IN THE WASHINGTON STATE COURT OF APPEALS
DIVISION THREE

STATE OF WASHINGON,	)	
	)	No. [redacted]
Respondent,	)	
	)	RENEWED MOTION
v.	)	FOR STAY OF
	)	SENTENCE PENDING
[redacted],	)	APPEAL FOLLOWING
	)	REMAND AND TRIAL
Appellant.	)	COURT'S RULING
	)	DENYING A STAY

I. IDENTITY OF PARTY AND RELIEF SOUGHT

[redacted] renews his request that this Court order his sentence stayed pending resolution of his appeal and set conditions of release or bond.

II. FACTUAL BACKGROUND

a. [redacted] *filed a request for conditional release or bond in this Court. A commissioner of this Court remanded for fact-finding by the trial court.*

Following a jury trial, [redacted] was convicted of one count of forgery stemming from an incident involving a fraudulent check for $156. The facts are set out in detail in [redacted] opening brief.

At the sentencing hearing on July 26, 2019, the trial court denied [redacted] request for a stay of his sentence pending appeal. RP 257-59. The court did not do so because [redacted] was a flight risk or

danger to the community. RP 257-58. Neither did the court find by a preponderance of the evidence that any delay from a stay would diminish the deterrent effect of the punishment. RP 258. Rather, exercising its discretion, the court reasoned a stay was inappropriate due to the jury's verdict of guilt and because about three years had elapsed since the charge was originally filed in July 2016. RP 257, 259.

A little over a year later, [redacted] asked this Court to exercise its authority under RCW 9.94A.585(3) and order conditional release or bond. Alternatively, he asked this Court for review of the trial court's decision denying a stay under RAP 8.2(b), or for remand for a new hearing. The primary argument in support was a change in circumstances due to the COVID-19 pandemic and the severe risk COVID-19 poses to [redacted] due to his health and incarceration at Coyote Ridge Corrections Center.

A commissioner of this Court heard argument by telephone on Wednesday, June 17, 2020. Several hours later, the commissioner issued a written ruling remanding the matter back to the trial court:

> This Court has determined that the superior court is in the best position to address [redacted] arguments and consider any evidence in this regard.
>
> Accordingly, IT IS ORDERED, the matter is remanded to the superior court to conduct a hearing within 14 days of the date of this Order and enter findings on [redacted]

[redacted] motion. The superior court shall transmit its decision to this Court within five days of the date of the hearing. The Clerk of the Court of Appeals will then immediately set the matter before a panel of judges for decision on release pursuant to RAP 8.3.

App. I (Commissioner's Ruling, June 17, 2020)

b. Notwithstanding this Court's ruling remanding the case for a fact finding hearing and a ruling within 5 days of this hearing, the trial court refused to set a live hearing and issued a belated ruling without any fact finding.

The next morning, Thursday, June 18, appellate counsel emailed the trial court a copy of the commissioner's ruling, stating that he was available to appear by phone or videoconference. App. II, at 5. He also included copies the filings in this Court related to [redacted] motion, along with a copy of the transcript from sentencing and [redacted] merits appellate brief. App. II, at 4-5.

Near the close of business day, the trial court's judicial assistant emailed the parties, stating that the trial court had "set this matter for hearing on June 24, 2020, at 8:30 a.m., without oral argument." App. II at 4.

On Friday, June 19, [redacted] objected, stating that this Court's ruling contemplated a live hearing and reiterated that counsel was

available to be heard by phone or video conferencing.[1] App. II at 4. [redacted] also submitted a memorandum in support of a stay.[2] App. II at 4. The trial court's judicial assistant sent a response stating that it had received the email and the additional filing. App. II at 3-4.

[redacted] filed additional evidence in support of his motion the next week, including a declaration from [redacted] along with additional evidence about the COVID-19 outbreak at Coyote Ridge Corrections Center. App. II at 1-3. The State filed nothing.

On Tuesday afternoon, June 30, appellate counsel emailed the court inquiring into the status of the trial court's ruling. Counsel reminded the trial court that under this Court's ruling, its decision had been due to be issued and transmitted on June 29, 2020. This was because the trial court had set its "hearing" for June 24, and this Court's ruling had stated that the trial court "shall transmit its decision to this Court within five days of the date of the hearing." App. I.

[1] Counsel also emailed the prosecutor, asking if the trial court's setting the matter without a live hearing was consistent with its reading of this Court's ruling. Counsel never received a response from the State.

[2] [redacted] also filed a copy in the trial court, which will be designated and transmitted to this Court.

On Wednesday afternoon, July 1, the trial court's judicial assistant emailed the parties a copy of its ruling denying [redacted] request. App. III. The trial court's ruling contains no explanation or reasoning in support of its denial. App. IV. Rather, the ruling simply recounts the evidence that the Court considered. App. IV. The email from the trial court's judicial assistance stated that the clerk of the court would transmit its ruling to this Court. App. III.

III. ARGUMENT

[redacted] renews his request that this Court exercise its authority under RCW 9.94A.585(3) and order a stay of his sentence pending appeal. Alternatively, reversal and the granting of [redacted]. [redacted] request is appropriate under RAP 8.2(b).

If not, because the trial court failed to abide by this Court's ruling remanding for findings, and the trial court's ruling does not permit meaningful review, this Court should remand for a new hearing.

a. This Court should exercise its authority under RCW 9.94A.585(3) and order that a stay be granted while Mr. Almaguer's appeal is pending.

"Pending review of the sentence, the sentencing court or the court of appeals may order the defendant confined or placed on conditional release, including bond." RCW 9.94A.585(3) (emphasis added). By its plain language, this provision grants this Court authority to order [redacted].

[redacted] release pending review. State v. Portomene, No. 81264-5-I, 2020 WL 2114633, at *3 (Wash. Ct. App. Apr. 29, 2020) (unpublished)[3]; see RAP 8.2(a) ("The conditions under which a defendant in a criminal case or a juvenile in a juvenile offense proceeding may be released pending review, or may obtain a stay of execution of sentence, are set forth in the criminal rules, juvenile court rules, and in statutes.") (emphasis added).

This Court should exercise this authority for three reasons. First, due to [redacted] health and incarceration, he is placed at an unnecessary increased risk of death or serious illness from COVID-19. Second, he is not a flight risk and does not pose a danger to the community. And third, [redacted] demonstrates a high probability of success in winning his appeal either as to reversal of his conviction or a new sentencing hearing.

Washington remains in the throes of a pandemic from COVID-19. Should [redacted] contract the virus, he may become seriously ill or die. [redacted], who is [redacted]-years-old, is at a high risk of severe illness or death from COVID-19 due to his health and condition of being [redacted]. See Dec. of [redacted] (App. V); Dec. of [redacted] (App.

[3] Cited for persuasive authority. GR 14.1.

VI); WA State DOC COVID-19 Screening, Testing, and Infection Control Guideline Version 18, at pages 6-7 (stating that person with diabetes is at a high risk of severe disease and complications from acquiring COVID-19) (App. VII)[4]; Christie v. Commonwealth, 484 Mass. 397, 399, 142 N.E.3d 55 (2020) ("COVID-19 is a particular risk to older adults and to individuals with underlying health conditions, such as cardiovascular disease, diabetes, and chronic respiratory disease").

The danger posed by COVID-19 to [redacted] is especially grave because he is incarcerated at Coyote Ridge Corrections Center. There has been an outbreak at this facility. As of writing, the number of confirmed cases at Coyote Ridge has soared to 180 inmates and 50 staff members. App. VIII.[5] Tragically, as the Department of Corrections recently reported, two incarcerated persons serving their sentences at Coyote Ridge have died. App. IX (press releases from Department of Corrections).[6] KUOW public radio has reported that the conditions at

[4] Available at: https://www.doc.wa.gov/news/2020/docs/wa-state-doc-covid-19-screening-testing-infection-control-guideline.pdf (last access July 2, 2020).

[5] Available at https://www.doc.wa.gov/corrections/covid-19/data.htm#confirmed (last accessed July 2, 2020).

[6] Available at https://www.doc.wa.gov/news/2020/06182020p.htm (last accessed July 2, 2020);

Coyote Ridge have deteriorated, creating harrowing conditions. This includes inmates lacking access to water and toilets, and only being allowed out of their cells for 30 minutes per day. App. X.[7]

It is appropriate take into account the risk to [redacted] from COVID-19 in consideration of a stay. As the Massachusetts Supreme Court has reasoned, "[i]n these extraordinary times, a judge deciding whether to grant a stay should consider not only the risk to others if the defendant were to be released and reoffend, but also the health risk to the defendant if the defendant were to remain in custody." Christie v. Commonwealth, 484 Mass. 397, 401, 142 N.E.3d 55 (2020). "In evaluating this risk, a judge should consider both the general risk associated with preventing COVID-19 transmission and minimizing its spread in correctional institutions to inmates and prison staff and the specific risk to the defendant, in view of his or her age and existing medical conditions, that would heighten the chance of death or serious illness if the defendant were to contract the virus." Id. at 401-02.

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https://www.doc.wa.gov/news/2020/06242020p.htm (last accessed July 2, 2020).

[7] Available at https://www.kuow.org/stories/another-inmate-dead-national-guard-deployed-for-mass-testing-at-this-washington-prison (last access July 2, 2020).

Granting [redacted] release will significantly reduce the risk from COVID-19 to his health. He has a supportive [redacted] and can reside with her in [redacted]. If necessary, [redacted] is willing to abide by "a home detention" through electronic home monitoring or its equivalent. See RCW 9.95.064; RCW 9.94A.030; State v. Swiger, 159 Wn.2d 224, 227, 149 P.3d 372 (2006). He submits, however, that this condition is not necessary given his record of complying with conditions of release. Further, electronic home-monitoring can be costly.

It will also benefit the public because the more people that are incarcerated in a confined facility, the greater the risk of spreading COVID-19. The more people in a facility, the more likely an inmate or staff member is likely to contract or transfer COVID-19. This increases the risk that a staff member may become infected and transfer it to the public. This is part of the reason why the governor and the Department took action to reduce the inmate population in Washington prisons by ordering early release for several groups of inmates. See Matter of Pauley, No. 81370-6-I, 2020 WL 3265574, at *6 (Wash. Ct. App. May 18, 2020).

Further, [redacted] is not a danger to others, as the prosecutor and the court below acknowledged at sentencing. [redacted] was convicted of forgery, a non-violent crime. Specifically, [redacted] was convicted of unsuccessfully trying to cash a fraudulent check for $156 at a

payday lender. [redacted] maintains he did not commit this crime and that he did not receive a fair trial. While he litigates his appeal, he has a place to stay in [redacted] with his supportive [redacted] He has a history of attending his court appearances. The trial court has never found that [redacted]. [redacted] is a danger to the community or that he was a flight risk.

Moreover, [redacted] opening brief shows that [redacted] appeal has substantial merit. During closing arguments, the prosecutor committed grave misconduct by inviting the jury to consider extrinsic evidence. Still, the trial court denied [redacted] motion for a new trial. [redacted] submits that this Court will likely reverse that denial. Alternatively, remand for resentencing is likely to occur because the State did not meet its burden to prove [redacted] offender score. This may result in a sentence that is significantly reduced from the sentence of 26 months, one which [redacted] may have already served because he has been incarcerated since July 2019. For this reason, this Court partially granted [redacted] motion to accelerate review and ordered that the appeal would be set before a panel of judges once the State files its brief, which is due on July 13, 2020.

Accordingly, this Court should order that [redacted] sentence be stayed and that he be released pending appeal. He should be released on personal recognizance. Alternatively, bond in the amount of $2,500, which

was the bond at trial, is appropriate. The conditions of release set in the trial court (prior to conviction) are appropriate to adopt for purposes of the appeal bond or release on personal recognizance. App. XI; Supp. CP __ (sub. no 8). The sentence should also be stayed until the appellate mandate is issued.

b. Alternatively, this Court should reverse the trial court's order refusing to stay the sentence or grant an appeal bond.

A trial court has authority to stay a sentence, including granting an appeal bond. RAP 7.2(f); CrR 3.2(h). Whether to grant a stay is discretionary. State v. Johnson, 105 Wn.2d 92, 96, 711 P.2d 1017 (1986). A statute, however, requires a trial court to deny a stay if the prosecution shows by a preponderance of the evidence any one of four grounds:

> Notwithstanding CrR 3.2 or RAP 7.2, an appeal by a defendant in a criminal action shall not stay the execution of the judgment of conviction, if the court determines by a preponderance of the evidence that:
>
> (a) The defendant is likely to flee or to pose a danger to the safety of any other person or the community if the judgment is stayed; or
>
> (b) The delay resulting from the stay will unduly diminish the deterrent effect of the punishment; or
>
> (c) A stay of the judgment will cause unreasonable trauma to the victims of the crime or their families; or
>
> (d) The defendant has not undertaken to the extent of the defendant's financial ability to pay the financial obligations under the judgment or has not posted an adequate

performance bond to assure payment.

RCW 9.95.062(1); State v. Cole, 90 Wn. App. 445, 447, 949 P.2d 841 (1998). A party can object to a denial of a stay by motion in the appellate court. RAP 8.2(b).

At the original appeal bond motion at the sentencing hearing, the the prosecution conceded that grounds (a), (c), and (d) in RCW 9.95.062(1) did not apply. RP 252-53. The prosecution only argued that a stay should be denied under ground (b). RP 252-53. [redacted] argued that the prosecution had not met its burden to prove the delay resulting from the stay would unduly diminish the deterrent effect of the punishment. RP 253-54. [redacted] is not a young man for whom punishment might need to be immediately imposed for it to have a deterrent effect. The punishment here would have a deterrent effect even if the appeal delays him serving the full sentence (assuming he is unsuccessful in his appeal).

While denying a stay, the court did not find that the prosecution had proved ground (b). RP 257-59. Instead, the court appears to have denied a stay because (1) "the presumption of innocence no longer exist[ed]" and (2) there was a three-year-period between the charge and the conviction. RP 257-58.

