STATE OF WASHINGTON

OFFICE OF THE CORRECTIONS OMBUDS

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November 13, 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 COVID-19 outbreak at the Coyote Ridge Corrections Center. We appreciate the opportunity to work collaboratively with DOC to amend current policies and practices to better ensure the health and safety of all incarcerated persons 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

OFFICE OF THE CORRECTIONS OMBUDS REPORT
INVESTIGATION OF THE CORONAVIRUS DISEASE 2019 (COVID-19) OUTBREAK AT COYOTE RIDGE CORRECTIONS CENTER (CRCC)
CONDUCTED BY CAITLIN ROBERTSON, ASSISTANT OMBUDS--EASTERN AND PATRICIA DAVID, MD MSPH CCHP, DIRECTOR OF PATIENT SAFETY AND PERFORMANCE REVIEW
REPORT EDITED BY JOANNA CARNS, OCO DIRECTOR

Summary of Concern

On the evening of May 8, 2020, a white, 70+ year-old man reported to CRCC medical staff that he was experiencing COVID-19 symptoms. After self-reporting his symptoms, DOC transferred him from CRCC's C Unit, B Side to the medical isolation unit. Forty-eight hours later, he was given a COVID-19 test, and another two days after that, CRCC learned the results – positive.

Following the positive test result, DOC transferred the man ("Patient Zero")[1] to the Regional Care Facility (RCF) at Airway Heights Corrections Center (AHCC) for better treatment and care. But in the time that passed from the person's first symptoms to his eventual transfer, the infection had already spread. By September 1, the number of COVID-positive incarcerated persons at CRCC grew to 233 with 73 staff having tested positive. Tragically, two incarcerated persons at CRCC died due to COVID.[2]

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 persons, 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 persons' health, safety, welfare, and rights.

OCO Investigative Process

- Interviewed 22 CRCC staff, including executive leadership, health services staff, and custody staff. The Facility Medical Director and the Health Services Manager initially refused multiple interview requests; however, in mid-September after receiving a preliminary draft of this report, as required by law, both agreed to be interviewed.

- Requested representatives from the Benton Franklin Health District and the Washington State Department of Health participate in this investigation. Invited participation from members of Teamsters 771, all but one did not respond.

[1] For the purpose of this report, we use the designation "Patient Zero" to refer to the index case within the CRCC incarcerated population, i.e., the first identified patient with a positive COVID-19 test.
[2] The two deaths were reviewed by OCO staff and are discussed in a separate report.

- Interviewed five CRCC Incarcerated Patients, with COVID-19 positive tests.

- Met in-person with six CRCC Incarcerated Patients, after they were tested but before receiving positive results, in the medical isolation area.

- Met in-person with CRCC Tier Representatives from every unit in the main complex.

- Reviewed DOC internal correspondence, fact finding documents, patient medical records, and mapping of Incarcerated Individuals and CRCC Staff.

- Reviewed the Center for Disease Control and Prevention (CDC)'s recommendations for correctional and detention facilities and DOC COVID-19 guidelines.

