May 7, 2020

I want to first follow up on some of the discussion from last week. I want to be clear that OCO DOES have oversight authority of DOC. OCO’s authority is very clearly spelled out in RCW Chapter 43.06C. We exist as a quality assurance and oversight mechanism to make sure that DOC follows its own policies, procedures, and relevant law. We receive complaints regarding the health, safety, welfare, and rights of the incarcerated, and we conduct a review of those complaints in relation to any violations of policy, procedure, or law. By law, we are not an advocate for the incarcerated or for staff. What does that mean to not be an advocate? The clearest example is a defense attorney – a defense attorney is supposed to be a “zealous advocate” for their client. Regardless of whether a person is guilty or not – and they don’t even want to know if you’re guilty – they’re going to advocate for you to get the best possible outcome for you. But an Ombuds office is unbiased, it’s not or shouldn’t be based on our opinion, or what we feel is right. We are looking at whatever the black and white policy, procedure, or law is and evaluating a person’s complaint in relation to that. Now we also can and do make recommendations for policy improvements, but we receive thousands of complaints and we can only do that in a small number of cases where we invest the time to do the policy and multi-state research, analysis, discussions with DOC, write a report – it’s a process.

So what does that mean for COVID-19? As mentioned, we look at what the established standard is – law, policy, procedure – etc. And here, this is a new situation, it’s evolving, no one was expecting this, and so the standard is still developing. The CDC put out interim guidance in late March, and those guidelines have just been revised. This is the only external standard by a US nationally-recognized authority. So, as previously mentioned, our primary work has been to evaluate how DOC’s COVID-19 response compares to these standards. We have monitored through the information that we have received from family members and from the incarcerated through our hotline, letters, the surveys that I have done – multiple methods.

The next piece of authority that we have is to put out reports with findings and recommendations. I have already put out two progress reports on DOC’s response relevant to the CDC interim guidelines that are available on our website, and I am in the process of putting together a much larger analysis, which I hope to have completed and sent to the legislature, Governor, and public by the end of June. This larger report will be the bulk of my personal work.

In addition, I did one on-site monitoring visit to Monroe and that report was published a week after the visit. I did hear on the call last week and through subsequent emails the desire from the community for us to do more monitoring visits, so my staff and I have developed a plan to do a handful of additional visits. Caitlin was out at AHCC today and will be going to CRCC next week. I will be going to SCCC on Tuesday and then do another monitoring trip to Monroe. Q will be going to Cedar Creek next week. We are still evaluating whether we will be going to any female facilities. It is not an easy decision to go in – I don’ t want to expose any incarcerated to the disease and I don’t want to carry it home. I’m not going to ask any staff to go in who don’t want to and I won’t allow them to be pressured to. We will be putting out a report afterward although it probably won’t happen as quickly as the Monroe one, but we’ll see.

What else is OCO doing? We are fulfilling our statutory role to provide information such as these weekly calls. I had Secretary Sinclair on one of our earlier ones – at the beginning, we were the only information coming out – and last week, I provided an opportunity to hear from Columbia Legal Services. I’m sharing what information I have. Next, although we have restricted what we will take in to medical, mental health, COVID-19 response, and bodily harm (PREA, use of force), we still have our caseloads from before. I will speak for myself – I have a toddler at home and I really feel only in this past week have I actually adjusted to this new normal and felt like I got my head above water. Our work is dependent upon communication from DOC staff to answer questions and to make any changes, so if DOC is not responding because they’re short staffed and responding to a pandemic, then we are also stuck. I feel like DOC has just recently adjusted as well, so we’re trying to get back into the right mode. We have been finalizing reports related to deaths and other open investigations and we hope to get those out in June or July. I am not in a rush because right now everything is COVID-19 focused.

We are still moving forward with our systemic issue reviews. I sent a letter to the 216 tier representatives to get their input and I sent out a google survey to the people who are signed up for my listserv through the OCO website. I am really excited about our forthcoming work related to recommendations for improvements with the disciplinary procedure. We had a UW law intern who has been handling all of our disciplinary cases who came up with a laundry list of recommendations and I sent a google survey to the disciplinary hearing officers that has also developed a number of great ideas.

So, now that it is clearer about OCO’s work and what we do, the next question is how is DOC’s response. I want to be clear that I am not talking about releases. I feel that sometimes community members come on this call and they express anger at myself or DOC because no action is going to be considered good enough unless it is the release of more people. I do not have the power to release anyone. The decision to release people is going to come from the Governor. And I want to note the Governor HAS made a decision to release up to 1,100 people. I think about 700 have been early released so far.