In the trial court's most recent ruling, the trial court denied Mr. Almaguer's request. But the court provided no explanation. App. IV. The court did not hold a live hearing, instead choosing to rule entirely on the submitted documentary evidence. The court entered no actual findings. App. I. It is well established that written findings and conclusions facilitate appellate review. See, e.g., State v. Head, 136 Wn.2d 619, 622, 964 P.2d 1187 (1998). And even written findings must be sufficiently specific to permit meaningful review. In re LaBelle, 107 Wn.2d 196, 218, 728 P.2d 138 (1986). Here, the trial court's decision simply recounts what evidence and filings the court considered. This is akin to a summary judgment ruling, where no fact finding occurs. CR 56(h).

The trial court's decision on remand was inconsistent and contravened this Court's order. This Court ordered the trial court to "enter findings on [redacted] motion." App. I. The trial court's failure to strictly abide by this Court's ruling was error. Bank of Am., N.A. v. Owens, 177 Wn. App. 181, 189-90, 311 P.3d 594 (2013).

Setting aside the problem about the lack of findings, the trial court's decision was incorrect and should simply be reversed. While this Court ordinary gives some deference to a trial court's ruling on an appeal bond request, no deference is owed in these circumstances. Here, the trial court relied entirely on a written record. Appellate review is generally

"a de novo standard in the context of a purely written record where the trial court made no determination of witness credibility." Dolan v. King County, 172 Wn.2d 299, 311, 258 P.3d 20 (2011). The exception is "where the trial court reviewed an enormous amount of documentary evidence, weighed that evidence, resolved inevitable evidentiary conflicts and discrepancies, and issued statutorily mandated written findings." Id. Thus, review is de novo because it is written record, the court did not resolve evidentiary conflicts, and did not issue written findings.

Here, the evidence shows [redacted] was not a risk to the community and he has a good track record of making his court appearances in Spokane. He has a place to shelter in place with his [redacted]. That the presumption of innocence no longer exists is not a valid reason to deny a stay. This fact is true in every appeal following a conviction and bond is appropriate in at least some cases. As for the length of time between the charge and conviction, this not sufficient reason to deny a stay, particularly given the evidence in favor of stay. Given the COVID-19 pandemic, the outbreak at Coyote Ridge, and the grave risk to [redacted]. [redacted] of death or serious illness if he contracts COVID-19, these facts weigh in favor of conditional release or bond. The trial court's decision to deny a stay should be reversed.

Alternatively, because the trial court abused its discretion by failing to follow this Court's instructions to hold a hearing and entering findings of fact, this Court should again remand for reconsideration of Mr. Almaguer's motion.

For these reasons and the reasons set out in the previously submitted materials, [redacted] respectfully asks that this Court to order conditional release and a stay of the sentence pending the appeal. The sentence should be stayed until the mandate is issued.

IV. CONCLUSION

[redacted] respectfully requests this grant conditional release or bond and order the trial court's sentence stayed pending resolution of the appeal.

Respectfully submitted this 2nd day of July, 2020.

Richard W. Lechich – WSBA #43296
Washington Appellate Project – #91052
Attorney for Appellant

Appendix I

Renee S. Townsley
Clerk/Administrator

(509) 456-3082
TDD #1-800-833-6388

The Court of Appeals of the State of Washington
Division III

500 N Cedar ST
Spokane, WA 99201-1905

Fax (509) 456-4288
http://www.courts.wa.gov/courts

June 17, 2020

Stephanie Jane Richards
Larry D. Steinmetz
Cnty Prosc Atty Ofc
1100 W Mallon Ave
Spokane, WA 99260-2043
Email

Richard Wayne Lechich
Gregory Charles Link
Washington Appellate Project
1511 3rd Ave Ste 610
Seattle, WA 98101-1683
Email

CASE # [redacted]
State of Washington v. [redacted]
SPOKANE COUNTY SUPERIOR COURT No. [redacted]

Dear Counsel:

Enclosed is your copy of the Commissioner's Ruling, which was filed by this Court today.

The Court, upon review of this matter, determined this case is appropriate for remand to the trial court.

Sincerely,

Renee S. Townsley
Clerk/Administrator

RST: res

c: Honorable Michael P. Price
Spokane County Superior Court
1116 W. Broadway
Spokane, WA 99260
Email

Ashley Callan
Spokane County Court Administrator
1116 W. Broadway
Spokane, WA 99260
Email

The Court of Appeals
of the
State of Washington
Division III

STATE OF WASHINGTON, Respondent, v. [redacted], Appellant.	)	No. [redacted] COMMISSIONER'S RULING

[redacted] has appealed his forgery conviction. He now moves for release pending appeal based, in part, on the risk he faces of contracting COVID-19 while serving his prison sentence.

This Court has determined that the superior court is in the best position to address [redacted] arguments and consider any evidence in this regard.

No. [redacted]

Accordingly, IT IS ORDERED, the matter is remanded to the superior court to conduct a hearing within 14 days of the date of this Order and enter findings on [redacted] motion. The superior court shall transmit its decision to this Court within five days of the date of the hearing. The Clerk of the Court of Appeals will then immediately set the matter before a panel of judges for decision on release pursuant to RAP 8.3.

Monica Wasson
Commissioner

Appendix II

From: Richard Lechich
To: Dorman, Katrinka
Cc: Richards, Stephanie J.; SCPA Appeals; Steinmetz, Larry
Subject: RE: [redacted] State v [redacted]
Date: Tuesday, June 30, 2020 3:32:00 PM
Attachments: image001.png
[redacted] Comm Ruling Remand to Trial ct-RES.pdf
COVID-19 Data Washington State Department of Corrections.pdf

Good afternoon,

Counsel for [redacted] is inquiring as to the status of the Court's ruling on this matter. The Court set a hearing date of Wednesday, June 24, 2020. The ruling from the Court of Appeals states: "The superior court shall transmit its decision to this Court *within five days* of the date of the hearing." Under counsel's reading of this ruling, this means a decision from this Court was due to be issued and transmitted on June 29, 2020. No decision, however, has been received yet.

If the court is still considering evidence, [redacted] submits the attached document from the Department of Corrections' website showing that, as of June 30, 2020, the number of confirmed COVID-19 cases at Coyote Ridge Corrections Center has risen to 171 inmates and 47 staff members.

Respectfully,

Richard Lechich
Washington Appellate Project
206-587-2711

From: Richard Lechich
Sent: Friday, June 26, 2020 10:46 AM
To: Dorman, Katrinka <KDORMAN@spokanecounty.org>
Cc: Richards, Stephanie J. <SRICHARDS@spokanecounty.org>; SCPA Appeals <SCPAAppeals@spokanecounty.org>; Steinmetz, Larry <LSteinmetz@spokanecounty.org>
Subject: Re: [redacted] State v [redacted]

[redacted] submits the attached press release from the Department of Corrections, which recounts a second death of an inmate at Coyote Ridge from COVID-19, as additional evidence in support of his motion for conditional release or bond pending resolution of his appeal.

Respectfully,

Richard Lechich
Washington Appellate Project
206-587-2711

From: Dorman, Katrinka <KDORMAN@spokanecounty.org>
Sent: Wednesday, June 24, 2020 4:43:21 PM
To: Richard Lechich
Cc: Richards, Stephanie J.; SCPA Appeals; Steinmetz, Larry
Subject: RE: [redacted] State v [redacted]

Received thank you.

Kati Dorman
Judicial Assistant to
Judge Michael P. Price, Department 5
(509)477-4766, Courtroom 204

SPOKANE COUNTY
SUPERIOR COURT

From: Richard Lechich [mailto:richard@washapp.org]
Sent: Wednesday, June 24, 2020 4:29 PM
To: Dorman, Katrinka <KDORMAN@spokanecounty.org>
Cc: Richards, Stephanie J. <SRICHARDS@spokanecounty.org>; SCPA Appeals <SCPAAppeals@spokanecounty.org>; Steinmetz, Larry <LSteinmetz@spokanecounty.org>
Subject: RE: [redacted] State v [redacted]

Please find attached a copy of a signed declaration from [redacted], which is submitted in support of [redacted] motion for conditional release or bond pending appeal. A copy will formally filed with the Court of Appeals.

Respectfully,

Richard Lechich
Washington Appellate Project
206-587-2711

From: Richard Lechich
Sent: Tuesday, June 23, 2020 6:01 PM
To: 'Dorman, Katrinka' <KDORMAN@spokanecounty.org>
Cc: Richards, Stephanie J. <SRICHARDS@spokanecounty.org>; SCPA Appeals <SCPAAppeals@spokanecounty.org>; Steinmetz, Larry <LSteinmetz@spokanecounty.org>
Subject: RE: [redacted] State v [redacted]

Please find attached additional evidence submitted by [redacted] in support of his motion for conditional release or bond pending resolution of his appeal. A copy will be formally filed tomorrow, June 24, 2020.

Respectfully,

Richard Lechich
Washington Appellate Project
206-587-2711

From: Dorman, Katrinka <KDORMAN@spokanecounty.org>
Sent: Friday, June 19, 2020 1:05 PM
To: Richard Lechich <richard@washapp.org>
Cc: Richards, Stephanie J. <SRICHARDS@spokanecounty.org>; SCPA Appeals <SCPAAppeals@spokanecounty.org>; Steinmetz, Larry <LSteinmetz@spokanecounty.org>
Subject: RE: [redacted] State v [redacted]

Received thank you.

Kati Dorman
Judicial Assistant to
Judge Michael P. Price, Department 5
(509)477-4766, Courtroom 204

SPOKANE COUNTY
SUPERIOR COURT

From: Richard Lechich [mailto:richard@washapp.org]
Sent: Friday, June 19, 2020 12:47 PM
To: Dorman, Katrinka <KDORMAN@spokanecounty.org>
Cc: Richards, Stephanie J. <SRICHARDS@spokanecounty.org>; SCPA Appeals <SCPAAppeals@spokanecounty.org>; Steinmetz, Larry <LSteinmetz@spokanecounty.org>
Subject: RE: [redacted] State v [redacted]

Counsel for [redacted] is of the view that the Court of Appeals' order contemplates a live hearing. He reiterates that he is available to be heard remotely via phone or zoom.

[redacted] also submits the transcript from the trial and sentencing, which was not included in the initial email. He also submits a memorandum in support of a stay, which will be formally filed later today with the court.

Respectfully,

Richard Lechich
Washington Appellate Project
206-587-2711

From: Dorman, Katrinka <KDORMAN@spokanecounty.org>
Sent: Thursday, June 18, 2020 4:42 PM
To: Richard Lechich <richard@washapp.org>
Cc: Richards, Stephanie J. <SRICHARDS@spokanecounty.org>; SCPA Appeals <SCPAAppeals@spokanecounty.org>; Steinmetz, Larry <LSteinmetz@spokanecounty.org>
Subject: RE: [redacted] State v [redacted]
Importance: High

Counsel,

The Court has set this matter for hearing on June 24, 2020, at 8:30 a.m., without oral argument. The Court will issue a written decision after this date. If counsel feel the need to add anything more to the record, please do so in writing and provide bench copies to the Court by email. Thank you.

Kati Dorman
Judicial Assistant to
Judge Michael P. Price, Department 5

(509)477-4766, Courtroom 204

SPOKANE COUNTY
SUPERIOR COURT

Notice: All email sent to this address will be received by the Spokane County email system and may be subject to public disclosure under GR 31.1 and to archiving and review.

From: Richard Lechich [mailto:richard@washapp.org]
Sent: Thursday, June 18, 2020 9:31 AM
To: Dorman, Katrinka <KDORMAN@spokanecounty.org>
Cc: Richards, Stephanie J. <SRICHARDS@spokanecounty.org>; SCPA Appeals <SCPAAppeals@spokanecounty.org>
Subject: Fw: [redacted] State v [redacted]

Good morning,

The Court of Appeals ordered that a hearing occur by July 1, 2020 on [redacted] motion to stay his sentence pending resolution of his appeal. Attached are copies of [redacted] motion that was that was filed in the Court of Appeals, the State's response, [redacted] reply, a signed declaration from [redacted] and the commissioner's ruling. A copy of [redacted] brief of appellant, filed in his appeal, is attached as well.

Counsel for [redacted] is available to appear by phone or, if the court is using zoom, by videoconference using that application.

Respectfully,

Richard Lechich
Washington Appellate Project
206-587-2711

From: Seymour, Ronelle <Ronelle.Seymour@courts.wa.gov>
Sent: Wednesday, June 17, 2020 4:04 PM
To: wapofficemail; SCPA Appeals
Subject: [redacted] State v [redacted]

Please see the attached Ruling.

Ronelle Seymour
Case Manager
Court of Appeals, Division III
500 North Cedar Street
Spokane, WA 99201-1905
Ronelle.Seymour@courts.wa.gov
(509) 456-3082

Appendix III

Spokane County No: [redacted]; COA Div. III No: [redacted] State v. [redacted]

Dorman, Katrinka <KDORMAN@spokanecounty.org>

Wed 7/1/2020 2:20 PM

To: Richards, Stephanie J. <SRICHARDS@spokanecounty.org>; SCPA Appeals <SCPAAppeals@spokanecounty.org>; Steinmetz, Larry <LSteinmetz@spokanecounty.org>; Richard Lechich <richard@washapp.org>;

Cc: Seymour, Ronelle <Ronelle.Seymour@courts.wa.gov>;

1 attachments (572 KB)

20200701135641771.pdf;

Counsel,

Please find attached an order filed by the Court. The Clerk's office should be forwarding it to Court of Appeals, Division III. Thank you.

Kati Dorman
Judicial Assistant to
Judge Michael P. Price, Department 5
(509)477-4766, Courtroom 204

SUPERIOR COURT

Appendix IV

SUPERIOR COURT, STATE OF WASHINGTON, COUNTY OF SPOKANE

STATE OF WASHINGTON, Plaintiff/Respondent, vs. [redacted] Defendant/Appellant.	CASE NO. [redacted] COA Division III No: [redacted] ORDER ON MOTION FOR STAY OF SENTENCE PENDING APPEAL

This matter comes before the Court for hearing on the Motion of Defendant/Appellant, [redacted] for Stay of Sentence Pending Appeal on June 24, 2020 at 8:30 a.m. The Defendant/Appellant is represented by Mr. Richard W. Lechich of the Washington Appellate Project. The State of Washington Plaintiff/Respondent is represented by Ms. Stephanie J. Richard and Mr. Larry Steinmetz Deputy Prosecuting Attorneys.