Timeline of Important Dates

Date	Relevant Information
3/18/2020	First COVID-19 test administered for I/I at CRCC: test result was negative
4/10/2020	Memo: Mandatory Use of Face Coverings for staff in all DOC locations
4/17/2020	Memo: Mandatory Face Coverings for Incarcerated Individuals and Residents
5/8/2020	Patient Zero self-reports symptoms at 2050 hours
5/9/2020	Patient Zero moved to the medical isolation area 0110 hours
5/11/2020	Patient Zero given COVID-19 test
5/13/2020	CRCC receives COVID-19 positive tests result for Patient Zero
5/13/2020	After receiving Patient Zero's positive test results, CRCC moves Incarcerated Patients (I/P) #1, 2, and 3 into the medical isolation area. I/P #1: cellmate of IP Zero's wheelchair pusher; I/P #2: IP Zero's cellmate; I/P #3: IP Zero's wheelchair pusher
5/13/2020	Patient Zero transferred to Regional Care Facility at AHCC
5/15/2020	First OCO Monitoring Visit at CRCC: OCO met with six Incarcerated Individuals in the medical isolation area, including I/P #1, 2, and 3
5/16/2020	CRCC receives three new COVID-19 positive test results for Patients from C Unit B Side: I/P #1, I/P #2, and I/P #3
5/16/2020	CRCC receives first COVID-19 positive test result not from C Unit B Side. I/P #4 resided in H Unit: confirmation that outbreak not isolated to one unit
5/16/2020	C Unit B Side placed on Quarantine
5/16/2020	I/Ps #1, #2, #3, and #4 transferred to Regional Care Facility at AHCC
5/17-18/2020	DOC's Chief Medical Officer on-site at CRCC
5/23/2020	Multi-person fight in Medium Units, resulting in CRCC placing all Medium Units on restricted movement "lockdown"
5/31/2020	25th I/I with positive tests results for COVID-19
6/10-11/2020	DOC's Deputy Chief Medical Officer deployed to CRCC
6/11/2020	All Medium and Minimum Units in the Medium Security Complex (MSC) placed on restricted movement "lock-down" including the suspension of all food and textile production at the Correctional Industries (CI) facility; CI laundry and food services continued to be operated by I/I essential workers

6/12/2020	Second OCO Monitoring Visit: current lockdown procedure of 20 minute out of cell rotation; after OCO recommendations, DOC increased out of cell time for all I/I to 30 minutes
6/17/2020	First Incarcerated Patient dies of COVID-19
6/17-20/2020	DOC's Chief Medical Officer deployed to CRCC
6/22/2020	Second Incarcerated Patient dies of COVID-19
6/24/2020	Mass testing begins for all I/I in the MSC
6/24/2020	Implementation of serial testing for all-staff in Medium Security Complex (MSC) and Medium Security Unit (MSU)
6/24-26/2020	DOC's Deputy Chief Medical Officer deployed to CRCC
7/1-3/2020	DOC's Deputy Chief Medical Officer deployed to CRCC
7/13/2020	Memo sent to All DOC Staff re: COVID-19 precautions for employees who carpool/vanpool

Findings

OCO's investigation revealed a number of outcomes – both positive and negative – in relation to DOC staff's response to the COVID-19 outbreak at CRCC.

A primary positive that cannot be understated is that even while COVID-19 spread throughout CRCC's main facility, it did not spread to the Minimum Security Unit (MSU), a 450+ bed facility which includes Sage-East, where a vulnerable population of elderly and assisted living incarcerated individuals reside. DOC took a number of additional precautions to protect the population, as documented by OCO's monitoring visit to CRCC. These precautions included the following:

- Prior to entering Sage-East, personnel walked through multiple layers of large plastic tarps (which act as a barrier), washed hands, sprayed down shoes with Germicidal Disinfectant, and donned a medical mask and gloves.
- All persons – both incarcerated and staff – appeared to take face coverings very seriously, as opposed to what was viewed on the main compound next door.
- Social distancing was better facilitated through multiple temporary housing spaces in education rooms, the library, and the visiting area of the MSU. The temporary housing areas provided some incentives to the persons living there through large televisions and an initial choice of their room configuration.
- An effort was reportedly made to limit potential transmission by staff by restricting staff to only working with certain units rather than traveling throughout the facility.

It is very likely that the medical fragility of the population housed in the MSU led to greater prevention measures; however, as the MSU reported zero positive cases even as positive cases grew in the main compound next door, it is a positive case study for how to mitigate the spread of the disease within a correctional setting.

A second positive identified from the investigation are the staff who continued to show up every day to work to take care of the incarcerated population. As will be discussed later in the report, CRCC experienced an immediate deficit of staff. Key staff – including the Facility Medical

Director and the Infection Prevention Nurse – initially stayed home because of personal and familial health concerns. In contrast, a key cohort of corrections staff and administrators continued to show up to work every day and staff from other institutions were voluntarily deployed to assist in responding to the epidemic outbreak and continue to provide for the safety and security of all in the facility.

