transferred from WSP-IMU to AHCC
6/2/2020	Assigned to bed NB10U

OCO Findings

- **OCO finds no evidence of staff knowledge of a prior relationship between the accused and the deceased, prior to the bed assignment. OCO also cannot substantiate allegations that staff were made aware prior to the assault.**

- Following interviews with involved staff members, OCO could find no evidence, prior to the bed assignment, of staff knowledge that the accused and deceased had a prior relationship, nor that this prior relationship had any bearing on classification or cell determinations. This finding is in line with both the Critical Incident Review (CIR) and independent WSP investigation.

- In Nora Unit at AHCC, the Tier Representatives help DOC staff with welcoming new incarcerated individuals to the unit. The Tier Reps walk the new people to their assigned cell, introduce them to their cellmate, and provide guidance in navigating the unit. As part of this process, the Tier Rep from B pod walked the accused to his assigned cell and introduced him to the deceased. This Tier Rep told OCO that the two seemed to immediately know each other. Additionally, the Tier Rep reported to OCO that he told a staff member that the two seemed to already be familiar. When asked, the staff member stated that he did not recall that conversation with the Tier Rep. Regardless, no current process exists to separate individuals simply based on prior knowledge of each other, without a known safety or security issue present. The Tier Rep stated that based on his observation of their interaction he was not concerned, as it is reportedly common for cellmates to know one another at AHCC, and he did not communicate concern to the staff member that might have prompted staff action.[1]

- The accused states that he told DOC staff that he had a problem with his cell assignment. OCO reviewed related video evidence and cannot independently substantiate that claim and found no evidence that the deceased nor the accused communicated with DOC staff about their cell assignment after the Tier Rep escorted the accused to the cell and prior to the assault. Multiple DOC staff stated that had either one communicated the exact nature of their prior relationship to unit staff they would have immediately started an investigation and separated the accused and the deceased.

- **OCO finds that DOC's current classification counselor review process is reliant upon individual staff reviewing individual records, and it is unlikely that staff would have been aware of a prior relationship based on the current process.**

    - OCO reviewed the case files of both the accused and the deceased. As also reported in the CIR, the names of the accused and the accused's mother appear in the deceased's file. Additionally, the accused's mother is listed as a contact in the accused's file. While this overlap exists, OCO acknowledges that the accused and deceased had different counselors, entered the facility at different times, and, prior to the assault, the deceased's name does not appear anywhere in the accused's file.

    - Prior to assigning the accused to a bed, DOC staff reportedly reviewed his case files, PREA Risk Assessment, and WaONE assessment. This review of his files

[1] When interviewed, the Tier Rep stated that his only concern at the time was the age difference, as the accused was 25 and the deceased was 70.

prior to the accused's arrival at AHCC reportedly did not reveal his connection to the deceased. The current process is to review the incoming person's files, which means that since the deceased had entered the unit months before his files were not reviewed prior to the accused's placement.

- DOC's current file management system does not have the ability to search uploaded documents of incarcerated persons and cross-reference for any prior relationships or connections.

- **OCO finds that the accused's transfer to AHCC was a result of a DOC Headquarters decision to promote him to medium custody, overriding the local facility's recommendation to keep him at maximum custody.**

  - OCO reviewed the accused's file and, similar to the CIR, notes that the accused is documented as participating in two separate incidents in December 2019, neither of which resulted in infractions. In the first incident at MCC-IMU, the accused is documented in a Behavior Observation Entry (BOE) as participating in an organized group disturbance by covering his cell window, yelling, and kicking his cell door so hard that the door appeared unsecured and the cell required maintenance in order to be returned to service. In a second December BOE, the accused is documented as becoming aggressive with staff and making ongoing threats of physical harm toward the Correctional Unit Supervisor (CUS) of MCC-IMU. These two BOE narratives are both marked as negative; however, the accused was not infracted for either incident.

