STATE OF WASHINGTON

OFFICE OF THE CORRECTIONS OMBUDS

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

February 11, 2021

Steve Sinclair, Secretary
Department of Corrections (DOC)

Office of the Corrections Ombuds (OCO) Investigative Report

Enclosed is an investigation report on two uses of force on Black men at Stafford Creek Corrections Center. This is a companion report to a simultaneously published investigation report about a third use of force on a Black man also at Stafford Creek Corrections Center, which is also available on OCO's website.

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
INVESTIGATION CONDUCTED BY ANGEE SCHRADER, ASSISTANT OMBUDS-GENDER EQUITY & REENTRY

Summary of Complaint/Concern

In December of 2020, the Office of the Corrections Ombuds began to receive complaints regarding Black prisoners' treatment at Stafford Creek Corrections Center. The complaints alleged that White officers were using an unnecessary amount of force, specifically on Black incarcerated men.

- Complainant A- On December 7, 2020, OCO began receiving complaints that a Black male incarcerated individual had lost his life during a use of force incident at Stafford Creek Corrections Center. OCO made a site visit to the facility and conducted a welfare check with the complainant. He reported to OCO that he had asked to use the bathroom on December 5, 2020 during a COVID lockdown and was denied access. He left his cell to use the bathroom, concerned that he may defecate himself and was sprayed with OC[1] spray by DOC officers. After he was sprayed, he fell backward, hit his head, and began to have a seizure. DOC staff called 911, and he was taken to the hospital. Upon return to Stafford, he was monitored in the infirmary then placed in solitary confinement.

- Complainant B- On December 14, 2020, OCO received a complaint regarding a Black male incarcerated individual at Stafford Creek Corrections Center. The complaint alleged the incarcerated individual was OC sprayed while on a scheduled video visit with a loved one by DOC staff. The incarcerated individual was then taken to solitary confinement. The concerned citizen had witnessed this incident take place while on the video visit.

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

- OCO reviewed relevant policies, including DOC Use of Force policy 410.200.

- OCO interviewed the complainants.

[1] OC is Oleoresin Capsicum, also known as pepper spray.

- OCO reviewed all video and audio evidence that was available.
- OCO reviewed all relevant medicals records from the date of the incidents, as well as aftercare.
- OCO reviewed all infraction paperwork filed.
- OCO reviewed the use of force packets.

Summary of Events

On December 5, 2020, the H-pod unit had been locked down for multiple hours due to COVID-19. Complainant A takes certain medications that cause him to urinate frequently. He had asked if he could use the bathroom and was told yes by a CO; while he was walking to the bathroom, a Sergeant told him to go back to his cell—what happens next is unclear since the staff has a different description of events than the complainant. There is no video evidence. According to staff reports, the complainant placed his arms and hands outside of his cell aggressively to stop the cell door from closing. According to Complainant A, staff pushed him into his cell and slammed the door on his leg and arm, which he could not get out. A DOC Sergeant reported he kicked Complainant A in the leg, and then another Sergeant said he sprayed him with OC spray twice. The first time, OC was sprayed under his cell door; the second time was through a crack in the door that targeted his face. This caused Complainant A to fall backward and lost consciousness.[2] 911 was called, and he was transported to the hospital for evaluation. He was charged with three infractions upon return to Stafford. After this incident, many incarcerated individuals believed that the DOC officers had killed the complainant. This rumor, combined with COVID-19 conditions, created a tense environment within the facility.

Two days later, on December 8, 2020, another Black male was sprayed with OC while sitting down on a video visit. Complainant B was on a scheduled video visit with a loved one in the H-pod dayroom. While he was on the visit, DOC staff approached him and told him to go to his cell. He did not understand why he would have to cut his video short when he still had 18 minutes. (Due to COVID-19, incarcerated individuals are not allowed out of their cell as often, and in-person visits were discontinued.) Complainant B did not get off the video visit when staff directed him to. As the visit continued, video evidence shows up to ten corrections officers slowly surrounding Complainant B, who was sitting down on his visit. After a short conversation with a staff person standing a few feet away from Complainant B, that same staff member sprays him in the face with OC spray, which his loved one witnesses on the video visit. Complainant B quickly stands up, regains his balance then charges the staff member who sprayed him. All of the surrounding officers then charge Complainant B, who had grabbed the staff member. OCO could see on surveillance video four to five officers have contact with Complainant B to restrain him. As this is happening the other incarcerated individuals in the pod begin to exit their cells. The incarcerated individuals then force the DOC officers out of the pod, fearing for their safety. DOC

[2] Medical staff is still unclear if he hit his head or had a seizure, however they do agree that he was struggling to breathe and was not faking an ailment.

was eventually able to safely regain control of the pod with de-escalation and negotiation tactics. No staff or incarcerated individuals are injured during the disturbance.