A third positive was DOC's decision to immediately move Patient Zero out of CRCC to a facility that could better provide treatment and close proximity to acute medical care. As will also be discussed later in the report, CRCC does not have adequate medical facilities to provide all but the most basic of care. Patient Zero presented as an elderly individual with comorbidities; as soon as the facility received confirmation of a positive test, he was removed from the facility and taken to the Regional Care Facility at AHCC. Although the loop of transferring individuals from CRCC to AHCC to MCC and then back to CRCC raises serious concerns about potential spread of infection, it is clear that CRCC did not have sufficient facilities to care for individuals at higher risk for complications due to COVID-19.

Despite the above positives, OCO also identified several issues that likely complicated the outbreak at CRCC, including: (1) a series of delays following first reported symptoms of Patient Zero; (2) physical and geographic limitations of the facility; (3) an organizational structure in which CRCC health services could not take a leadership role in the outbreak response; (4) high staffing shortages; and (5) limited self-reporting among incarcerated individuals.

Series of Delays Following First Reported Symptoms of Patient Zero

- ***Delay in Administration of Tests.*** On the Friday evening of May 8, 2020, Patient Zero was evaluated for COVID-19 symptoms. A nursing note in his medical records indicates that a COVID-19 test was ordered for May 11, 2020, the following Monday. When asked about the multi-day delay in administering a test, DOC responded "that was done on a Friday night at almost 09:00 PM. Unfortunately, we do not have any labs that go out on the weekend so we have to get them done and sent out Monday through Friday." Subsequent DOC facilities have reported administering and receiving tests "24/7 and over the weekend." CRCC received Patient Zero's positive COVID-19 test results five days after first documenting his COVID-19 symptoms.

- ***Delay in Response to Reported Symptoms.*** Several incarcerated individuals relayed that they were not immediately evaluated by health services staff even after they reported symptoms in line with COVID-19. As one example substantiated through DOC's contact mapping document, on May 18, 2020, one unit porter reported to custody staff that he was not feeling well and asked to be allowed to drop in for a health check. Custody staff said that he needed to first sign up for a sick call. Four days later on May 22, 2020, with a 102-degree temperature, he was finally seen by health services and moved to isolation and tested. Two days later, on May 24, 2020, he was transferred to the Regional Care Facility and on May 26, 2020, CRCC learned that he had tested positive.

- ***Delay in Quarantine.*** CRCC waited until a positive COVID-19 test result to start a large-scale quarantine of those who were potentially exposed. On May 16, 2020, eight days

after Patient Zero was evaluated for COVID-19 symptoms and three days after his positive test result, CRCC put C Unit B Side on full quarantine. By that point, the outbreak had already spread to multiple units.

  - On May 23, CRCC significantly restricted movement across the main complex; however, this was in response to a critical multi-person incident rather than a response to COVID-19. In hindsight, this likely played a positive role in reducing the spread of the disease.

  - On June 11, more than one month after the start of the outbreak, CRCC placed all units in the Medium Security Complex (MSC) on restricted movement "lockdown" including the suspension of all food and textile productions at the Correctional Industries (CI) facilities.

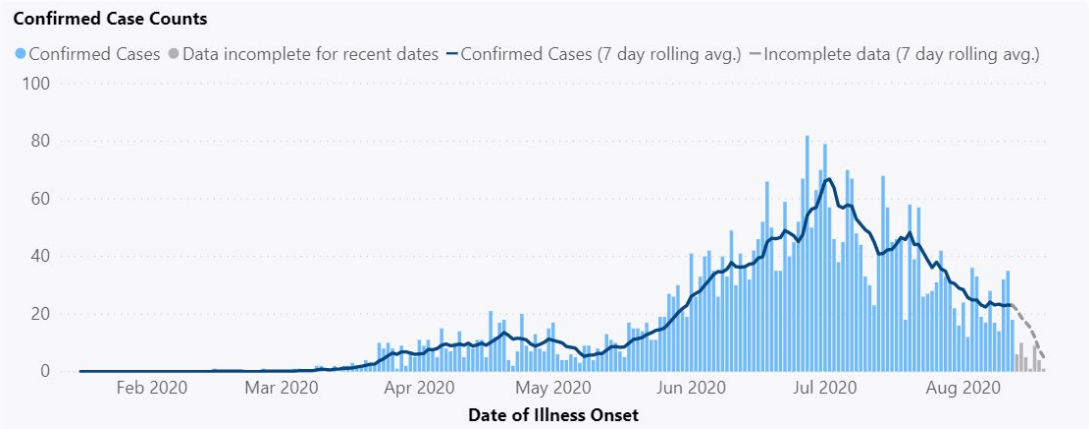
  - Subsequent DOC protocols have been updated to now reflect a distinctly different process: quarantine and isolation based on symptoms and mass testing in units once an outbreak is identified.