The Court has in mind trial which took place in this matter May 7, 2019 through May 8, 2019 in Spokane County Superior Court and the Jury's Guilty Verdict entered May 8, 2019. The Court has also considered and reviewed the following:

1. Transcript of Spokane County Superior Court Jury Trial filed 1/27/2020 with the Court of Appeals of the State of Washington Division III.
2. Brief of Defendant/Appellant with attachments thereto filed 5/13/2020 with the Court of Appeals of the State of Washington Division III.

3. Emergency Motion to Stay Pursuant to RCW 9.94A.585(3) and For Review of Trial Court's Denial of Stay Under RAP 8.2(b) filed 5/26/2020 with the Court of Appeals of the State of Washington Division III (not to be confused with Defendant's Motion and Memorandum to Stay Sentence pending appeal filed on 7/25/2019 in Spokane County Superior Court).
4. Declaration of [redacted] filed 6/2/2020 with the Court of Appeals of the State of Washington Division III.
5. Response to Emergency Motion to Stay Sentence Under RCW 9.94A.585(3) and For Review of Trial Court's Denial of Stay under RAP 8.2(b) filed 6/3/2020 with the Court of Appeals of the State of Washington Division III (not to be confused with the State's Response to Defense Motion to Stay Sentence filed in Spokane County Superior Court on 7/25/2019).
6. Reply in Support of Emergency Motion to Stay Sentence and Order for Release Pending Appeal filed 6/4/2020 with the Court of Appeals of the State of Washington Division III.
7. Commissioner's Ruling and Remand entered 6/14/2020 with the Court of Appeals of the State of Washington Division III.
8. Memorandum in Support of Stay of Sentence Pending Appeal with Attachments thereto emailed to Spokane County Superior Court Department 5 on 6/19/2020.

9. Additional Evidence in Support of Stay Pending Appeal with Attachments thereto emailed to Spokane County Superior Court Department 5 on 6/24/2020.
10. Press Release from the Department of Corrections emailed to Spokane County Superior Court Department 5 on 6/26/2020.
11. Documentation from the Washington State Department of Corrections detailing confirmed COVID-19 cases at Coyote Ridge Corrections Center emailed to Spokane County Superior Court Department 5 on 6/30/2020.

NOW THEREFORE, mindful of evidence and argument submitted by Defendant/Appellant, [redacted] in Support of a Stay of Sentence Pending Appeal and evidence/argument submitted by the State of Washington, Respondent, in opposition to Emergency Motion to Stay Sentence and otherwise being fully advised as to inmates in the custody of the State of Washington Department of Corrections, who have been diagnosed with COVID-19 as well as, inmates specifically housed at Coyote Ridge Corrections Center who may have been diagnosed with COVID-19, and otherwise being fully advised, NOW FINDS AS FOLLOWS:

Defendant/Appellant [redacted] Motion for Stay of Sentence Pending Appeal should be and is, forthwith **DENIED**.

DATED: June 30, 2020

Michael P. Price
Superior Court Judge

Appendix V

THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION THREE

State of Washington, Respondent, v. [redacted], Appellant.	)))))))))	No. [redacted] DECLARATION OF [redacted]

As stated in [redacted] motion for this Court to order an appeal bond, attached is a copy of a signed declaration by [redacted] in support of his motion.

Respectfully submitted this 2nd day of June, 2020.

Richard W. Lechich – WSBA #43296
Washington Appellate Project – #91052
Attorney for Appellant

STATE OF WASHINGON, Plaintiff/Respondent, v. [redacted] Defendant/Appellant.	)	Trial No. [redacted] CoA No. [redacted] Declaration of [redacted]

[redacted] declares the following and that if called as a witness he would testify that:

1. I am a [redacted]
2. I am incarcerated at the Coyote Ridge Corrections Center. I am appealing my conviction for forgery.
3. Among my health conditions, I am a [redacted]
4. Healthcare staff from the Department of Corrections have identified me as being at an increased risk from COVID-19.
5. My conditions of confinement increase my risk. Social distancing is virtually impossible. An individual adjacent to my cell has been quarantined due to possible exposure to COVID-19.
6. If granted an appeal bond, I would abide by any conditions of release during the pendency of my appeal.
7. I am married and have a supportive [redacted] Washington. If released, I would reside with her.

The foregoing is true and correct to the best of my knowledge

DATED this 27th day of May, 2020

Julian Almaguer

Julian Almaguer

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION THREE

STATE OF WASHINGTON,	)	
	)	
RESPONDENT,	)	
	)	
v.	)	NO. [redacted]
	)	
[redacted],	)	
	)	
APPELLANT.	)	

DECLARATION OF DOCUMENT FILING AND SERVICE

I, MARIA ARRANZA RILEY, STATE THAT ON THE 2ND DAY OF JUNE, 2020, I CAUSED THE ORIGINAL **SIGNED DECLARATION OF APPELLANT** TO BE FILED IN THE **COURT OF APPEALS – DIVISION THREE** AND A TRUE COPY OF THE SAME TO BE SERVED ON THE FOLLOWING IN THE MANNER INDICATED BELOW:

[X] LARRY STEINMETZ, DPA	( )	U.S. MAIL
[SCPAappeals@spokanecounty.org]	( )	HAND DELIVERY
[lsteinmetz@spokanecounty.org]	(X)	E-SERVICE VIA PORTAL
SPOKANE COUNTY PROSECUTOR'S OFFICE		
1100 W. MALLON AVENUE		
SPOKANE, WA 99260		

SIGNED IN SEATTLE, WASHINGTON THIS 2ND DAY OF JUNE, 2020.

X_____

Washington Appellate Project
1511 Third Avenue, Suite 610
Seattle, Washington 98101
Phone (206) 587-2711
Fax (206) 587-2710

WASHINGTON APPELLATE PROJECT

June 02, 2020 - 4:01 PM

Transmittal Information

Filed with Court:	Court of Appeals Division III
Appellate Court Case Number:	[redacted]
Appellate Court Case Title:	State of Washington v. [redacted]
Superior Court Case Number:	[redacted]

The following documents have been uploaded:

- [redacted]_Affidavit_Declaration_20200602160125D3994565_5018.pdf
  This File Contains:
  Affidavit/Declaration - Other
  The Original File Name was washapp.060220-01.pdf

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- lsteinmetz@spokanecounty.org
- scpaappeals@spokanecounty.org
- wapofficemai@washapp.org

Comments:

Sender Name: MARIA RILEY - Email: maria@washapp.org
Filing on Behalf of: Richard Wayne Lechich - Email: richard@washapp.org (Alternate Email: wapofficemail@washapp.org)

Address:
1511 3RD AVE STE 610
SEATTLE, WA, 98101
Phone: (206) 587-2711

Note: The Filing Id is 20200602160125D3994565

Appendix VI

THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION THREE

State of Washington, Respondent, v. [redacted], Appellant.	)))))))))	No. [redacted] DECLARATION OF VICTORIA ALMAGUER

As stated in [redacted] motion for conditional release or bond pending resolution of his appeal, attached is a copy of a signed declaration by [redacted] in support of her husband's request.

Respectfully submitted this 25th day of June, 2020.

Richard W. Lechich – WSBA #43296
Washington Appellate Project – #91052
Attorney for Appellant

STATE OF WASHINGON,	)	
	)	Trial No. [redacted]
Plaintiff/Respondent,	)	CoA No. [redacted]
	)	
v.	)	Declaration of
	)	[redacted]
[redacted]	)	
	)	
Defendant/Appellant.	)	
	)	

[redacted] declares the following and that if called as a witness she would testify that:

1. I am married to [redacted]
2. [redacted]
3. I am in support of my husband's request for an appeal bond or release on personal recognizance.
4. If [redacted] was released, he would reside with me at my address.
5. Among my husband's health conditions is that he is [redacted]
6. I believe that COVID-19 poses a serious risk to my husband's health and believe release is in his best interests.

[redacted]

The foregoing is true and correct to the best of my knowledge

DATED this 30 day of June, 2020

[redacted]

[redacted]

RICHARD LECHICH
WASHINGTON APPELLATE PROJECT
1511 THIRD AVE., SUITE 610
SEATTLE, WA 98101

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION THREE

STATE OF WASHINGTON,	)	
	)	
RESPONDENT,	)	
	)	
v.	)	NO. [redacted]
	)	
[redacted],	)	
	)	
APPELLANT.	)	

DECLARATION OF DOCUMENT FILING AND SERVICE

I, MARIA ARRANZA RILEY, STATE THAT ON THE 25TH DAY OF JUNE, 2020, I CAUSED THE ORIGINAL **DECLARATION** TO BE FILED IN THE **COURT OF APPEALS – DIVISION THREE** AND A TRUE COPY OF THE SAME TO BE SERVED ON THE FOLLOWING IN THE MANNER INDICATED BELOW:

[X]	LARRY STEINMETZ, DPA [SCPAappeals@spokanecounty.org] [lsteinmetz@spokanecounty.org] STEPHANIE RICHARDS [srichards@spokanecounty.org] SPOKANE COUNTY PROSECUTOR'S OFFICE 1100 W. MALLON AVENUE SPOKANE, WA 99260	( ) U.S. MAIL ( ) HAND DELIVERY (X) E-SERVICE VIA PORTAL

SIGNED IN SEATTLE, WASHINGTON THIS 25TH DAY OF JUNE, 2020.

X_____

Washington Appellate Project
1511 Third Avenue, Suite 610
Seattle, Washington 98101
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Fax (206) 587-2710

WASHINGTON APPELLATE PROJECT

June 25, 2020 - 4:16 PM

Transmittal Information

Filed with Court:	Court of Appeals Division III
Appellate Court Case Number:	[redacted]
Appellate Court Case Title:	State of Washington v. [redacted]
Superior Court Case Number:	[redacted]

The following documents have been uploaded:

- [redacted]_Affidavit_Declaration_20200625161624D3477626_9339.pdf
  This File Contains:
  Affidavit/Declaration - Other
  The Original File Name was washapp.062520-01.pdf

A copy of the uploaded files will be sent to:

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- scpaappeals@spokanecounty.org
- srichards@spokanecounty.org
- wapofficemai@washapp.org

Comments:

Sender Name: MARIA RILEY - Email: maria@washapp.org
Filing on Behalf of: Richard Wayne Lechich - Email: richard@washapp.org (Alternate Email: wapofficemail@washapp.org)

Address:
1511 3RD AVE STE 610
SEATTLE, WA, 98101
Phone: (206) 587-2711

Note: The Filing Id is 20200625161624D3477626

Appendix VII

WA State DOC COVID-19 Screening, Testing, and Infection Control Guideline Version 18

The purpose of this guidance document is to allow the Washington State Department of Corrections (DOC) to better respond to the emerging COVID-19 outbreak. This document covers screening, assessment, testing and infection control of patients housed in Washington DOC facilities.

VIEW GUIDELINE UPDATES

Table of Contents:

Screening

1) **Patients presenting with symptoms prior to Health Services contact**: Direct the patient to immediately don a surgical mask and place them in an isolated area and contact Health Services.
2) **Intersystem intakes (Patient arriving from other than a DOC facility)**: All intersystem intakes coming into DOC facilities will have a temperature taken and will be asked the two screening questions listed below as a. and b. If any of the three screening items are positive the patient should immediately don a surgical mask and be place in an isolated area.
    a) Intersystem intakes originating from the community, such as patients from community custody field offices, work release, or community custody violators in jails will be screened prior to transport. If the patient screens positive they should be transported by staff in PPE including an N95 mask per the **Transportation of patients with suspected or confirmed COVID-19 disease** section below.
3) **Patients presenting with symptoms in Health Services:** Patients with symptoms concerning for COVID-19 should immediately don a surgical mask and be placed in an isolated area.
4) **Intrasystem intakes (Patients transferring to another DOC facility):** All intrasystem intakes should have a temperature taken prior to boarding and upon exiting the transport bus. If the patient has temperature greater than 100.4F immediately direct the patient to don a surgical mask, place them in an isolated area, and contact health services.
5) **Active screening of staff:** All staff entering DOC facilities will be screened for signs and symptoms of COVID-19 with questions and a temperature check. Staff screening positive will not be allowed entry to the facility and will have follow up through the secondary staff screening process.
6) **Active screening of patients prior to entering Health Services**: All patients entering Health Services areas for scheduled or unscheduled care will be screened for signs and symptoms of COVID-19 with questions and a temperature check. Patients screening positive will immediately don a surgical mask and be placed in an isolated area for evaluation according to the Health Services Evaluation section below.

Health Services Evaluation

1) Any health care provider making contact with patients referred from the screening section above should don personal protective equipment listed below *before* the evaluation:
    a) Fit-tested N95 mask
    b) Gloves
    c) Eye protection defined as goggles or face shield
    d) Gown
    e) If not fit tested use PAPR instead of N95
2) For instructions on proper donning and doffing of PPE see the following video and/or document. The purpose of this video is to demonstrate proper donning and doffing of PPE. For detailed guidance regarding

appropriate PPE for each clinical situation see the PPE matrix or the Infection Control and Prevention section of this document.