OCO's investigation and findings raise several concerns about the lack of de-escalation tactics used by DOC staff and unnecessary use of force. OCO has additional concerns regarding the lack of working handheld recording devices utilized by DOC staff and the fabricated information written by DOC staff in their incident reports.

OCO Findings

OCO finds that both incidents were possibly avoidable and better addressed through verbal intervention and de-escalation techniques.

- DOC policy 410.200 states: "The following criteria will be followed when the Use of Force is necessary: 1. All reasonable steps will be taken to de-escalate or prevent any incident that would likely result in the Use of Force. Employees will exercise good judgment, discipline, caution, objective, reasonableness, and restraint when using force.
    - Based on the timeline written in the incident reports by staff for complainant A and lack of video evidence, OCO could not substantiate that staff attempted to de-escalate the situation.
    - Based on video evidence, OCO finds that staff did not attempt to de-escalate the situation with Complainant B.

- Complainant A was upset because he needed to use the bathroom and was prevented from doing so by staff. He alleged that he had been in his cell four hours without access to the bathroom.[3] DOC staff asserted that they needed to secure the bathroom and that he would not have had to wait long. However, based on OCO's review, four staff members were able to respond to the use of force incident but were unable to assist him in using the bathroom.
    - The incident reports written by DOC staff stated the incident began at 5:25, and OC spray was dispersed at 5:27. It does not seem possible that any attempts to de-escalate the situation could have been made in two minutes.

- Complainant B had scheduled his visit two weeks in advance. OCO substantiated through audio evidence that he asked officers why he had to terminate his visit and they did not respond to him other than directives for him to cell in. OCO notes that DOC staff have the ability to simply turn off the video visit rather than escalating to a use of force.

- OCO notes that this is similar to the earlier SCCC use of force cited in the companion report, which also involved a Black male and no obvious attempts by SCCC staff to deescalate prior to the use of force.

[3] OCO could not substantiate this allegation due to the lack of preservation of video evidence.

Not only was there a failure to deescalate, OCO finds that both incidents were instead escalated by staff.

- According to the incident report, before Complainant A was sprayed with OC, he was kicked by a Sergeant in the leg. The Sergeant stated Complainant A was obstructing his cell door with his leg, and the kick was justifiable. Complainant A maintains that his arm and leg were stuck in the door.

- OC spray was dispersed the first time under the door of Complainant A's cell. The second time OC spray was dispersed in Complainant's A's face. This caused the incarcerated individual to fall backwards, hit his head, lose consciousness, and potentially caused a seizure. The incident changed from a disagreement that could have been resolved with a conversation to a serious medical emergency.

- Video evidence from both the dayroom and the JPAY video did not show Complainant B acting in an aggressive manner. He was sitting in front of the JPAY kiosk with his attention on the screen. A total of ten officers surrounded Complainant B while he was sitting down. Only six minutes lapsed from when the officers approached Complainant B to when he was sprayed in the face with OC.

Both complainants reported excessive lengths of time waiting for decontamination.

- When OCO interviewed Complainant A two days after the incident, he reported that he still had OC spray on his body. OCO could not substantiate this allegation, but does note that since was taken out of the facility straight to the hospital, DOC staff did not have the opportunity to decontaminate him on site and it is unclear what protocols were followed when he returned. OCO did speak to the segregation sergeant immediately after the interview, who assured her that the complainant would receive a shower immediately.

- According to the incident report written by DOC staff, Complainant B was not decontaminated until three hours after OC contact.
    - Complainant B alleged that DOC staff placed him in a hot shower and laughed. OCO could not substantiate either allegation.

OCO finds that DOC staff provided false statements regarding their actions for utilizing OC spray on Complainant B in their incident reports.