- ***Delay in Compliance of Mandated Face Coverings.*** Speaking from CRCC after returning from the Regional Care Facility at AHCC, another Incarcerated Individual told OCO, "at the early stages, the officers refused to wear masks, they put it on us. But, we're not out in it. They [DOC] forced us to wear masks before staff." Perhaps surprisingly, some staff felt that DOC Headquarters' decision to not immediately mandate face coverings, and ideally medical masks, for all people inside CRCC was an example of short-sighted management and bad leadership. One staff said, "HQ made statewide decisions that put us [CRCC Incident Command Team] in unfair and difficult positions. None of us have ever experienced anything like this before, not even HQ. We should have had masks, not the fabric ones, actual masks. HQ was too slow with mandating that everyone wear them. We were waiting on HQ."

Physical and Geographic Limitations of CRCC

- ***Geographic Limitations.*** CRCC is located in Connell, Washington, more than 45 miles from the nearest Regional Medical Center and access to outside medical resources in the community is limited. Emergent medical cases are transported to the nearest Regional Medical Center by utilizing volunteer-run, emergency medical transportation. Given the potentially rapid progression of COVID-19 symptoms, which for many patients in the community includes the need for a ventilator to assist with breathing, swift access to a local hospital is critical.
  - Further complicating the picture for CRCC is that Franklin County, Washington, in which CRCC is located, experienced a fast progression of COVID-19 cases in the second half of May through August 2020 (see chart below).[3]

[3] https://www.doh.wa.gov/Emergencies/NovelCoronavirusOutbreak2020COVID19/DataDashboard



- As documented in various news articles, the areas surrounding CRCC seemed unable to obtain widespread face covering compliance for many reasons, including socio-political opinions. In fact, one DOC staff at HQ said that he lodged in the Tri-Cities for one week while observing the response to the outbreak at CRCC and during that time he and the other HQ employee were "incredibly, the only people he saw wearing masks." The local community's perception of the severity of COVID-19 likely contributed to many staff members being mapped out due to their interactions outside of work.

- Not only were DOC staff at a higher risk of contracting the disease in their local community, many staff utilized carpool/vanpool methods to commute to work, resulting in shared airspace and possible spread of infection. While it may be impossible to isolate exactly how COVID-19 entered the facility, in multiple public conversations, DOC's HQ leadership have stated that they know that staff are the most likely way COVID-19 enters their facilities. OCO heard reports of staff commuting by carpool/vanpool and refusing to wear a face covering.

- ***Facility Design Limitations.*** Most of DOC's major facilities have an infirmary, where higher-level healthcare services such as focused nursing, complex wound care, or intravenous antibiotic treatment can be administered to patients. CRCC was built without this capability.

    - CRCC has an Extended Observation Unit (EOU), which is an area of the clinic only intended for short stay medical observation. The level of care that can be provided in the EOU is less than what can be provided at an infirmary.

    - The minimum units in the main complex are dry cells, meaning they do not have running water or toilets. These units are less expensive to build and require less staff to maintain; however, they were not built with the foresight of pandemic preparedness. The fact that there is no running water, toilets, or showers necessitated ongoing movement in and out of the cells and mixing of the population.

An Organizational Structure in Which CRCC Health Services Could Not Take a Leadership Role in the Outbreak Response

- ***ICP Structure.*** Recognizing that COVID-19 is a health care crisis, HQ directed CRCC to organize a dual discipline command structure in which anytime the Incident Command Post (ICP) was open, a representative from medical was expected to be present. Yet, OCO learned that most health services staff believed that custody staff controlled the facility's response to the outbreak. As is often the case in many prisons, there is a perceived disparity between the importance of the roles of health services and custody staff. During many interviews OCO heard that at CRCC the custody staff are of primary importance and the health services staff often feel ancillary. Not only does health services staff feel this difference, they suggested it should be reversed. However significant this perceived inequity is in normal operations, during the outbreak tensions rose between health services and custody staff.