3) Nurse performs a clinical assessment, including temperature check, and asks the following 2 screening questions:
   a) Do you have a fever **OR** any new cough, shortness of breath, sore throat, diarrhea, or loss of taste/smell?
   b) Did you have contact with someone with possible COVID-19 in the previous 14 days?
4) If the answer to either screening questions is yes, or temperature is greater than 100.4F, notify a healthcare practitioner for further assessment:
   a) If a practitioner is available onsite they will assess the patient clinically and decide whether symptoms are compatible with COVID-19 disease. If yes proceed to step C.
   b) If no practitioner is onsite the nurse will discuss the patient's case with the practitioner.
   c) All patients screening positive for symptoms or fever who are placed in isolation should be tested for COVID-19 disease as described in the Testing Procedure section below.
   d) The practitioner will determine the following:
      i) Level of care based on acuity
         (1) To emergency department for severely ill patients
         (2) To a negative pressure room for any non-severely ill patient if one is available and the patient requires IPU level care, under airborne medical isolation precautions. Facilities may establish alternative isolation units with 24 hour nursing coverage which are an acceptable alternatives for patients requiring this level of medical care.
         (3) Living unit medical isolation with contact and droplet precautions for patients with mild illness.
            (a) Patients isolated in a living unit with suspected or confirmed COVID-19 will have nursing assessments and vital signs at least every shift
      ii) Patients remaining in the facility will have the following diagnostic workup:
         (1) During influenza season (September through the end of March) perform rapid influenza testing
         (2) Perform COVID-19 testing according to the Testing Procedure section below
            (a) If the initial COVID-19 test is negative AND it is influenza season (September through the end of March) send a viral respiratory panel (Interpath # 2910) along with the second COVID-19 test
         (3) Consider other diagnostic testing as clinically appropriate, i.e. chest x ray for community acquired pneumonia
      iii) In the event that the patient is unable to be tested but for whom clinical suspicion remains, the patient should be isolated for presumptive COVID-19 disease.

Testing Procedure

1) Sample collection and testing:

   a) Upper respiratory samples appropriate for COVID-19 testing can include any of the following. Patient collected nasal anterior and mid-turbinate samples should be preferred in settings where N95 masks are in short supply. All sampling techniques require synthetic tipped swabs, such as dacron, nylon, or polyester, without wooden handles:

      i) Nasopharyngeal (NP) swab:

         (1) NP swab sample collection is considered an aerosol generating procedure that requires the clinician to wear full PPE including an N95 mask.

         (2) Perform NP swab on both sides of the nasopharynx, with either one swab or two depending on composition of testing kit and swab availability

         (3) Please review the following nasopharyngeal swab sample collection guidance:

            (a) NP swab is clinician collected only
            (b) NP swab guidance document
            (c) NP swab demonstration video

      ii) Nasal mid-turbinate swab:

         (1) Nasal mid-turbinate swab can be clinician or patient collected.

         (2) Use a flocked tapered swab. Tilt patient's head back 70 degrees. While gently rotating the swab, insert swab less than one inch (about 2 cm) into nostril (until resistance is met at turbinates). Rotate the swab several times against nasal wall and repeat in other nostril using the same swab.

      iii) Anterior nares specimen swab:

         (1) Anterior nares specimen swab can be clinician or patient collected.

         (2) Using a flocked or spun polyester swab, insert the swab at least 1 cm (0.5 inch) inside the nares and firmly sample the nasal membrane by rotating the swab and leaving in place for 10 to 15 seconds. Sample both nares with same swab.

   b) There are currently three options for COVID-19 testing:

      i) Washington State DOH/public health laboratory:

         (1) Refer to Washington DOH COVID-19 Specimen Collection and Submission Instructions for guidance on collecting, submitting, and shipping of test samples.

         (2) When the decision is made to test patients for COVID-19 use the following lab testing equipment:

            (a) Nasal swab (any of the 3 described above) in viral transport media testing tube is the preferred testing sample in all patients. Use only synthetic sterile swabs.

(b) Test sputum **if easily available** using a sterile specimen cup. Do not induce sputum in patients who are not producing sputum.

(3) Use the Washington State DOH Sample Submission Form to submit test samples to the state DOH lab.

(4) Write the provided PUI# on the submitter section of the submission form.

(5) Send samples via Federal Express pickup using supplied packaging that complies with the IATA/DOT regulations for shipping category B biological substances. Laboratory personnel can review the following guidance for more shipping information about shipping samples through Federal Express. Shipping labels will be provided for both testing laboratories.

ii) Interpath Laboratory:

(1) Testing through Interpath can be accomplished according to the instructions below. Testing through Interpath does not require specialized supplies for packaging and shipping as samples are picked up through the established Interpath lab courier.

(a) Order COVID-19 PCR testing as an unlisted test

(b) Preferred specimen: Nasal Swab (any of the 3 described above) in Viral Transport Media

(c) Alternate specimen: Nasal Swab (any of the 3 described above) in Sterile Tube w/Saline

(d) Preferred submission: Nasal Swab (any of the 3 described above) in Viral Transport Media

(i) Submitted frozen

(e) Alternate submission: 1 mL Nasal Swab(any of the 3 described above) in Sterile Tube w/Saline

(f) Submitted frozen

(g) Handling: State Patient Address

(h) Rejection criteria: Calcium alginate swabs or swabs with wooden shafts

(i) Stability:

(i) Ambient: Unacceptable
(ii) Refrigerated: 3 Day(s)
(iii) Frozen: 2 Month(s)
(iv) Incubated: Unacceptable

iii) University of Washington Virology Lab:

(1) Use the following testing instructions and the linked UW Virology COVID-19 test requisition.

(2) Send samples via Federal Express pickup using supplied packaging that complies with the IATA/DOT regulations for shipping category B biological substances. Laboratory personnel can review the following guidance for more shipping information about shipping samples through Federal Express. Shipping labels will be provided for both testing laboratories.

2) Notify facility Infection Prevent Nurse, Facility Medical Director, and Health Services Manager

Patients at High Risk for Severe COVID-19

1) Patients with underlying conditions and those with advanced age are at higher risk for severe disease and complications if they acquire COVID-19. Patients with the following conditions should be considered at high risk:

    a) Aged 50 years or older**
    b) COPD or moderate to severe asthma
    c) Cardiovascular disease including hypertension
    d) Patients who are immunosuppressed based on diagnosis or due to medication
    e) Cancer
    f) Morbid obesity (BMI >40)
    g) Diabetes, particularly if poorly controlled
    h) Chronic kidney disease including those with ESRD on dialysis
    i) Hepatic cirrhosis
    j) Pregnancy or the immediate post-partum period

2) The following recommendations should be made for patients identified as high risk :

    a) Wear issued face covering when out of cell or when within 6 feet of others
    b) Perform frequent hand hygiene
    c) Perform frequent cleaning of cell throughout the day

        i) Highly discourage the use of bleach as this can exacerbate conditions for those patients with underlying lung disease

    d) Avoid contact of high-touch surfaces
    e) Limit movement in the facility
    f) Social distancing (stay at least 6 feet from others) should be maintained during Day Room, Yard, Gym, Dining Halls, Religious Services, Pill Line, and other areas where the incarcerated population congregates.

** National Institute of Corrections recognizes that incarcerated population ages 50 and above are considered elderly

Clinical Care of Patients with Suspected or Confirmed COVID-19

1) Triage for appropriate care setting of suspected or confirmed COVID-19 patients:

a) COVID-19 can display a very wide range of disease severity, from asymptomatic and mild upper respiratory symptoms to severe lower respiratory tract disease with ARDS and multiple organ failure. Therefore triage to the appropriate care setting and subsequent monitoring are important aspects of clinical care for patients with COVID-19.

b) Risk factors for severe disease and mortality include the following:

i) Lung disease including COPD and asthma

ii) Cardiovascular disease including hypertension and cardiomyopathy

iii) Diabetes

iv) Immunosuppression due to diagnosis or medication

(1) History of Transplant

(2) HIV with CD4 <200 or detectable viral load

(3) Immune modulators or immunosuppressive medications including corticosteroid treatment at the equivalent of 20 mg of oral prednisone or more daily

v) Cancer

vi) Chronic kidney disease

vii) Cirrhosis

viii) Age 50 years old or greater

c) Patients with one or more of the risk factors above should be considered at high risk for clinical deterioration and should be monitored closely regardless of initial care setting.

d) Patients with confirmed or suspected COVID-19 disease can be triaged into the following groups based on the clinical evaluation:

i) Mild disease: Patients with mild disease may have fever, cough, upper respiratory tract symptoms, myalgias, and fatigue without significant dyspnea or hypoxia (oxygen saturation 96% or greater).

ii) Moderate to severe disease: Patients with significant dyspnea, hypoxia (oxygen saturation less than 96%) or other clinical evidence for severe disease should be triaged to a higher level of care.

(1) If hypoxia is mild (92-95% on room air) and the patient is otherwise clinically stable admission to an inpatient unit or other unit with 24 hour nursing coverage, with on- site diagnostic evaluation may be considered:

(a) In addition to the diagnostic testing described in the Health Services Evaluation section above, at a minimum perform a chest x ray and the following lab studies:

(i) CBC with differential
(ii) CMP
(iii) CRP
(iv) LDH (Interpath #1018)
(v) INR
(vi) D-dimer (Interpath #2657)
(vii) Creatine kinase (CK) (Interpath #1015) and troponin (Interpath #2688)
(viii) lactic acid (Interpath #2092)

(b) Patients in this group with risk factors for severe disease are at high risk for rapid clinical deterioration. Consider emergency department evaluation as indicated based on clinical judgement.

(2) If hypoxia is severe (inability to maintain oxygen saturation above 95% on 4L supplemental O2 or greater) or there is other clinical evidence of severe disease, including sepsis, cardiac

complications, or coagulopathy, the patient should be transferred to the emergency department for further diagnostic evaluation and treatment.

2) Treatment and monitoring of outpatients with suspected or confirmed COVID-19 and mild disease as defined above:

a) Treatment for patients with mild disease is supportive:

i) Patients with mild disease will be isolated in a living unit and will have nursing assessments every shift. Signs of clinical deterioration that should provoke transfer to a higher level of care or further diagnostic assessment include:

(1) Hypoxia with oxygen saturation less than 96% on room air
(2) Development of significant dyspnea
(3) Inability to tolerate oral intake
(4) Clinical evidence for sepsis, cardiac complications, or coagulopathy.

ii) Supportive care can include oral hydration, anti-emetics if indicated, and analgesics/antipyretics:

(1) Prefer acetaminophen for fever and myalgias

(2) Anecdotal reports initially suggested NSAIDs may have been associated with worsening COVID-19 disease in some patients. Currently there is no evidence to support either harm or safety for use of NSAIDs in patients with confirmed or suspected COVID-19. In the face of this uncertainty acetaminophen should be used preferentially for pain and fever in this patient group, however NSAIDs can be used intermittently based on clinical judgement on a case by case basis if no contraindications are present.

(3) Nebulized treatments should not be used as they may aerosolize virus. If bronchodilator treatment is needed metered dose inhalers can be used.

iii) For patients in the mild disease category be aware that early experience with COVID-19 cases suggests the potential for clinical deterioration **five to ten days after illness onset**, including the onset of respiratory failure, sepsis, and cardiac complications.

iv) There are no data to suggest a link between ACE inhibitors and ARBs with worse COVID-19 outcomes. These medications should be continued unless the clinical picture warrants holding them (ex. hypotension).

3) Treatment and monitoring of the COVID-19 patient admitted to an inpatient unit or similar setting:

a) Patients initially triaged to an inpatient unit care setting or another unit with 24 hour nursing coverage, or admitted to one after return from an emergency department evaluation or hospitalization for COVID-19:

i) Admit to negative pressure room with airborne medical isolation precautions if available

ii) Until further evidence for benefit and safety is available anti-viral agents are not recommended.

iii) Supportive care ordered as described above for patients with mild illness

iv) Supplemental oxygen by nasal cannula if patient is dyspneic or O2 saturation is less than 96% on room air.

v) Close monitoring for clinical deterioration including worsening hypoxia, with awareness of the potential for severe disease to develop 5-10 days after illness onset.

vi) Clinical factors that should provoke consideration for transfer to a higher level of care:

(1) Need for greater than 2L supplemental oxygen to maintain saturation above 92%

(2) Bilateral infiltrates on chest x ray suggesting moderate to severe pneumonia

(3) Elevated D Dimer > 1000 ng/ml

(4) Elevated CRP > 100

(5) LDH >245

(6) CPK > 2x ULN

(7) Abnormal/elevated troponin

(8) Elevated AST and ALT

(9) Significant lymphopenia or neutrophilia:

(a) Calculate absolute neutrophil to absolute lymphocyte ratio: if 3.0 or greater the patient should be considered at high risk for clinical deterioration **OR**

(b) Absolute lymphocyte count <0.8

(10) Lactate > 4

(11) New creatinine elevation

(12) Other clinical findings based on clinical judgement of medical team

vii) Consider monitoring diagnostic studies recommended above through the course of illness until clear clinical improvement is seen.

viii) Patient may transfer back to living unit medical isolation for the remainder of the medical isolation period after clinical improvement is seen and the risk for deterioration has passed.

4) For questions or consultation regarding management of patients with suspected or confirmed COVID-19 call the DOC COVID medical duty officer phone: 564-999-1845

Infection Control and Prevention

1) Definitions:

a) Medical isolation: Separating a symptomatic patient with a concern for a communicable disease from other patients.

b) Quarantine: Separating asymptomatic patients who have been exposed to a communicable disease from other patients.

c) Cohort: Grouping patients infected with or exposed to the same agent together. Isolated and quarantined patients should NOT be cohorted together.

2) All incarcerated individuals in facilities, including work releases, will wear DOC provided mandatory routine face coverings.

3) PPE must be changed between EVERY patient in isolation or quarantine any time there is close contact except in the following situations:

   a) Regional Care Facilities and tiers, units or pods of isolation units where ALL patients have a confirmed positive result for COVID-19:
      i) It is not necessary to change eye protection, mask/respirator, and gown between each patient.
      ii) Hand hygiene and new gloves are still needed between each patient. This can be achieved by double gloving, removing the outer gloves, disinfecting the inner gloves, and putting on a new outer gloves between patients.
      iii) All PPE should be changed if visibly soiled.

4) **Asymptomatic patients testing positive for COVID-19:**

   a) follow the following infection control procedure:

      (1) Place in medical isolation for 14 days from the date of the positive test if the patient remains asymptomatic

      (2) If the patient subsequently becomes symptomatic, follow the isolation criteria in Medical Isolation section below

      (3) After the isolation period is complete the patient should enter post-isolation convalescent housing for 7 days.