- The first incident report CO [1] wrote on December 8, 2020, said, "He refused and said he would have to be sprayed." OCO substantiated the complainant did say that. However, on December 14, 2020, the same CO wrote in a second incident report that the complainant said, "if you spray me with that, I am going to get you." Based on audio from the JPAY visit, OCO substantiated the complainant did not say that.

- In his incident report, CO [2] wrote that the complainant said, "I am coming for you" if OC is deployed. Based on the audio recorded on the JPAY visit from this incident, OCO substantiated the complainant did not say that.

- In his incident report, CO [3] wrote that the complainant stated, "You will need more back up, and you are going to get your butt kicked." Based on the audio recording from the JPAY video visit from this incident, OCO substantiated the complainant did not say that.

- DOC staff's infraction report said Complainant B threatened to "kick their butt." OCO substantiated that the complainant did not say that.

- In his incident report, Sergeant [X] stated he "moved [the complainant] to a shower for decontamination due to staff assault that resulted in OC exposure." OCO substantiated based on video evidence that this was an OC exposure that resulted in staff assault**.**
    - OMNI records also state that Complainant B "assaulted a staff member that resulted in a Use of Force," which is incorrect. It is very important that DOC records are corrected because allegations of a staff assault can negatively impact a person throughout their incarceration as well as any future attempts on his behalf to ask for release.

OCO finds multiple failures by SCCC staff to properly document the incidents through video evidence.

- Following OCO's request, DOC's only video evidence related to the use of force on Complainant A is the housing unit camera. The entirety of Complainant A's use of force incident happens just off camera and therefore OCO could not fully evaluate the actual incident but must rely on staff statements, which, as stated above, may not be accurate.
    - DOC stated that the housing unit camera was malfunctioning and that they had submitted a work order to be fixed. However, when OCO asked for verification of that work order, it was found that the work order had not been submitted after all.
    - In the use of force packet for Complainant A, staff reported the first camera they tried to use did not have memory and the second camera had a dead battery. On the housing unit camera footage, a CO is visible obtaining a handheld camera ten minutes <u>after</u> the use of force incident and filming for over ten minutes; however, DOC stated that this was the camera without memory and therefore no video evidence could be salvaged.

- In the companion investigation report of a prior use of force on a Black man at SCCC, SCCC administrators also told OCO that the handheld camera footage could not be obtained because one of the handheld video cameras had a full memory and the other handheld video camera did not have a memory card. SCCC staff issued a directive that the handheld video cameras must be verified to be in working order every shift. It does not appear that staff followed this directive.

The repercussions of these use of force incidents for the complainants are serious and longlasting, even when DOC itself has concern with the use of force.

- As a result of the incident, Complainant A initially received three major infractions[4] and was placed in solitary confinement for two months, not to mention the medical emergency that has unknown lasting impacts on his health.

    - OCO also notes that Complainant A did not receive a hearing for his infractions until February 1, 2021, while housed in solitary confinement. This incident took place on December 5, 2020.
        - On March 6, 2020, DOC's policy change regarding administrative segregation went into effect. This change decreased the amount of time an individual could be kept in administrative segregation pending investigations, hearings, and other administrative processes from 47 days to 30 days. This policy change is part of DOC's work with the Vera Institute and stated intention to reduce the amount of time individuals spend in administrative segregation.

- DOC staff has indicated concerns regarding staff actions in Complainant B's incident and has initiated an investigation. Nevertheless, Complainant B received four major infractions[5] and was found guilty of all of them before SCCC administrators even reviewed the use of force packet.
    - For one of the infractions – threatening – OCO substantiated that this was based on false statements by DOC staff.
    - Due to this incident, Complainant B received a prohibited placement at Stafford Creek and was transferred across the state to Eastern Washington, far away from his family and support. He is being placed in maximum custody placement, which is restrictive housing for at least six months.

- OCO notes another common thread with the companion investigation report in that in that incident, DOC also had concerns about the force used and yet the person also was placed in extended solitary confinement, followed by maximum security placement. He also reportedly suffered an injury.

Additional Concerns

- OCO determined that the same Sergeant disseminated the OC spray in both incidents.[6]

- The use of force packets for both complainants were not reviewed by DOC staff until February 1, 2021.

[4] One of the major infractions was reduced to a minor infraction. The others remained major infractions.
[5] 506 Threatening, 509 Refuse to Disperse, 704 Assaulting a staff member, and 717 Refusal/Resisting.
[6] Although not directly involved in the use of force incident in the companion investigative report, he was a responder to the incident.