    - The Health Services Manager (HSM) is a part of the ICP. However, OCO learned that many health services staff believe that the HSM did not push forward their recommendations to the ICP. In responding to this accusation, the HSM reminded OCO that with only one mandatory health services representative on the ICP there was a power imbalance. Not only was there only one mandatory health services staff part of the ICP, the HSM was very new in this role and many staff told OCO that they felt the HSM was tempted to "play the hero" and said far too often, "I can do it, we don't need outside help." After reviewing a preliminary draft of this report, the HSM agreed to be interviewed by OCO. During the interview he defended his leadership style. Ultimately, the HSM suggested to OCO that he believed that part of his role was to support the health services staff to stay motivated and that he did advocate for increased staffing. However, while staffing remained low he felt it is was imperative to keep a positive outlook by telling his staff that they could handle the situation with the resources available to them at the time. While OCO heard conflicting reports from staff and the HSM, what is known is that, like in many DOC facilities, the CRCC HSM is an administrator with little medical training and he was new to CRCC. Both of these factors may have played a role in the HSM not feeling empowered to push forward the needs of health services staff over custody decisions.

    - The Facility Medical Director (FMD) is not a permanent member of the ICP. Although the FMD's role is to ensure that the clinical care delivered in their facility is appropriate, and despite an infectious disease pandemic seeming to require greater input from healthcare staff onsite, the ICP was not modified to always include the FMD.

- ***HQ Medical Leadership***. Once the first incarcerated person tested positive HQ medical leadership immediately stepped in to make decisions; the Chief Medical Officer (CMO) was first on-site at CRCC May 17-18, 2020. As HQ stepped in, however, health services staff reportedly felt micromanaged or, worse, some felt that the "left hand didn't know what the right hand was doing." OCO heard many staff state that the FMD used sound

medical judgement in deciding to order tests for the three incarcerated patients with close contact to Patient Zero. Yet, the CMO and other HQ leadership staff "chastised" the FMD for going beyond the current protocols, even though the patients ultimately tested positive. When asked about the reported interaction with the FMD, the CMO responded that she did not chastise but did remember "reiterating to the staff the current protocols."

- ***Questions About the FMD's Availability.*** The FMD was not consistently inside the secure perimeter for the majority of the CRCC outbreak response and multiple health services staff stated confusion as to his whereabouts. He is recorded as entering the main complex's secure perimeter the following percentage of possible scheduled work days: 22.22% in March and April; 66.67% in May; 11.11% in June; and 38.46% through July 22nd.[4] Initially the FMD refused to be interviewed; however, after receiving the preliminary draft of this report, the FMD made attempts to clarify his availability during the outbreak. The FMD asserts that while he was often away from the facility in March and April because of personal and familial health concerns, when he returned to the facility and wanted to join the ICP he was told that there was not a chair for him. Rather, he was instructed to sit in a small conference room, near the ICP conference room so as to be available should the ICP wish to speak with him. OCO obtained confirmation from two sources that this updated information is correct.

    - The FMD plays a critically important role in maintaining the health and safety of the population. As the facility's lead, medical professional with significant historical, institutional knowledge, one would expect the FMD to have readily available insights into the unique needs of the CRCC population. An FMD would likely not need to rely on charts to make decisions, but rather use their on-the-ground experience of the population. However, OCO learned that even though the FMD was instructed to be stationed outside the ICP so as to be readily available to answer their questions, consistently the ICP relied on the HSM to make time-sensitive medical decisions without always consulting the FMD. As stated above, the HSM, who is the FMD's supervisor, is an administrative employee with minimal medical training and the only mandatory health services member of the ICP.