5) **Medical isolation:**

   a) Medical isolation is applied to those patient newly identified as having an influenza-like illness or other symptoms potentially caused by COVID-19.

   b) As soon as staff become aware that a symptomatic patient is suspected or confirmed as a COVID-19 case, staff should direct the patient to put on a surgical mask until the patient can be isolated.

      i) Each housing unit and Shift Commander's office will maintain a supply of surgical masks
      ii) Surgical masks will be made available in clinic waiting rooms
      iii) Staff will work to isolate the patient and notify medical if they are identified outside the clinic

   c) If the patient is off the living unit at the time COVID-19 symptoms are noted, staff working with the patient will notify the applicable housing unit that they are sending the patient back for single cell confinement until the patient can be assessed by medical

      i) If a single room is not immediately available, confine the patient at least 6 feet away from others until they have been evaluated by medical

   d) If the patient is already in the living unit, isolate the patient in their cell and notify medical

   e) Droplet Precautions will be initiated

i) Droplet Precaution Medical isolation signs will be hung outside the room at cell front

ii) Proper PPE will be available outside the medical isolation cell or somewhere easily accessible

iii) All staff must wash hands with soap and water or with alcohol sanitizer prior to entering a patient's cell and removing gloves.

f) **PPE for medical isolation**:

i) In the following situations PPE will be comprised of an **N95 mask, eye protection, gown, and gloves:**

(1) Patients with suspected or lab confirmed COVID-19 while symptomatic with cough or sneezing.

(2) While performing diagnostic nasopharyngeal swab sample collection or any other potentially aerosol generating procedures.

ii) In the following situations PPE will be comprised of a **surgical mask, eye protection, gown, and gloves:**

(1) When speaking with a symptomatic patient from outside of a medical isolation cell with an open door. Speaking to a patient from outside a medical isolation cell with the door closed does not require PPE other than general use face covering.

(2) Any patient who has tested negative for COVID-19 but remains in medical isolation and continues to be symptomatic

(3) Patients with suspected or lab confirmed COVID-19 without cough or sneezing.

iii) All staff must wash hands with soap and water or with alcohol sanitizer after leaving a patient's cell and removing gloves.

iv) A trash bin and bag, hand sanitizer, and gloves should be available immediately outside the cell or unit to assist staff in proper doffing of PPE.

g) Medical isolation of patients with suspected or confirmed COVID-19

i) Custody will work with medical staff to determine the best location to house patients on medical isolation status.

ii) If single cell not available, it is acceptable to cohort patients with COVID-19 together if they both/all have lab confirmed disease and are not thought to have other communicable diseases concurrently (i.e. influenza or another viral respiratory disease).

iii) Symptomatic isolated patients must be housed separately from asymptomatic exposed patients (quarantined).

iv) If possible avoid isolating patients with suspected or confirmed COVID-19 in cells with open bars.

h) As a general rule, isolated patients will not be allowed out of the cell unless security or medical needs require it

i) If an isolated patient needs to be out of their cell, they will don a surgical mask during the necessary movement

ii) Staff will ensure that the patient goes where directed by communication between the sending and receiving area staff

iii) Any pill line medications will be delivered by medical staff unless medical staff determines the need for a different protocol

i) **Clinical management of medical isolation patients**:

i) Patients isolated in a living unit with suspected or confirmed COVID-19 will have nursing assessments and vital signs at least every shift, with referral to a practitioner as clinically indicated.

ii) Medical practitioners should document an assessment on patients in medical isolation for confirmed or suspected COVID-19 each business day until they are asymptomatic for 24 hours.

iii) Patients with laboratory confirmed COVID-19, or who were not tested but are suspicious for COVID-19, will remain in medical isolation until they have been asymptomatic for 14 days.

iv) Patients who tested negative for COVID-19 will remain in medical isolation until:

(1) they have been asymptomatic for 14 days, unless they have a documented or confirmed alternative diagnosis that explains their symptoms, such as in the following examples:

(a) Mild respiratory illness with a positive influenza test
(b) Fever explained by infection at another site, such as UTI or cellulitis

OR

(2) they have been asymptomatic for at least 72 hours and have tested negative for COVID-19 twice with at least 48 hours between tests

v) Patients isolated for suspected or confirmed COVID-19 disease who become asymptomatic:

(1) After an isolated patient is asymptomatic for 24 hours the intensity of monitoring can be decreased to once daily temperature and symptom checks at cell front. Patients with recurrence of symptoms should be evaluated by a medical practitioner.

(2) Recommended PPE for these asymptomatic medical isolation nursing checks will include **surgical mask, gown, and gloves**.

vi) Unless transfer to a setting for a higher level of medical care is required, all medical care should be delivered in the patient's medical isolation cell.

6) **<u>Quarantine:</u>**

a) Patients who are asymptomatic but have been in close contact with confirmed or suspected COVID-19 patients should be quarantined.

b) Close contacts of patients who test negative for COVID-19 may only be released from quarantine if the associated symptomatic patient tests negative for COVID-19 on two tests at least 48 hours apart:

i) If repeat testing is not available close contacts of patients testing negative once for COVID-19 may be released from quarantine 14 days after their last contact with the symptomatic patient per the Medical Isolation section above.

c) Close contacts of patients who test positive for COVID-19 will remain in quarantine 14 days after the last exposure to the patient.

d) Quarantined patients can be housed alone or cohorted with other quarantined patients from the same exposure.

i) If a quarantined patient develops symptoms of COVID-19, they will be immediately removed from quarantine if they were housed with other asymptomatic patients, and placed into medical isolation. If cohorted with other asymptomatic patients the quarantine period for those patients will be reset to day 0 of 14.

ii) If the symptomatic patient lived in dormitory-style housing, consider quarantining an entire dorm or wing of a housing unit, especially if multiple cases occur.

e) **PPE for staff interacting with quarantined patients**:

(1) Staff performing tier checks in open dorm style housing units should remain 6 feet away and have patients sit on their beds. PPE worn during these tier checks includes **gloves.**

(2) Staff performing nursing or medical assessments on quarantined patients requiring close contact including in open dorm style housing units, should don the following PPE: **surgical mask, gown, eye protection and gloves.**

(3) Staff interacting with quarantined patients in units with barred cells WITHOUT contact and staying at least 6 feet away do not require PPE other than a **routine face covering**.

(4) Staff performing a temperature check through a closed cell door with an open cuff port should don the following PPE: **surgical mask, eye protection, and gloves**.

f) Staff performing nursing assessments of patients in quarantine should do so by discussing development of symptoms and perform temperature check at the cell front after donning PPE outlined above.

g) Disposable thermometers should be used by patients if available. If multi-use thermometers must be used they should be disinfected in between patients.

h) If the patient develops symptoms or fever a full assessment should be done by entering the cell in PPE appropriate for symptomatic patients including full PPE with N95 mask.

i) Patients in quarantine should don a **surgical mask** anytime they leave their cell.

j) Patients in quarantine will be assessed twice daily by nursing staff. The assessment will include a temperature check and monitoring for development of any symptoms. If the patient develops symptoms while in quarantine they will be assessed by a medical practitioner per Health Services Evaluation section step #3.

i) For stand-alone camps Health Services staff will determine scheduling to accommodate assessment of quarantined patients 7 days per week.

k) Any pill line medications will be delivered to the quarantined patient by medical staff unless medical staff determines the need for different protocol.

l) A trash bin and bag, hand sanitizer, and gloves should be available immediately outside the cell or unit to assist staff in proper doffing of PPE.

m) Unless transfer to a setting for a higher level of medical care is required, all medical care should be delivered in the patient's quarantine cell.

n) Signage indicating that the quarantine cells are under droplet precautions will be hung at the unit or tier level.

7) **Facility management of isolated/quarantined patients:**

a) If possible, cluster cases in medical isolation within in a single location/wing within the facility to help streamline ongoing assessments and delivery of services to the affected population

b) If patients need to be isolated/quarantined in a living unit, allowances will be made to accommodate patients in this location

i) Television, playing cards and/or other recreational activities will be provided
ii) There will be no cost to the patient for the duration of their stay

c) All patients placed in medical isolation/quarantine will be issued hygiene kits and new clothing as needed

d) Provision of health care

i) Routine health care will be provided at cell front.

ii) Medications will be given at cell front

iii) Insulin and other diabetic services will be given at cell front

iv) Routine mental health services will be provided at cell front

v) Emergency medical needs will be assessed immediately by medical personnel, as required. Patient will be transported as deemed necessary if a higher level of medical care than can be delivered in the unit is required. There is not a medical indication for restraints during transport. Patient will don a surgical mask if it is not contraindicated.

e) Meals will be provided by Food Services and delivered to the cell.

i) The Unit staff will notify Food Services at the beginning of each shift the number of meals that are needed

ii) **Gloves** will be worn when picking up used trays

f) Education Programs will be suspended

g) **Phone Use in Medical Isolation:**

i) **Phone Use in Medical Isolation for Areas WITH In-Cell Phone Use:**

(1) Allow one 10-minute phone call every 7 days while on isolation, unless otherwise authorized

(2) Staff shall don appropriate PPE:

(a) Symptomatic patients with presumed or confirmed COVID-19: **N95 respirator, eye protection, gown, and gloves**

(b) Asymptomatic patients with presumed or confirmed COVID-19: **surgical mask, eye protection, gown and gloves**

(3) Staff shall cover the phone handset with a plastic sleeve and use tape/bands to cinch both ends to enclose the entire handset

(4) Patient will wear a surgical mask, if they are medically able to do so

(5) Staff shall pass the handset of the phone to the patient via the cuff port or an opening of the door if necessary

(6) Staff shall have the patient wash his/her hands immediately after using the phone

(7) Staff shall carefully remove the plastic sleeve from the phone and dispose of it in the garbage container

(8) Staff shall remove PPE appropriately and then sanitize or wash hands as per protocol

(9) Staff shall spray disinfectant over the entire phone, let it sit for 10 min., and put on new gloves before wiping it off

ii) **Phone Use in Medical Isolation for Areas WITHOUT In-Cell Phone Use:**

(1) Facility will designate staff member to make weekly status update phone calls to person identified by patient

(2) When a patient is placed into medical isolation, he/she shall be asked to provide the name and telephone number of a person for a weekly phone call, which will be provided to the designated staff person making the call

(3) Designated staff will verify no current restrictions on contact exist prior to making call

(4) Designated staff will make call to identified person to notify of placement into medical isolation, as well as a weekly call to update on status

(5) Designated staff will note the call by placing a chrono in OMNI

h) **Showers in Medical Isolation**:

i) Patients in Medical Isolation will be allowed to maintain personal hygiene including showers according to the following:

(1) Patients should be offered 1 shower per week starting after day 7 in isolation.
(2) These patients can be rotated, and must remain at least 6 feet apart.
(3) The patients must wear a **surgical mask** at all times while out of their cell.
(4) PPE for unit staff having close contact with patients:
    (a) **N95 mask, disposable gown, gloves, and eye protection**
(5) The showers will need to be disinfected according to the manufacture's guidelines after each shower.
(6) PPE for staff or incarcerated individuals cleaning showers used by patients in Medical Isolation:
    (a) **surgical mask, disposable gown, gloves and eye protection**

8) **Post-isolation convalescent housing:**

a) Patients testing positive for COVID-19 may continue to shed virus after the isolation period is complete. To prevent potential spread of COVID-19 disease from patients in this phase they will be cohorted to together in less restrictive living arrangements than isolation or quarantine housing.

b) The period of post-isolation convalescent housing will be 7 days, after which the patient can return to their usual housing unit.

c) Post-isolation housing patients do not require routine medical monitoring but should have access to acute care through a sick call process.

d) If routine medical care is required by post-isolation patients it should be delivered in the housing unit if possible.

e) **PPE for staff in interacting with post-isolation patients**:

(1) For staff in close contact including medical assessments don a **surgical mask, gown, and gloves**

(2) Staff not in close contact do not require PPE other than a **routine face covering**.

9) **Routine Pre-procedure COVID-19 Testing:**

a) Community health care providers may require routine COVID-19 testing of asymptomatic patients prior to surgical or other procedures.

i) Patients may be housed in their usual housing units without special quarantine or isolation procedures while awaiting test results.

ii) Staff interacting with these patients may do so without additional PPE other than a **routine face covering.**

iii) Patients testing positive should follow guidance above regarding asymptomatic COVID positive patients.

10) **Intersystem Transfer Separation:**

a) Intersystem transfer separation can include individuals entering or exiting DOC custody that require separation from the general population to reduce the potential risk of COVID spread

b) **Intake separation**:

i) This section applies to all intersystem intakes into DOC facilities, including:

(1) Community custody violators

(2) Patients arriving from county jails or other detention facilities

(3) Work release and GRE returns

ii) Patients in these categories should be separated from the general population at the receiving facility for 14 days after arrival

iii) Patients arriving together at the facility on the same day can be cohorted together

iv) Additional PPE, other than a **routine face covering**, is not needed when interacting with asymptomatic patients in intake separation status.

v) If a patient in routine intake separation becomes symptomatic they should enter Medical Isolation, and the remaining intake cohort should be placed in quarantine for 14 days.

c) **Separation Prior to Work Release Transfer**:

i) For facilities with active COVID-19 cases:

(1) For patients eligible for transfer to work release, prior to finalizing their transfer orders, notify the COVID medical duty officer to discuss the need for separation prior to transfer.

(2) Depending on the extent of potential transmission within the facility, a decision may be made to initiate transfer separation prior to work release transfer.

(a) The purpose of transfer separation is to separate individuals awaiting work release transfer from the rest of the population for a period of 14 days

(b) Patients in transfer separation can be housed together

(c) Additional PPE, other than a **routine face covering**, is not necessary for staff interacting with patients on transfer separation.

11) **Protective Separation**

a) Housing units with a high concentration of individuals at high risk for severe COVID-19 may be placed on protective separation status in order to reduce the risk of introduction and transmission of virus.

i) At the current time the following units are on protective separation status:

(1) CRCC-Sage

(2) AHCC K unit

ii) Special direction to staff working on protective separation units:

(1) Only necessary and assigned staff should have access to this unit

(2) Staff must wash hands before entering and exiting the unit

(3) Staff will remove and store their routine face covering and don a new surgical mask prior to entering the unit.