  - In May of 2020, the accused's classification counselor at WSP completed a review of his maximum custody progression. In the review, the counselor notes that his last major infractions were in May and June of 2019. Additionally, the counselor notes that he had two separations and no prohibited placements. The counselor recommended that he maintain maximum custody and facility (WSP-IMU) until all his expectations can be met. The WSP Facility Risk Management Team (FRMT) and the WSP Correctional Program Manager (CPM) of the unit all agreed that the accused should retain maximum custody until he met all facility plans and Behavior and Programming Plan (BPP) expectations.

  - After the facility completed the first portion of the review, a Corrections Specialist 4 at DOC Headquarters conducted a review, per DOC Policy 320.250. The Corrections Specialist noted that the accused had been infraction free since being placed in maximum custody in June of 2019, had completed some programming, and recommended to the Headquarters MAX Custody Committee that the accused be promoted to medium custody because on "May 14th he scores Medium custody." He also recommended that the accused be transferred to AHCC. Later, the Headquarters MAX Custody Committee agreed that the accused should be assigned medium custody and transferred to AHCC.[2] In the

[2] In follow-up communication with a member of the Headquarters MAX Custody Committee who had been involved in the accused's review, the member relayed his belief that the committee did review and were aware of the

plan, the committee's narration for their override decision is "behavior can be managed in medium custody."

- If the accused had received infractions for the incidents in December of 2019, he would not have been infraction free since June 2019, as described in his review. It is possible then that the Headquarters MAX Custody Committee may have determined that the accused should remain in maximum custody, which was the recommendation of the WSP committee. Instead, the Headquarters MAX Custody Committee overrode the facility review and in June 2020, the accused was released to medium custody and transferred to AHCC. Per DOC Policy 320.250, the Headquarters MAX Custody Committee has the final determination of placement.

Outcomes

- According to numerous DOC staff, following the finalization of DOC's Critical Incident Review, the Headquarters MAX Custody Committee is currently using a more cautious approach with classification overrides. OCO would recommend a more thorough, including increased documentation of the committee's decision-making, rather than a more cautious approach, and is generally supportive of less restrictive placements if a full review of all available information has been conducted.

Recommendations

- During the course of this investigation, OCO had numerous collaborative and productive conversations with DOC staff which helped to inform these recommendations. Throughout the investigation, OCO was often told that it is very common for incarcerated people to know or be aware of their cellmate prior to being placed together. Furthermore, OCO acknowledges that if either the accused or the deceased had reported their existing relationship to unit staff, protocol dictates that an immediate investigation be implemented and the two separated pending the result. While this homicide is a specific and unique case, OCO believes that other, less catastrophic, similar cell assignments may occur in the future. Therefore, in order to mitigate the potential for unnecessary harm, OCO makes the following two recommendations.

    - In order to augment existing classification counselor review processes, when the next file management system upgrade is made, prioritize obtaining the capability to electronically cross reference uploaded documents to mine for overlaps in multiple incarcerated individuals' files.

accused's negative BOEs. Further, he stated that BOEs without serious infractions are frequently discussed as part of Headquarters MAX Custody Committee decision-making. OCO's general understanding is that if negative behaviors do not receive infractions, it is assumed that there was insufficient evidence and they are not weighted as much in the Headquarters MAX Custody Committee's decision-making as infractions would be.

- Develop and implement a waiver form, which will be automatically triggered should staff become aware that cellmates have a pre-existing relationship prior to assignment of the same cell. If utilized, this low-tech form will enable DOC staff to proactively document that the incarcerated individuals do not believe that they are in danger with their assigned cellmate. This form will not supersede existing protocols and procedures which trigger investigations and segregated placements. Corrections already utilizes similar forms, such as the below *Personal Security Needs Assessment Waiver*, which AHCC staff provided to OCO as an example of an existing protocol and waiver.

Department of Corrections
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DEPARTMENT OF CORRECTIONS
AIRWAY HEIGHTS CORRECTIONS CENTER
P.O. Box 1899 • Airway Heights, WA 99001-1899

PERSONAL SECURITY NEEDS ASSESSMENT WAIVER

Inmate Name:	DOC Number	Housing Unit

I have been interviewed this date to determine my personal security needs. The following statement, which I have checked and initialed, clearly indicates my desire to remain in general population. I assume full responsibility for my safety. If I feel I need protective custody to let staff know immediately.