- ***Absence of the IPN***. The Infectious Prevention Nurse (IPN) plays a key role in responding to an infectious disease outbreak. CRCC's IPN screened out in early April and did not return to the facility until May 7, 2020; he was reportedly not provided a laptop to work from home. During this time, the IPN should have led the contact mapping training process before the first COVID-19 positive result. Instead, the ICP custody staff took on the extra burden of implementing a contact mapping process and strike team to perform this critical task. OCO heard many reports of leadership working extremely long hours, with little time for rest, and focused primarily on contact mapping. Once the IPN returned from administrative leave in early May, OCO heard reports that "no one listened to the IPN" and that the HSM consistently dismissed the IPN's trained medical opinions. Moreover, the IPN was not regularly included in the daily operations of the ICP and has since been reassigned.

[4] CRCC's Non-Custody Staff Accountability Rosters from March 1- July 22, 2020.

High Staffing Shortages

- ***Critical Staffing Shortages.*** Hundreds of CRCC staff utilized some type of leave during the months of May through July. Reportedly, the majority due to COVID-19 related reasons such as personal health concerns, screened out from contact mapping, or due to potential exposure off-site. It is normal for hundreds of staff to utilize leave during a pay period, which could be for a few hours or multiple days. However, the below data show that a significantly greater number used more than three days of leave than during the same time periods in 2019. In fact, multiple staff commented on the increased leave with comments like, "those of us who are still here" or "those of us who came to work every day" or "I'm one of the very few who has been here the whole time." CRCC leadership assert that despite this shortage, all of the essential posts were filled; it is difficult to determine what impact the staffing shortages had as many programs and activities were cancelled and the facility was on modified operations but, at a minimum, OCO observed low staff morale, to which the staffing shortages almost certainly contributed.

All CRCC staff on three or more days of leave in 2019 and 2020

Pay Period	Number of CRCC Staff	
	2019	2020
May 1-15	116	142
May 16-31	131	195
June 1-15	240	220
June 16-30	133	242
July 1-15	138	205
July 16-31	156	245

CRCC Prison Staff on three or more days of leave in 2019 and 2020

Pay Period	Number of CRCC Staff	
	2019	2020
May 1-15	99	130
May 16-31	118	174
June 1-15	223	203
June 16-30	114	221
July 1-15	121	166
July 16-31	140	221

Additional DOC staff deployed to CRCC

Pay Period	Number of DOC Staff
May 1-15	0
May 16-31	0
June 1-15	27
June 16-30	73

July 1-15	58
July 16-31	5

Rapid Hire Correctional Officers

Month	Number of Rapid Hires
May	13
June	0
July	0

- Staffing shortages are a particular concern during a healthcare crisis. According to numerous CRCC staff, prior to the COVID-19 outbreak there were staff shortages in health services and these shortages increased as some high-risk staff chose to stay home and others were mapped out due to potential exposure.

CRCC Health Services Staff on three or more days of leave in 2019 and 2020

Pay Period	Number of CRCC Staff	
	2019	2020
May 1-15	14	11
May 16-31	11	18
June 1-15	15	14
June 16-30	15	17
July 1-15	15	20
July 16-31	15	14

- ***More Staff Training Needed.*** As depicted above, with the staffing shortages, CRCC utilized fill-in staff from other facilities, contract health services staff, and hired through the rapid hire process. While understandable, this resulted in employment of staff who may have had limited knowledge of DOC policies and did not have knowledge of the institution, the incarcerated population, nor the newly employed tactics to handle the population in the midst of an outbreak.
    - One infection prevention tactic CRCC staff used was a cohort model in every unit to group people together and reduce the potential spread of the disease. However, OCO uncovered multiple reports of cohort breakdowns due to confusion and inconsistent operations. The replacement staff working in units did not have the benefit of unit knowledge (such as knowing the population and experience with demeanor and personalities). Moreover, without a thorough explanation of the importance of maintaining cohorts, mistakes happened. These breakdowns in cohorts resulted in unnecessary interactions between members of different cohorts which made the mapping process more confusing and time consuming, not to mention, may have contributed to avoidable spread. One staff member said, "we couldn't catch it, we were constantly chasing instead of getting ahead."