(4) No staff interacting with quarantined and isolated individuals should be entering these units during their assigned shift

iii) Special direction to incarcerated individuals living on special units:

(1) Individuals are restricted to their living unit

(2) Patients are provided a routine face covering for use at all times

(3) Patients are restricted from eating in main chow halls and meals are delivered to the living unit

(4) Individuals shall be given pill line at their cells

(5) Individuals should be allowed to self-quarantine if they choose

12) **PPE Requirements for Prisons and Work Release Staff:**

a) **Tyvek suites** are not considered appropriate PPE for the purpose of this guideline and should not be used when contacting patients with suspected or confirmed COVID-19 or those on quarantine.

b) Contact with asymptomatic individuals who are not on medical isolation or quarantine:

i) **Gloves** (follow normal practice)

c) Contact with individuals on medical isolation (symptomatic):

i) In the following situations **N95 mask, eye protection, gown, and gloves** should be worn:

(1) Contact with incarcerated individuals with suspected or lab confirmed COVID-19 while symptomatic (cough or sneezing).

ii) In the following situations **surgical mask, eye protection, gown, and gloves** should be worn:

(1) When speaking with a symptomatic patient from outside of an medical isolation cell

(2) Any contact with a patient who has tested negative for COVID-19 but remains on medical isolation

(3) Any contact with incarcerated individuals with suspected or lab confirmed COVID-19 without cough or sneezing.

iii) In the following situations PPE will be comprised of **gloves**:

(1) Passing items through a closed door cuff port and NO face to face contact

(2) If possible, avoid medical isolation in cells with open bars

d) Contact with quarantined (asymptomatic) individuals:

i) Open bay units:

(1) Close contact (ex. Temp check): **surgical mask, gown, gloves, eye protection**
(2) No close contact (example walking through unit): **gloves**

ii) Dayroom/or other close quarters:

(1) Close contact (within 6 feet): **surgical mask, gown, gloves, eye protection**
(2) No close contact (example walking through unit): **gloves**

iii) Pat searches:

(1) **Surgical mask, gown, gloves** (for every person pat searched), **eye protection**

iv) Closed door cells with *cuff port*:

(1) Passing items through cuff port and NO face to face contact: **gloves** only
(2) No contact at all (talking through the door): **No PPE required**
(3) Close contact: **surgical mask, gloves, eye protection**

v) Bar cells:

(1) Close contact (ex. temp check): **surgical mask, gown, gloves, and eye protection**

e) Staff active screening of patients or staff at entry into facilities, health services, or other :

i) **Active screening without use of a protective barrier:**

(1) **Surgical mask, gown, gloves and eye protection**

(2) **When an active screener should change PPE:** If a facility active screener comes within 6 feet of a staff member or patient that screens positive PPE should be removed and discarded, hand hygiene should be performed, and new PPE should be donned prior to resumption of screening.

ii) **Active screening while using protective barrier:**

(1) PPE should consist of **gloves and routine facemask/covering**

(2) The screener should stand behind the protective barrier. Temperature should be taken by reaching around the barrier. The screener should ensure they are positioned so that the barrier blocks any potential respiratory droplets from the screened individual. If no contact was made between the screener and the screened individual gloves do not need to be changed between screenings, unless they are visibly soiled or torn.

13) **Environmental Cleaning**

a) Enhanced frequency of cleaning and disinfection procedures of high touch surfaces is recommended for COVID-19 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.

b) Disinfectant must be:

i) EPA-approved as a hospital/healthcare or broad spectrum disinfectant
ii) Contain quaternary ammonium

c) Management of laundry:

i) Laundry from medical isolation or quarantine patients and cells will be placed in yellow bags and transported in rice bags. Contents should be washed/treated as infectious laundry.

d) Food service management:

i) Meals for isolated and quarantined patients should be served in disposable clamshells. If trays are used staff should wear gloves and wash hands before and after handling.

e) Medical waste from medical isolation and quarantined cells can be discarded using the regular waste disposal process.

f) Any individuals involved in cleaning rooms occupied by isolated suspected or confirmed COVID-19 cases, including DOC staff and employed incarcerated individuals, should wear the following PPE: **surgical mask, gown, eye protection and gloves**.

g) Any individuals involved in handling laundry and food services items of patients in medical isolation or quarantine, without entering the cell, should wear the following PPE:

i) **Gown and gloves**

h) Rooms occupied by quarantined patients who are moved prior to the complete 14 day period, should be similarly cleaned only by individuals wearing the following PPE: **surgical mask, gown, eye protection and gloves**.

14) All staff working in DOC locations must wear an approved face covering while on duty.

15) Recommended personal protective equipment for both Health Services and Prisons/Work Release staff is summarized in the linked PPE matrix.

Reuse of N95 Respirators:

Supplies of N95 respirators are in increased demand creating critical shortages during infectious diseases outbreaks. Existing CDC guidelines recommend a combination of approaches to conserve supplies while safeguarding health care workers in such circumstances. In these situations, existing guidelines recommend:

- Minimizing the number of individuals who need to use respiratory protection
- Using alternatives to N95 respirators where feasible
- Implementing practices allowing reuse of N95 respirators when acceptable during encounters with multiple patients

1) **Reuse of N95 respirators**:
   a) Re-use can occur under the following conditions:
      i) N95 respirators must only be used by a single individual and should never be shared
      ii) Use a full face shield that covers entire extent of N95 respirator and/or surgical mask over an N95 to reduce surface contamination of the respirator. For aerosol generating procedures, both a face shield and surgical mask are necessary for re-use.
      iii) Keep used respirator in a clean dry paper bag between uses
      iv) Write your name on the bag and elastic straps of the N95 so that the owner is clearly identified (Do not write on the actual mask)
      v) Use a new paper bag each time the respirator is removed
   b) Always use clean gloves when donning a used N95 respirator and performing a user seal check.
   c) Perform hand hygiene over gloves before touching or adjusting the respirator as necessary

d) Discard gloved after the N95 is donned and any adjustments are made to ensure the respirator is sitting comfortably on your face with a good seal.
e) Perform hand hygiene. Anytime one touches the N95, perform hand hygiene again.

2) Do NOT reuse and DISCARD N95 respirators if:
   a) The N95 respirator becomes visibly soiled with blood, respiratory or nasal secretions, or other bodily fluids
   b) The N95 respirator becomes visibly damaged or difficult to breathe through
   c) The straps are stretched out so they no longer provide enough tension for the respirator to seal to the face
   d) The nosepiece or other fit enhancements are broken
   e) If the inside of the respirator is touched inadvertently
   f) The respirator was used during an aerosol generating procedure, except when the respirator is protected by a surgical mask as described below.

3) **Donning and Doffing of N95 respirator**:
   a) Donning a **NEW** N95 respirator:
      i) Perform hand hygiene
      ii) Remove routine face covering
      iii) Perform hand hygiene
      iv) Don gown
      v) Don gloves
      vi) Don a new, fit-tested N95 respirator and adjust as necessary
      vii) Don a full face shield ensuring it fully covers both eyes and respirator
      viii) Perform patient care activities

   b) Donning a **USED** N95 respirator:
      i) Perform hand hygiene
      ii) Remove routine face covering
      iii) Perform hand hygiene
      iv) Don gloves
      v) Remove the used N95 respirator from the paper bag by the straps
      vi) Don the respirator without touching the front of the mask
      vii) Sanitize gloves and adjust the mask for comfort and to ensure a good face seal
      viii) Remove gloves and perform hand hygiene
      ix) Don gown, new gloves, and full face shield

   c) Doffing an N95 respirator:
      i) When finished with patient care prior to leaving isolation area, remove gown and gloves and discard
      ii) Perform hand hygiene
      iii) Don new gloves
      iv) Leave isolation area
      v) Immediately outside isolation area, remove gloves
      vi) Perform hand hygiene
      vii) Put on new gloves
      viii) Remove face mask by touching only the ear pieces
      ix) Remove respirator touching only the straps

x) Place respirator in a new, clean paper bag labeled with the user's name
xi) Remove gloves
xii) Perform hand hygiene
xiii) Put back on routine use mask

Release of Patients into the Community

1) Patients in medical isolation: For any patient with suspected or confirmed COVID-19 disease in medical isolation who is releasing from a DOC facility, the Health Services Manager, Infection Prevention Nurse and Facility Medical Director will have a conference call with the COVID-19 medical duty officer (**564-999-1845)** prior to release for discussion of release planning.
2) Patients in quarantine: Upon release from DOC custody while on quarantine status, patients will be provided a surgical mask and will be directed to self-quarantine in their place of residence until the remainder of their 14 day quarantine period. Direction should be given that they should immediately report to their CCO via phone to arrange future reporting requirements.

Transportation of Patients with Suspected or Confirmed COVID-19 Disease

1) This section refers to transportation of patients under Washington DOC jurisdiction to or between DOC facilities who are confirmed or suspected (by a licensed medical provider) to have COVID-19 disease. This includes community custody violators, work release/GRE returns, and patients currently housed in DOC facilities.
2) No patient with confirmed COVID-19 disease will be transported into or between DOC facilities without approval of the CMO in consultation with the COVID-19 EOC.
3) For any patients with confirmed or suspected (by a licensed medical provider) COVID-19 disease being transported into or between DOC facilities custody officers, community custody officers, or other DOC staff in close contact with the patient, will don the following personal protective equipment:
    a) A pair of disposable examination gloves
    b) Disposable medical isolation gown
    c) Any NIOSH-approved particulate respirator (i.e., N-95 or higher-level respirator)
    d) Eye protection
    e) If unable to wear a disposable gown or coveralls because it limits access to duty belt and gear, ensure duty belt and gear are disinfected after contact with individual.
4) The transport vehicle will be cleaned and disinfected after use.
5) For any patients on quarantine for contact with a suspected or confirmed COVID-19 case DOC staff will don the following PPE:
    a) A pair of disposable examination gloves
    b) Disposable medical isolation gown
    c) Surgical mask

Contact Tracing and Case Reporting

1) Cases of suspected and confirmed COVID-19 will be thoroughly investigated by the Infection Prevention Nurse (IPN):
   a) Review the patient's cell and living unit location, job, classes, etc. to determine who could have been exposed and needs to be quarantined.
   b) If in the course of the contact tracing it is apparent that DOC staff may have had close contact with the confirmed or suspected COVID-19 case the IPN will send an email with case details to the following Occupational Health email address: DOCoccupationalhealthandwellness@DOC1.WA.GOV
   c) The decision to classify a contact as close or high risk and requiring quarantine will be a clinical decision by the IPN taking into consideration the guidance described here. IPNs should strongly consider consultation with a DOC Infectious Disease physician or local/state public health departments if any uncertainty exists regarding how to classify a contact with a suspected or confirmed COVID-19 case.
   d) A close, or high risk, contact with potential COVID-19 cases will be defined as follows for the purpose of this guideline:
      i) Being within approximately 6 feet of a person with confirmed or suspected COVID-19 for a prolonged period of time, defined as at least several minutes. Examples include caring for or visiting the patient or sitting within 6 feet of the patient in a healthcare waiting room.
      ii) Having unprotected direct contact with infectious secretions or excretions of the patient (e.g., being coughed on, touching used tissues with a bare hand).
   e) Contact not considered close or high risk include briefly entering the patient room without having direct contact with the patient or their secretions/excretions, brief conversation with a patient who was not wearing a facemask.
   f) Mitigating and exacerbating factors should be considered in determination of contact risk. For example a suspected or confirmed COVID-19 case will be more likely to transmit disease if they are actively coughing during the contact, and less likely if they are wearing a facemask.
   g) Report the need to isolate a patient and the need to quarantine other patient/s as indicated to the Health Care Manager or designee who will then notify the Superintendent at the facility, Facility Medical Director, and Headquarters EOC.
   h) Enter the information about the case of suspected/confirmed COVID-19 and the information about the exposed patients on the Influenza like illness log.
   i) The results of contact investigations will be communicated to the Facility Medical Director, HSM, and facility Human Resources who will help ensure that people who have been exposed are identified, notified, and all appropriate infection control measures are put in place to reduce transmission (masking, quarantine, cohorting etc.)

2) All COVID-19 test results for DOC patients should be reported via phone to the COVID medical duty officer (phone **564-999-1845**), FMD, IPN, and facility COVID incident command post immediately upon receipt from the testing lab.
   a) Notification of positive COVID tests should also be sent to the following email address: doccovid19cases@doc1.wa.gov.
   b) The IPN will update the contact investigation and review medical isolation/quarantine status of the tested and exposed patients after receipt of test results.
   c) Occupational Nurse Consultants will, in communication with the IPN, review the case for potential close contacts among DOC staff.

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Guideline Update Log

03/06/2020: Under Heath Services Evaluation, section 3.iii, added subsection 3 to include criteria for isolating patients who are suspected COVID-19 who cannot be tested.

Under Infection control and Prevention section C.5, d. "COVID-19 patients will not be isolated in an IPU, unless they require IPU level of medical care." was deleted.

Under Infection control and Prevention section C.9 added.

Section Transportation of patients with suspected or confirmed COVID-19 disease added.

03/09/2020: Section Contact Tracking and Case Reporting added

Section Health Services Evaluation 3.3.2 changed to reflect updated DOH and CDC testing guidance

03/11/2020: Section Health Services Evaluation part 2 added instruction for donning and doffing PPE.

Section Contact Tracking and Case Reporting added guidance and definitions for determining risk of contact with suspected or confirmed COVID 19 cases.

Section Contact Tracking and Case Reporting changed COVID-19 log to Influenza-like illness log.

03/12/2020: Section Health Services Evaluation part 5 Testing Procedure updated

03/13/2020: Section Testing Procedure information regarding testing through Interpath labs

03/17/2020: Section Screening Intrasystem Intakes changed to require temperature screening at both boarding and exiting the transport bus.

Section Health Services Evaluation 3A (screening question #1) changed from AND to OR

Section Infection Control and Prevention changed to reflect updated PPE requirements for staff evaluating quarantined patients

03/18/2020: Section Infection Control and Prevention changed the duration of medical isolation recommended

Section Testing Procedure, deleted #3 regarding Interpath Labs, as they are no longer performing COVID testing

Section Health Services Evaluation added information regarding when to order COVID testing in the context of influenza test results

03/19/2020: Section Infection Control and Prevention, changed criteria for use of N95 mask when in contact with isolated patients.