Check	Initials	Statement
		I do not feel that I need to be segregated from the general population for my safety, I am not aware of any enemies among the inmate population, and do not believe that I am in any danger
		The circumstances or persons that caused my placement in Administrative Segregation are no longer present in this institution. I therefore request to be released from Administrative Segregation and returned to general population.

Inmate Signature	DOC Number	Date:
Staff Witness Signature	**Title**	**Date:**

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
P.O. Box 41100 • Olympia, Washington 98504-1110

December 7, 2020

Joanna Carns
Office of Corrections Ombuds
2700 Evergreen Parkway NW
Olympia, WA 98505

Dear Ms. Carns:

The Washington Department of Corrections appreciates the opportunity to respond to the OCO Report on the 'investigation into the recent death of a person incarcerated at Airway Heights Corrections Center' completed by the Office of Corrections Ombuds.

Upon the unfortunate death of the person incarcerated at Airway Heights Corrections Center, the department launched both an internal and external set of investigations to review the death and determine any systems needing improvement. The scope of the investigation also included culpability of the department in the individual's death. The finding of the external investigation was that the department properly followed all procedures in place to protect the incarcerated population. The recommendations set forth by the OCO will further enhance the department's procedures to protect the incarcerated population.

After the internal review of this incident, the Assistant Secretary for Prisons in partnership with the Assistant Secretary for Reentry, updated the existing DOC Form 17-087 Separation/Prohibition Additional/Removal Questionnaire with two additional questions:

- Does the individual know any individual(s) currently incarcerated with the department who:
    - Would be a safety/security risk to their self or others? □Yes □No
    - Committed a crime against them or their friend/family member/significant other? □Yes □No

Adding these two questions should give classification more definitive information (if answered honestly) when decided facility housing assignments.

Per the agency's health services webpage, over the most recent five calendar years, the Washington Department of Corrections has experienced two homicides of those housed within its correctional facilities. Per the agency's data analytics webpage, the average daily population (ADP) for the state's correctional facilities is 16,000 individuals. The Department takes very seriously the health and welfare of each individual committed to its custody. The information provided by the OCO was useful to ensure the Department of Corrections is doing everything it can to ensure an incarcerated person's time in the agency's correctional facilities is a fair and safe space for all incarcerated individuals.

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Recommendation	Response
Develop and implement a waiver form, which will be automatically triggered should staff become aware that cellmates have a pre-existing relationship prior to assignment of the same cell. If utilized, this low-tech form will enable DOC staff to proactively document that the incarcerated individuals do not believe that they are in danger with their assigned cellmate. This form will not supersede existing protocols and procedures which trigger investigations and segregated placements. Corrections already utilizes similar forms, such as the attached Personal Security Needs Assessment Waiver, which AHCC staff provided to OCO as an example of an existing protocol and waiver.	The department is currently analyzing *DOC Policy 420.120 Cell/Room Assignment* and determining a subsequent process for utilizing such a form or other practices in alignment with this recommendation.
In order to augment existing classification counselor review processes, when the next file management system upgrade is made, prioritize obtaining the capability to electronically cross reference uploaded documents to mine for overlaps in multiple incarcerated individuals' files.	The department agrees to document this functionality as a potential feature for a new correctional file management system as it looks to modernize or replace the current offender management system.

We also appreciate your team's understanding of the unique processes across facilities and the addition of policies and procedures being put in place to address them. We are working towards proactivity and improving quality assurance processes throughout the department. Moving forward, Washington Department of Corrections will continue to collaborate with the Office of the Corrections Ombuds to implement additional policies, procedures, and security measures to continue to improve the facility operations.

Sincerely,

Steve Sinclair, Secretary
Washington Department of Corrections

"Working Together for SAFER Communities"