- A nursing note dated June 18, 2020, from one of the two individuals whose death is attributed to COVID-19, states that CRCC received a call from a nurse at Kadlec Regional Medical Center asking permission to have a medical procedure performed. The note includes "Call placed to medical duty officer, Practitioner duty officer HCM2 & FMD. Unable to get permission due to no answer from HCM2 and FMD." Per DOC Policy #610.010 *Offender Consent for Health Care, Section G: Emergency Medical Treatment When No Surrogate Decision Maker is Available:* "1. If a reasonable clinician would conclude that delaying medical or dental service might put the offender at significant risk, permission to treat will be obtained from the Chief Medical Officer or Chief of Dentistry, as applicable and if time permits." As noted earlier in the Timeline of Important Events on page 3, DOC's Chief Medical Officer was deployed to CRCC June 17-20, 2020. However, the note does not include mention of trying to contact the Chief Medical Officer who was deployed to CRCC on that date and ostensibly available to make this medical decision per policy.

Limited Self-Reporting Among Incarcerated Individuals

- Many staff shared their overall frustration with the minimal amount of I/I self-reporting symptoms during the outbreak. Instead of being able to rely on self-reporting, investigation and surveillance tactics like listening to phone conversations, monitoring video visits and JPay messaging, and reviewing incoming and outgoing mail became the main method of identifying sick people. Many staff said they were frustrated with the amount of outside family members suggesting that people hide their symptoms and try to "ride it out in their cell."

- Based on interviews with the incarcerated, OCO believes that rumors, both incorrect and correct, of conditions of confinement for people placed in medical isolation contributed to the minimal cases of self-reporting. Reports of dirty cells, including feces and leftover food covering the walls in the isolation unit at Monroe (where a number of people were transferred for convalescing), and being handcuffed and transported in vehicles that looked like "dogcatcher trucks with no windows," likely convinced many people that reporting symptoms would result in placement in punitive type conditions.

    - DOC staff attempted to address the low self-reporting via a video of CRCC's Superintendent speaking directly to the population regarding the outbreak. The video, played on rotation on the facility's TV channels, shows the leadership earnestly asking for help and compliance from the population in stopping the spread of the outbreak, including a sincere request to self-report.

    - In comparison to these concerns regarding the isolation units at CRCC and Monroe, OCO heard many reports of the positive conditions at the Regional Care Facility at AHCC with one person saying "they treated us real good, it was clean and the officers and staff were really nice." As discussed above relative to the MSU, CRCC also was able to incentivize incarcerated individual movement in

that unit with additional televisions and the incarcerated individual having some say in their arrangement.

- Last, related to the rumors of poor conditions of confinement for individuals in medical isolation, individuals also reported to OCO that efforts to obtain corrective action through the grievance procedure were quashed, with their grievances returned to them for "re-write" or "not-grievable, due to the Governor's proclamations." Many people suggested that if DOC was not willing to address the poor living conditions then why would anyone want to self-report and experience, what felt like them to be, punishment in isolation.

Recommendations

DOC is reportedly already in the process of conducting its own internal investigation into the outbreak response. **An overarching recommendation is that DOC develop its own list of lessons learned that it distributes to all of the facility superintendents and that it creates an action plan for any future outbreaks**.

In addition to the above, OCO has the following recommendations based on its findings from the CRCC investigation, almost all of which can also be found in OCO's prior publication, *Recommendations Related to the DOC COVID-19 Response,*[5] as well as the OCO report on the deaths due to COVID-19, as these reviews occurred simultaneously and informed each other.

Promptly

- Related to the above cited nursing note in which a person needing emergent care at the external hospital and the Chief Medical Officer was not contacted in violation of DOC Policy 610.010, **DOC should update and clarify this policy to reflect any desired changes to the process for emergency medical treatment when a patient is unable to give consent and no surrogate is available. Once updated, a review of the working agreements between DOC and regional hospitals should be conducted by Health Services administrative leadership, so that the hospitals where incarcerated individuals receive treatment are aware of DOC's process. Finally, the policy should be reviewed with all Health Services staff, including CRCC health services staff, so that calls requesting permission for treatment are promptly directed to the appropriate decision maker(s).**

Prior to Symptoms in a Facility

- **DOC should monitor communicable disease activity in the community, and upon measuring a demonstrable increase, DOC should require staff to wear masks and initiate enhanced hygiene measures.**

[5] https://oco.wa.gov/sites/default/files/COVID-19%20Workgroup%20Report%20Final.pdf

- **Similarly, if an increase in communicable disease activity is seen in the community, DOC should work to gain staff compliance with social/physical distancing and face coverings while off-duty.** DOC can utilize existing state public awareness campaigns to assist with staff education, and should work with the union to gain compliance for the safety of the entire facility.