03/20/2020: Section Infection Control and Prevention, changed monitoring of isolated patients after they become asymptomatic to once daily at cell front

03/25/2020: Section Patients at High Risk for Severe COVID-19 added

Section Infection Control and Prevention added statement regarding release from quarantine requirements

Section Health Services Evaluation added pharyngitis to screening questions

Section Infection Control and Prevention, added PPE Requirements for Prisons and Work Release Staff

03/27/2020: Section Testing Procedure- deleted reference to need for PUI number and approval prior to sending COVID tests to the Washington DOH public health lab

Section Release of Patients into the Community added direction for patients on quarantine status at the time of release

04/03/2020: Section Testing Procedure added NP swab demonstration video

Section Infection Control and Prevention added eye protection to PPE needed for evaluation of quarantined patients

Section Infection Control and Prevention, PPE for Work Release and Prisons Staff, added criteria for changing PPE for screeners

04/07/2020: Section Clinical Care of Patients with Suspected or Confirmed COVID-19 added

Section Screening added statements about active screening of staff and patients

Section Infection Control and Prevention changed waste disposal from biohazard red bag/bin to regular trash bins.

04/15/2020: All sections changed 'isolation' to 'medical isolation'

Section Clinical Care of Patients with Suspected or Confirmed COVID-19 added recommendation to use metered dose inhalers instead of nebulizers for administration of bronchodilators.

Section Infection Control and Prevention added link to recommended PPE matrix.

Section Release of Patients in the Community changed notification for patients releasing who are on medical isolation

Section Clinical Care of Patients with Suspected or Confirmed COVID-19 changed criteria for starting supplemental oxygen to less than 96% on room air

Section Testing Procedure added back Interpath Laboratory as they have resumed COVID-19 testing

Section Testing Procedure added statement to perform NP swabs of both sides of the nasopharynx

04/21/2020: Section Infection Control and Prevention added statement that Tyvek suites are not appropriate PPE for this purpose and should not be used.

Section Infection Control and Prevention added statement that quarantined patients must don a surgical mask anytime they leave their cells.

Section Infection Control and Prevention added statement regarding all staff wearing approved face coverings while on duty.

Section Patients at High Risk for Severe Covid-19 changed interventions for high risk and very high risk patients

Section Contact Tracing and Case Reporting changed positive COVID test result reporting to include COVID medical duty officer and COVID cases email box.

	Section Health Services Evaluation added diarrhea and loss of taste/smell to screening questions.
	Section Infection Control and Prevention added statement regarding droplet precaution signs in quarantine units
	Section Infection Control and Prevention added subsections h. and i. regarding phone use in medical isolation
4/24/20	Section Infection Control and Prevention subsection PPE requirements for Prisons and Work Release Staff added use instructions and PPE for staff using barriers during active screening
	Section Health Services Evaluation linked PPE video
	Section Testing Procedure added information regarding anterior nasal and nasal mid-turbinate swab sample collection
	Section Health Services Evaluation eliminated influenza testing and added statement regarding testing for influenza during influenza season
5/6/20	Section Testing Procedure added statement that patient collected nasal swabs should be preferred if N95 masks are in short supply and removed preference for NP swabs in all testing situations
	Section Infection Prevention and Control added statement regarding mandatory use of routine face coverings by incarcerated individuals.
	Section Health Services Evaluation added statement that all patients entering isolation will be tested for COVID-19.
	Section Infection Control and Prevention added subsection Post-isolation Convalescent Housing
	Section Infection Control and Prevention added two negative tests at least 48 hours apart as new criteria for release from isolation and associated quarantine
	Section Infection Control and Prevention added subsection Routine Pre-procedure COVID-19 Testing
	Section Patients at High Risk for COVID-19 Disease deleted ‘very high risk’ section
	Section Infection Control and Prevention added subsection Asymptomatic Patients Testing Positive for COVID-19
	Section Infection Control and Prevention added subsection Showers in Medical Isolation
	Section Infection Control and Prevention added subsection Routine Intake Separation
	Section Infection Control and Prevention added subsection Protective Isolation Prior to Work Release Transfer
5/15/20	Section Infection Control and Prevention added information for each care situation regarding when to change PPE
	Section Infection Control and Prevention added subsection Protective Separation
	Section Reuse of N95 Respirators added
	Section Health Services Evaluation changed testing criteria for viral respiratory panel

Section Infection Control and Prevention subsections Routine Intake Separation and Separation Prior to Work Release Transfer were combined into Intersystem Transfer Separation and the period of pre-work release separation was changed to 14 days

Appendix VIII

COVID-19 Data

Confirmed Cases

Current as of Wednesday, July 1, 2020. Numbers are updated Monday-Friday, except for holidays.

Incarcerated Population COVID-19 Confirmed Cases

A confirmed case is counted at the facility/location where the case was confirmed. After confirmation, an individual may be transported to another correctional facility/location to receive appropriate level of care.

Location	Number Confirmed Cases	Number of Deaths
Prisons		
Airway Heights Corrections Center	0	0
Cedar Creek Corrections Center	0	0
Clallam Bay Corrections Center	0	0
Coyote Ridge Corrections Center	180	2
Larch Corrections Center	0	0
Mission Creek Corrections Center for Women	0	0
Monroe Correctional Complex	19	0
Olympic Corrections Center	0	0
Stafford Creek Corrections Center	0	0
Washington Corrections Center	1	0
Washington Corrections Center for Women	0	0
Washington State Penitentiary	2	0
Work Release		
Ahtanum View Work Release	0	0
Bellingham Work Release	0	0
Bishop Lewis Work Release	0	0
Brownstone Work Release	0	0

Location	Number Confirmed Cases	Number of Deaths
Eleanor Chase House Work Release	0	0
Helen B. Ratcliff Work Release	0	0
Longview Work Release	0	0
Olympia Work Release	0	0
Peninsula Work Release	0	0
Progress House Work Release	0	0
Reynolds Work Release	7	0
Tri-Cities Work Release	1	0
Other		
Community Medical Center	1	0
Totals		
All Locations	211	2

Staff COVID-19 Confirmed Cases

Staff includes department employees and contracted staff. All staff confirmed cases are self-reported.

Location	Number Confirmed Cases	Number of Deaths
Business & Training Offices		
Olympia Area Offices	2	0
Mill Creek Regional Performance Center	8	0
Prisons		
Airway Heights Corrections Center	2	0
Cedar Creek Corrections Center	0	0
Clallam Bay Corrections Center	1	0
Coyote Ridge Corrections Center	50	0
Larch Corrections Center	0	0
Mission Creek Corrections Center for Women	0	0
Monroe Correctional Complex	11	1
Olympic Corrections Center	0	0

Location	Number Confirmed Cases	Number of Deaths
Stafford Creek Corrections Center	0	0
Washington Corrections Center	2	0
Washington Corrections Center for Women	0	0
Washington State Penitentiary	2	0
Work Release		
Ahtanum View Work Release	2	0
Bellingham Work Release	0	0
Bishop Lewis Work Release	0	0
Brownstone Work Release	0	0
Eleanor Chase House Work Release	0	0
Helen B. Ratcliff Work Release	0	0
Longview Work Release	0	0
Olympia Work Release	0	0
Peninsula Work Release	2	0
Progress House Work Release	0	0
Reynolds Work Release	2	0
Tri-Cities Work Release	0	0
Community Corrections (See Community Facilities Map for section designations)		
Community Corrections Section 1	1	0
Community Corrections Section 2	3	0
Community Corrections Section 3	0	0
Community Corrections Section 4	0	0
Community Corrections Section 5	0	0
Community Corrections Section 6	6	0
Community Corrections Section 7	0	0
Other		
Community Medical Center	0	0
Totals		
All Locations	94	1

Demographics

The below tables represent the demographic information for confirmed cases of COVID-19 in the incarcerated population. See the Agency Fact Card for more information about the demographics of the total incarcerated population. Other statistical reports are available at Data Analytics page.

Current as of Friday, June 26, 2020. Numbers are updated on the last business day of the week.

Age of Confirmed COVID-19 Cases in the Incarcerated Population

Age Range	Number of Individuals	Percentage of Confirmed Cases	Percentage of Total Incarcerated in Age Range
Under 22	2	1.4%	2.8%
22-25	6	4.1%	7.4%
26-30	17	11.6%	15.3%
31-35	15	10.3%	17.7%
36-40	20	13.7%	16.2%
41-45	19	13%	11.4%
46-50	16	11.0%	9.2%
51-55	14	9.6%	7.6%
56-60	13	8.9%	5.6%
61-65	11	7.5%	3.5%
66-70	5	3.4%	1.7%
Over 70	8	5.5%	1.6%

Race of Confirmed COVID-19 Cases in the Incarcerated Population

Race	Number of Individuals	Percentage of Confirmed Cases	Percentage of Total Incarcerated by Race
White	95	65.1%	69.6%

Race	Number of Individuals	Percentage of Confirmed Cases	Percentage of Total Incarcerated by Race
Black	27	18.5%	17.6%
American Indian/Alaska Native	10	6.9%	5.9%
Asian/Pacific Islander	9	6.2%	4.3%
Other	3	2.1%	1.6%
Unknown	2	1.4%	1.0%

Ethnicity of Confirmed COVID-19 Cases in the Incarcerated Population

Hispanic Origin	Number of Individuals	Percentage of Confirmed Cases	Percentage of Total Incarcerated by Hispanic Origin
No	120	82.8%	85.5%
Yes	25	17.2%	14.5%

Regional Care Facilities

The Washington Department of Corrections (DOC) is taking deliberate steps to continue to mitigate the spread of infection to the incarcerated population, staff and general public.

Suitable locations, referred to as a Regional Care Facility (RCF), were previously identified by department leaders and key stakeholders, including local facility subject matter experts. These RCF's would safely and comfortably house incarcerated individuals who have tested positive for COVID-19 and may require more comprehensive medical attention and physical isolation from healthy populations, but do not require hospitalization. Should an infected individual's medical conditions or needs become severe, the department and agency medical personnel will work collaboratively with hospital partners to provide the necessary medical care.

(Current as of Wednesday, July 1, 2020. Numbers are updated Monday-Friday, except for holidays)

Incarcerated individuals from the Confirmed Cases chart are transported, when necessary, to one of the regional care facilities listed below.

Regional Care Facility	Incarcerated Individuals Housed
Airway Heights Corrections Center	10
Washington Corrections Center (Shelton)	0
Monroe Correctional Complex	0

Testing, Isolation & Quarantine

Current as of Wednesday, July 1, 2020. Numbers are updated Monday-Friday, except for holidays.

Testing Among Incarcerated Housed in Prison & Work Release Facilities

Screening and testing is conducted based on the guidance of the WA State DOC COVID-19 Screening, Testing, and Infection Control Guideline

Number of Tests Completed	Number of Negative Results	Number of Positive Results	Number of Pending Lab Results
2,554	2,197	211	146

Isolation and Quarantine Among Incarcerated Population

Isolation: separating a symptomatic patient with a concern for a communicable disease from other patients.

Quarantine: separating from other individuals those who are not showing symptoms yet have been exposed to an individual with a contagious disease.

Federal quarantine and isolation currently apply to the following diseases: cholera; diphtheria; infectious tuberculosis; plague; smallpox; yellow fever; viral hemorrhagic fevers; influenza caused by new or re-emergent flu viruses that are causing, or have the potential to cause, a pandemic; and severe acute respiratory syndromes (which may include COVID-19).

Number of Incarcerated Individuals in Isolation	Number of Incarcerated Individuals in Quarantine
227	1,825

Appendix IX

PRESS RELEASE: First Incarcerated Individual in Washington Dies of COVID-19

Released June 18, 2020

Contact Janelle Guthrie, (360) 764-9791
Department of Corrections

TUMWATER – On Wednesday, June 17, 2020, an incarcerated patient of the Washington state correctional system passed away due to COVID-19. Victor Bueno, 63, had been transported to a local medical center on May 31, 2020 for treatment of COVID-19 where he remained until the time of his passing.

Mr. Bueno was most recently admitted to the state's correctional system on Sept. 28, 2017 for a protection order violation out of Kitsap County. His estimated release date had been Sept. 19, 2020. Mr. Bueno had been housed in long-term minimum custody at the Medium Security Complex of Coyote Ridge Corrections Center (CRCC) in Connell, Wash.

