



STATE OF WASHINGTON

OFFICE OF THE CORRECTIONS OMBUDS

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

May 14, 2020

Steve Sinclair, Secretary
Department of Corrections (DOC)

Office of the Corrections Ombuds (OCO) Investigative Report

Attached is the official report regarding the OCO investigation into staff actions during the recovery of an escaped individual who had been residing at Olympic Correction Center. We look forward to working with DOC to amend current policies and practices to better ensure that all incarcerated persons' health, safety, and rights are 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,

A handwritten signature in black ink that reads "Joanna Carns".

Joanna Carns
Director

cc: Governor Inslee

**OCO INVESTIGATION
INVESTIGATION CONDUCTED BY CHRISTY KUNA, ASSISTANT OMBUDS –
WESTERN DIVISION**

REPORT BY CHRISTY KUNA AND JOANNA CARNS, OCO DIRECTOR

Summary of Complaint/Concern

On or around August 16, 2019, the Office of the Corrections Ombuds (OCO) received a complaint on behalf of an escaped but re-captured incarcerated individual, which alleged the following:

- The complainant cited that on August 13, 2019, DOC staff ordered staff to pull the housing unit fire alarm at Olympic Correctional Center to “parade” the returned incarcerated individual in front of others in order to “ridicule/degrade” the incarcerated individual. The complaint was later amended to include that the decision to pull the fire alarm was ordered by DOC high level administrative staff.

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 Actions

- As part of this investigation, OCO reviewed DOC policy regarding staff conduct expectations, and Reporting and Reviewing Critical Incidents. OCO also reviewed related grievances, email and phone activity between specific staff, reviewed supporting documents and contacted incarcerated individuals, as well as DOC staff for additional information.

OCO Findings

- The incarcerated individual (I/I) in this case is diagnosed with a mental health condition which includes sensitivity to environmental sounds and light and difficulty sleeping. OCC staff were aware that the I/I was particularly sensitive to lights and noise.
- OCC staff reportedly had an agreement in place with the I/I that would allow for a transition from his current placement on a quieter tier to a two man cell with a four walls and a door. DOC mental health staff indicated that the purpose of the transition was to

better prepare the I/I for his future release and dealing with equally or more challenging situations.

- According to the I/I, subsequent placement with a cellmate resulted in a decline in the I/I's mental health that may have precipitated the I/I's decision to escape. The cellmate allegedly had a "noisy fan," "a guitar" and a "bright lamp" that reportedly aggravated the I/I's mental health condition. Further, the I/I alleged that the new cellmate had been harassing him, was abusive towards him and treated the I/I poorly. The I/I reported the concerns to DOC, explaining that he was under significant stress and duress due to the change and was experiencing complications with his mental health.
- On August 11, 2019, the I/I escaped from Olympic Corrections Center (OCC). The I/I reported to OCO after the fact that the above changes and the impacts to his mental health are what prompted the escape.
- OCO reviewed video which documented the escort of the escaped I/I as he was returned to the OCC facility.¹ In the video the DOC van transport can be seen pulling into the unsecured parking lot of the OCC Administration building. The van stops at the farthest end of the unsecured parking lot (approximately 100 feet away from the camera operator) and directly in front of the HOH living unit. The HOH living unit and the fencing of the security perimeter is visible and incarcerated population can be seen lining along the inside of the secured perimeter fencing of the unit. The sound of the fire alarm is going off in the background. The side door of the escort van opens and the escaped I/I is escorted out of the van. Several officers in uniforms can be seen holding guns near the van during this time. Several staff can also be seen standing in the parking lot area, observing the escaped I/I as he is escorted across the unsecured perimeter, in restraints. Multiple staff telling the officers, "Good job guys!", "Good job!" repeatedly as they walk the escaped I/I past the camera operator. The I/I is then escorted past the camera operator and walks approximately 20+ more feet until he is escorted into the secured perimeter. People can be heard saying, "Yay" and clapping can be heard in the background as the I/I walks up the walkway with escorts and goes toward the Ozette living unit.
- OCO finds concern with the fact that DOC chose to walk the escaped I/I 100-200 feet across an unsecured parking lot when the escort van could have pulled up to the Ozette unit gate and promptly escorted the escaped I/I directly into the secured perimeter.
- OCO finds it unprofessional that staff were standing around the parking lot congratulating staff for capturing the I/I, cheering and clapping as the I/I is under escort and walking to the secured perimeter.
- OCO finds that there is no established protocol governing facility actions following the return of an escaped I/I. There is established protocol related to fire alarms, which pertains more to standard drills. This use of the fire alarm clearly was not a standard drill.

¹ The video was from a DOC work cellphone. DOC informed OCO that there had been a camera malfunction and the video from the hand held camera wasn't able to be retrieved and therefore could not be reviewed.

- According to interviews with the staff responsible for the decision to pull the fire alarm, the fire alarm was pulled in order to “impact the population” in relation to the escaped I/I being caught and “message the capture.” OCO finds that utilizing the fire alarm in this way created both danger and a security risk to the incarcerated population and staff. One staff reported it was “chaos” in the unit since the standard practices were also not followed in relation to a typical fire drill and count. Purposefully crowding incarcerated individuals along the fence also cannot be considered a correctional best practice.
- OCO could not find evidence to substantiate that the purpose of pulling the fire alarm was intentionally to cause the I/I humiliation. However, this was in fact the reported impact on the I/I.
- OCO could not find any evidence to substantiate that the decision to pull the fire alarm was ordered by high level DOC administrative staff.
- It does not appear that there was any report made in relation to the “fire drill” taking place during the critical incident while in a limited movement status, nor was there an investigation into staff actions. DOC launched an investigation into the escape of the incarcerated individual, but while the investigative report provides detailed narrative regarding activity that took place between August 11 and August 13, 2019, it fails to mention that the facility engaged in a “fire drill” during the critical incident and limited movement at OCC.

Outcomes

- DOC verbally reprimanded the responsible staff for his decision to initiate the fire alarm and allow for the incarcerated individual to be walked back into the secured perimeter of OCC and taken into the Secured Housing Unit (SHU).

Recommendations

- In the future, similar reports of staff ordering irregular activity that are outside of protocol and that potentially impact the safety and security of the institution should be formally investigated.
- DOC should implement a clear policy and procedure regarding how staff are expected to manage the return of an escaped individual to their receiving facility.



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

June 16, 2020

Joanna Carns
Office of Corrections Ombuds
PO Box 43113
Olympia, WA 98504

Dear Ms. Carns:

The Washington Department of Corrections appreciates the opportunity to respond to the OCO Report on the 'the OCO investigation into staff actions during the recovery of an escaped individual who had been residing at Olympia Corrections Center' completed by the Office of Corrections Ombuds.

Recommendation	Response
In the future, similar reports of staff ordering irregular activity that are outside of protocol and that potentially impact the safety and security of the institution should be formally investigated.	The Department of Corrections conducts investigations at the level deemed necessary by the appointing authority. The event was investigated by DOC leadership and there was constructive discussion between administration and facility level leadership on appropriate ways to handle the return of an incarcerated individual from an escape.
DOC should implement a clear policy and procedure regarding how staff are expected to manage the return of an escaped individual to their receiving facility.	The Department of Corrections has clear expectations of how staff are to show professionalism and respect in the workplace with the incarcerated population, colleagues, and external stakeholders. Each facility currently has their own localized operational protocol for the return of individuals to their facility following an escape. As each facility is unique, the creation of a system wide protocol would be inadequate for operational needs.

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 facilities is a fair and safe space for all incarcerated individuals.

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

"Working Together for SAFER Communities"



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

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"