Outcomes

- Complainant A's initial infraction of staff assault was changed to a horseplay/unauthorized contact, which is a general (minor) infraction.[7]

- After a conversation with the Superintendent on February 5, 2021, Complainant A was moved from solitary confinement back to general population.

- DOC has launched an investigation into DOC staff's conduct in the Use of Force on Complainant B. It is unknown that any investigation has been initiated regarding staff conduct that resulted in the use of force involving Complainant A, although it resulted in a medical emergency for him.

- Following OCO's request for use of force data from all institutions, including a racial breakdown of the persons involved, DOC Research and Data Analytics unit initiated an analysis of racial disparity in DOC uses of force.

Recommendations

- DOC should initiate its own investigation related to staff behavior during both incidents and take any necessary corrective action.

- Use of force incidents should be reviewed within 30 days and prior to disciplinary hearings, if at all possible.

    - If DOC administrators find concerns about staff actions in precipitating use of force incidents, consideration for that should be given as part of the disciplinary hearing and particularly any sanctions.

- DOC staff should train all custody staff on using de-escalation tactics instead of force, starting with SCCC as a pilot.

- DOC should offer regular training for custody staff centered around race equity and racial bias/discrimination, starting with SCCC.

- OMNI records need to be updated to reflect correct information for Complainant B.

- Complainant B should have the "threatening" infraction removed from his record.

- All cameras should be checked regularly to ensure they are in proper working order and charged.

    - DOC should also consider the potential benefits of utilizing body cameras.

[7] As stated in an above footnote, the other infractions remain major infractions on his record.

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

March 12, 2021

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 Investigation Report on the 'two uses of force on Black men at Stafford Creek Corrections Center' completed by the Office of Corrections Ombuds.

Recommendation	Response
DOC should initiate its own investigation related to staff behavior during both incidents and take any necessary corrective action.	The department has reviewed the incidents mentioned in this report. Following the department's review, an investigation into the actions of those involved has been initiated. The results of the investigation will better inform any necessary corrective action.
Use of force incidents should be reviewed within 30 days and prior to disciplinary hearings, if at all possible. • If DOC administrators find concerns about staff actions in precipitating use of force incidents, consideration for that should be given as part of the disciplinary hearing and particularly any sanctions.	The department, in conversations with the OCO, has mutually agreed to consider an appropriate time frame to conduct the policy required use of force reviews during the next policy review cycle.
DOC staff should train all custody staff on using de-escalation tactics instead of force, starting with SCCC as a pilot.	When employees are met with resistant/aggressive behavior and ongoing de-escalation techniques fail to resolve the situation, unless an emergent need to intervene is present, employees shall call for supervisory presence before taking any additional action. The Assistant Secretary for Prisons will message this expectation/reminder to all prison employees in a written directive. The department shares the belief that conflict

	avoidance, de-escalation tactics and trauma informed methods are preferred method of engaging with those in its custody and preventing potential use of force situations. As such, the department agrees additional emphasis on these skills should be created and/or enhanced for employees in multiple training and learning environments.
DOC should offer regular training for custody staff centered around race equity and racial bias/discrimination, starting with SCCC.	In coordination with the State Human Resources Office and in accordance with Executive Order 12-02, the Department is working with the equity, diversity, inclusion and respect (EDIR) team to create an EDIR policy, which will create an anti-racism statement that will inform a department strategic plan on EDIR. Encompassed within the plan will be trainings to address concerns around race equity and racial bias/discrimination.
OMNI records need to be updated to reflect correct information for Complainant B.	The department has worked to ensure that the records reflect correct information for this individual.
Complainant B should have the "threatening" infraction removed from his record.	The department has transcribed the audio recording of this conversation for review. After this review, the department will take appropriate action.
All cameras should be checked regularly to ensure they are in proper working order and charged. • DOC should also consider the potential benefits of utilizing body cameras.	Although post orders, on shift training, and OJT require employees to ensure all assigned equipment is present and in working order DOC agrees to reemphasize this expected practice to employees with responsibility specific to cameras. DOC has determined body cameras are cost prohibitive without additional budget allocations.

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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. The Department takes seriously allegations of racial injustice and will address any substantiated allegations with appropriate measures.

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,

Julie a Mark

on behalf of
Steve Sinclair, Secretary
Washington Department of Corrections