- **DOC should engage in greater preparedness and training, including the following:**

    - **Each facility should develop and publish a working cohort model within every unit before the first symptomatic patient is identified**. Once a symptomatic person is identified, the cohort model should immediately be implemented per affected unit(s). In addition, staff should be trained on cohort modeling so that they understand the importance of strictly maintaining every cohort.

    - **Develop and implement formal training for staff related to contact tracing.**

    - **With the knowledge that a large number of staff will be out of the facility on leave during an infectious disease pandemic, easy-to-implement training should be developed and implemented so that new staff coming into the facility can be quickly acclimatized to the facility.** If not already in practice, all post orders and facility specific operational memoranda should be updated and a training binder should also be implemented specifically for staff with no prior understanding of the facility or the population so that staff can quickly gain the knowledge that they need to effectively run the institution, with a diagram of the cohort model in existence.

Once a Person Develops Symptoms

- **From the moment that a person (either incarcerated or staff) reports or is discovered to have symptoms, the entire unit in which the person had regular contact (or cohort if a cohort model has been implemented) should be placed on immediate quarantine.**

- **Clear identification of trigger for DOC's response to an outbreak at a facility.** DOC should develop a clear definition of an *outbreak* which, once met, triggers a cascade of events including but not limited to cessation of transfers between units, cessation of transfers between facilities, discontinuation of staff rotations between units, launch of contact tracing efforts, expanded testing, etc.

- **DOC should provide greater amounts of PPE to the incarcerated population – face coverings at a minimum – upon request, and face shields or alternatives for those who physical or mental health conditions are exacerbated by wearing a cloth face covering.**

- **Full-time, on-site clinical leadership at all times at the start of the outbreak and for the duration that it lasts.**

    - Clinical leadership should move to 24/7 coverage, with a minimum of on-site presence of the leadership daily. If the Facility Medical Director cannot be physically present, alternate in-person coverage should be provided, such as by the Chief Medical Officer or designee.

- The Facility Medical Director should be a mandatory member of the facility Incident Command Post (ICP).

- **DOC should perform more rigorous screening and testing, including the following:**
  - Medical surveillance via daily mass screening of the entire population.
  - Testing of staff when there are increased cases in the community surrounding a facility.
  - Once an incarcerated person tests positive at a facility, testing should be expanded to include all close contacts, as well as all those in the incarcerated person's unit who fall within the CDC high-risk groups.
  - Implementation of on-site rapid diagnostic (antigen) testing for COVID-19.

- For the welfare of the persons in medical isolation and to improve self-reporting by potentially infected persons across the compound**, DOC should take immediate action to improve conditions of confinement for those in medical isolation.** Suggestions include:
  - Increased free phone calls with family
  - Ensured JPay access, if possible, including video visitation
  - Books, magazines, newspapers, printed articles of interest to the population
  - Materials created/made available by the chaplain
  - Increased visits from mental health providers
  - Ensured access to personal property, including address book
  - Visualization/mental imagery guides
  - Basic art materials (drawing, painting, clay, beading)
  - Working radio and television for every cell
  - Food treats (energy bars, popcorn, occasional cookies and other sweets)
  - Origami and other crafts
  - Daily showers or at least every other day
  - Recreation activities, preferably out of cell, but at least in-cell.

- Also related to improving self-reporting by potentially infected incarcerated persons**, DOC should, on a weekly basis, distribute to incarcerated people and staff information such as number of positive cases at their facility, proper personal hygiene, and significance of social distancing and ensure an individual's COVID-19 related complaints are addressed, whether through the grievance program or otherwise.**