So, I am looking at DOC’s actions that they can take other than release. The fact of the matter is that DOC has either met or made progress toward almost all of the CDC guidelines – I’m still evaluating the revised guidelines, but in terms of the ones that were released in March, those they have mostly met. They have imposed social distancing, they are wearing masks, they have reduced interfacility transfers, they are isolating people who are symptomatic, they have been sending notices to the incarcerated, they are doing regular meetings with tier representatives and with the local family councils, they are posting information on their website.

I want to be clear that I am not saying that there is no more work to be done – far from it. I have a meeting next week with DOC to discuss expanded testing, which we feel is important. I do want to speak about the testing numbers. I have been seeing on social media and receiving emails about the high positive rates in some jurisdictions like Ohio and the federal system. I want to be clear what they are talking about is a rate. Out of the number tested – whatever that number is – 60-70% are testing positive in Ohio, federal system, etc. In comparison, Washington’s rate is actually good – it’s about 7%, which is in line with the community. Proportionally, Washington is testing far more people than the federal system, and our rate is a tenth. Since the assumption is that the more serious cases are those that are symptomatic and they are more likely to test positive, the fact that more tests could be conducted would not necessarily and probably wouldn’t increase the positive rate. So while I agree that more people want to be tested because we want to catch and treat the disease early, particularly if people are at high risk for complications, the rate is very good.

Other items of interest - WCC created 60 bed intake separation unit in R unit. When brand new people from jail come in, they are all sent to that unit for 14 days and receive health screenings. It is not technically a quarantine area, but it is to separate them from the population. Take temperatures daily. Want to make sure that they’re not symptomatic. Health screenings for staff and any person who comes in are all happening.

Regional health facilities- concept is that these are other than living unit spaces – at Shelton using chapel, same as at AHCC. Chapel is cleared out. Overflow/Higher care needs only that would be housed there. If they became even higher level of care needed, they would be taken to a hospital. Getting ready to load in some state of the art equipment. The current plan is to keep the area sealed off until they activate it.

Caitie shared her key findings from her monitoring visit to Airway Heights. [I missed taking notes during the call, so these are pulled from the key findings from her draft report, which are similar to what she shared on the call.]

* Throughout the OCO monitoring visit, the monitor observed calm interactions between staff and incarcerated individuals, between staff and staff, and within the incarcerated population. The overall observable atmosphere among DOC Staff and the incarcerated population was a low energy level and a feeling of tiredness. The facility was quieter and seemed less busy than under “normal operations.” The reductions in noise, interactions, and presence of people frequently moving around the facility are, likely, all expected results of implementing physical distancing protocols.
* The facility appeared clean and orderly. Porters were observed cleaning throughout the facility with Hepastat 256. Bottles of Hepastat 256 were observed widely available throughout the facility.
* The monitor observed throughout the facility (Main and MSU) a nearly 100% compliance with staff wearing face coverings (fabric cloth coverings, surgical masks, etc.) and a nearly 100% compliance with the incarcerated population wearing face coverings (DOC provided surgical masks and bandanas). The monitor observed:
	+ Two separate interactions of staff reminding other staff to pull up their face covering; the mistake was quickly corrected with no negative interaction observed.
	+ One interaction of a staff member reminding an incarcerated person to pull up their face covering; the mistake was quickly corrected with no negative interaction observed.
* As discussed with kitchen staff, white foam, single use, food containers are not designed to maintain heat for long periods of time. Additionally, the large, mesh-like, shelving transportation devices are not insulated. Therefore, the temperature of delivered food is not optimal; kitchen staff agree. Purchasing better equipment and implementing a different delivery protocol, which can provide for more optimal food temperature at time of delivery, would improve this process.
* Implementing a grab and go meal process which utilizes white foam, single-use, food containers has created a huge amount of non-biodegradable waste, as observed throughout the facility. If this meal process is likely to be indefinitely maintained, consider implementing the use of a more environmentally friendly takeout container product.

Q&A

* Are your visits announced? Yes. When I did inspections in Ohio, they were unannounced, and we had the same concerns. The reality is that it is almost impossible to do a truly unannounced visit. Once you hit the front gate, the information goes out across the compound. [Later addition post-call – we also want to attend the tier rep meetings and perhaps meet separately with the tier reps, which takes notice and planning.]
* What are the criteria for DOC tests? As of right now, it’s when people are symptomatic for COVID-19 – fever, cough, sore throat. We have heard concerns/allegations that DOC is not testing everyone in isolation and we are trying to follow up on that by asking for results for everyone, but we also have not received any specific names of people in isolation who have NOT been tested, so please send those to us if you have them.
* Concern from Reynolds Work Release that her loved one had been transported to WCC with someone who is COVID positive. Joanna said to email her the information and she would look into it. Another allegation that incarcerated persons were transferred back to Shelton because they were sick. [Later addition – DOC said that this is not their protocol, but Joanna is going to look further into it if she receives names.]