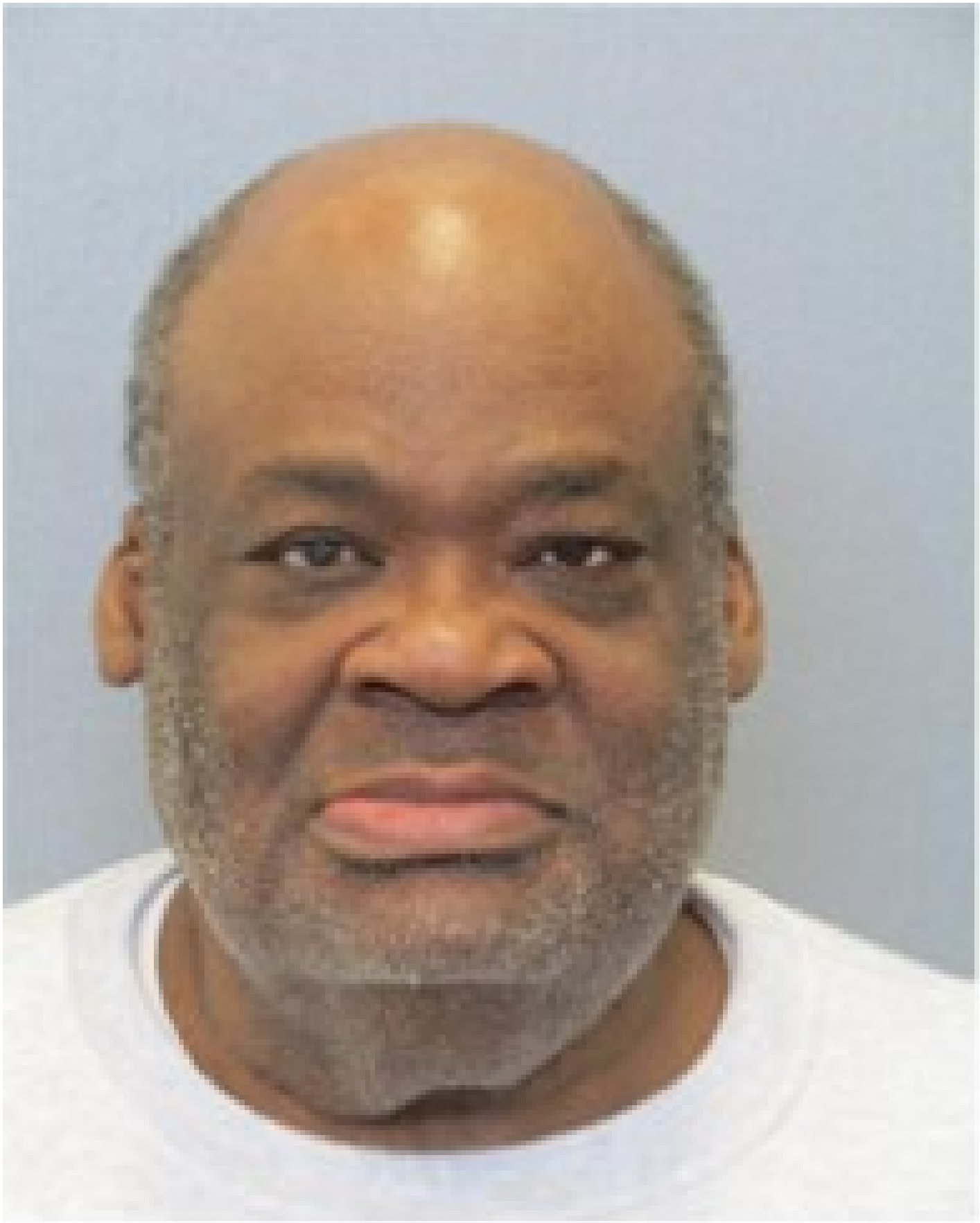
"The Department of Corrections is saddened by this loss," said Corrections Secretary Stephen Sinclair. "The health and safety of the incarcerated individuals, the community and our staff remains our top priority."

On June 11, 2020, the CRCC Medium Security Complex was placed on restricted movement to further contain the spread of COVID-19 across the incarcerated population and staff. On June 17, 2020, the facility announced plans to test all staff within the facility and incarcerated individuals housed at the Medium Security Complex.

Corrections is working with the Washington Department of Health to develop the plan and more information on the process for testing will be available in the coming days.

The facility currently has:

- 38 confirmed cases of COVID-19 among staff, including four in Correctional Worker Core training, and 91 confirmed cases among its incarcerated population, as of June 18, 2020;
- 17 individuals in isolation, meaning the individuals have symptoms and are separated from healthy people, as of June 17, 2020; and,
- 1,784 individuals in quarantine as of June 17, 2020, meaning they were exposed but do not have symptoms and are separated from healthy people.



Victor Bueno, 63

PRESS RELEASE: Second Incarcerated Individual in Washington Dies of COVID-19

Released June 24, 2020

Contact Janelle Guthrie, (360) 764-9791
Department of Corrections

CONNELL – At approximately 7 p.m., on Monday, June 22, 2020, incarcerated individual William Bryant, 72, passed away at a local medical facility due to COVID-19. He was transported from the long-term minimum custody unit in the Medium Security Complex (MSC) at the Coyote Ridge Corrections Center (CRCC) in Connell, Wash. for outside medical treatment on June 13, 2020, where he remained until the time of his passing.

"The Department of Corrections is sad to announce its second COVID-19 related death," said Corrections Secretary Stephen Sinclair. "We've continued to escalate our response at Coyote Ridge to help prevent the spread of this virus and protect the staff as well as the remaining individuals housed there."

Mr. Bryant was serving a 68-month sentence for first-degree child molestation out of Grays Harbor County. His earliest release date was April 14, 2022.

Coyote Ridge began COVID-19 testing of employees at the MSC and Minimum Security Unit (MSU), as well as the incarcerated population at the MSC today, Wednesday, June 24, 2020. Coyote Ridge is working in partnership with the Benton-Franklin Health District, Washington State Department of Health and the Washington National Guard to conduct the testing. Department of Health and National Guard employees are providing assistance with the testing of the Coyote Ridge employees and incarcerated individuals, similar to the testing efforts in surrounding communities.

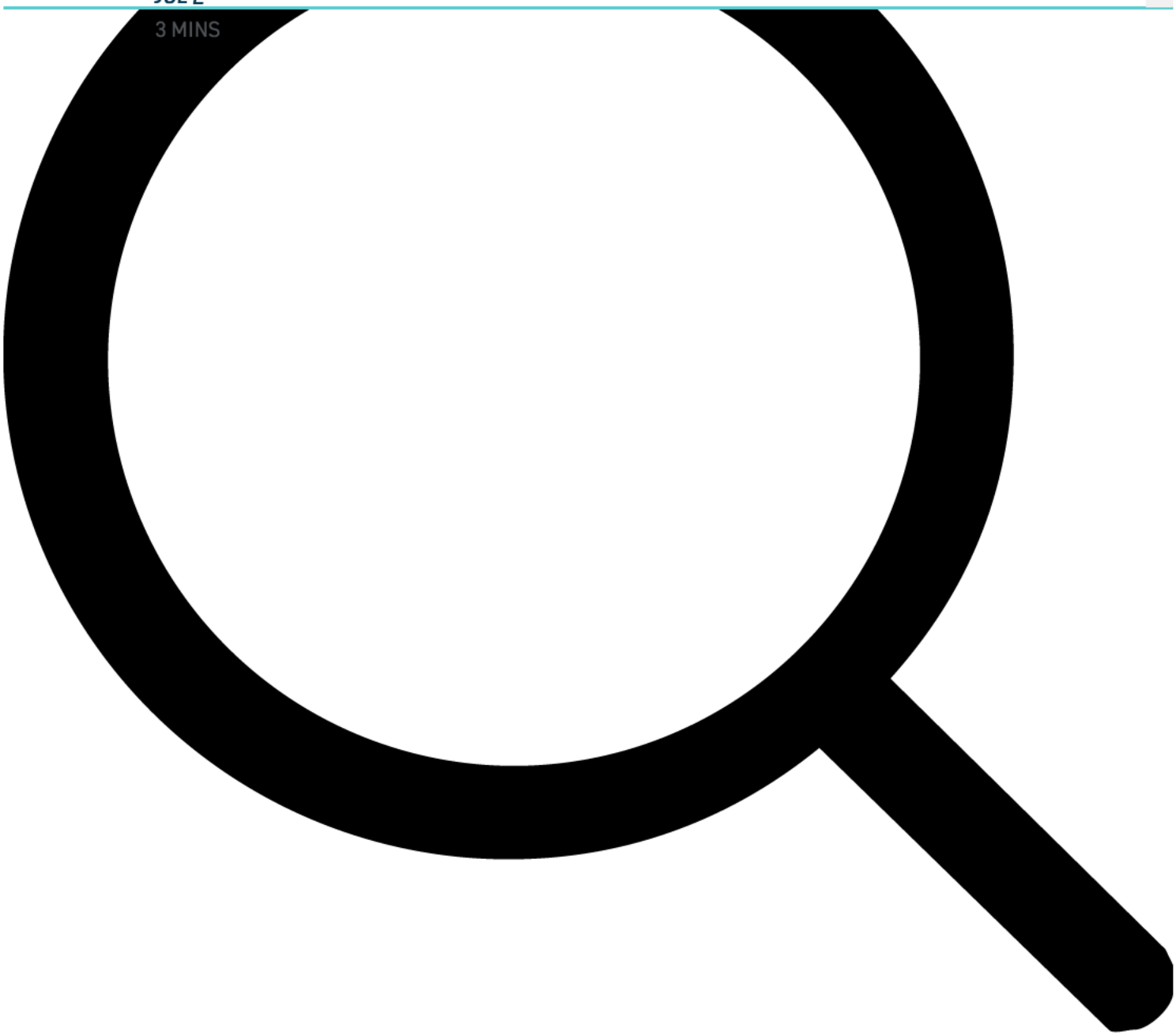
The facility currently has:

- 43 confirmed cases of COVID-19 among staff, including 4 in Correctional Worker Core training, and 110 confirmed cases among its incarcerated population as of June 24, 2020;
- 23 individuals in isolation, meaning the individuals have symptoms and are separated from healthy people, as of June 23, 2020; and
- 1,852 individuals on quarantine as of June 23, 2020, meaning they were exposed but do not have symptoms and are separated from healthy people.

Corrections has added a column on its web site to document COVID-related deaths and will post future deaths at that location.

William Bryant, 72

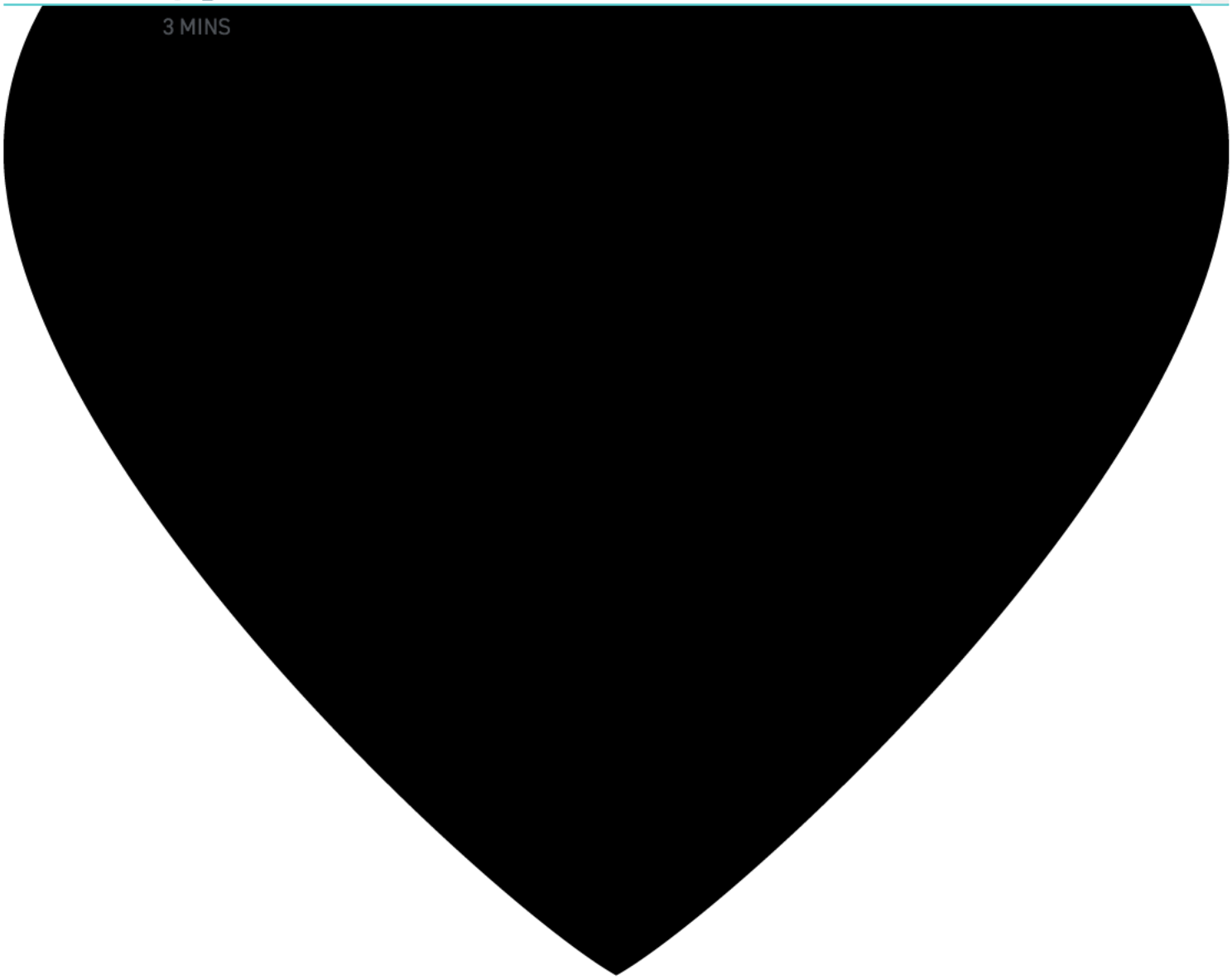
Appendix X



LATEST NEWSCAST: THURSDAY, JUL 2
3 MINS

Updated: 09:00 AM PT

PRINT SCHEDULE



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Another inmate dead, National Guard deployed for mass testing at this Washington prison

BY  Ashley Hiruko

Debbie Stricker cries herself to sleep every night, worried about her son, an inmate at the Coyote Ridge Corrections Center. Over the last two weeks, Sticker's son has sent her messages that detail declining conditions at the prison, as inmates have been confined to their cells for more than 23 hours per day, to prevent the spread of coronavirus.

"They just now came around to give diabetics their insulin shots. That should happen around 7:30 a.m. but they don't have any food to go with it," her son said in an electronic message on June 13.

"When my cellie [a diabetic] asked where his food was after taking his shot, he was told 'I don't know,' and had the door slammed in his face."

"What they are doing here is a violation of the Eighth Amendment. If they can't take care of us

The outbreak is concentrated within the Medium Security Complex portion of the prison, which houses more than 1,800 inmates. The total prison population is typically more than 2,400.

As of June 23, a total of 41 staff and 100 inmates have tested positive for the virus. That's more than four times the number of cases confirmed at the Monroe Correctional Complex, which previously had the worst outbreak.

The first Covid-19 death connected to the state's prisons was that of Berisford Anthony Morse, a correctional officer who worked at the Monroe Correctional Complex. He died on May 17, due to complications related to Covid-19.

To date, two incarcerated people have died of Covid-19 in Washington state. Both of them were housed at Coyote Ridge in Eastern Washington, the Washington State Department of Corrections reported on June 24.

Victor Bueno, 63, was the first inmate to die of Covid-19 in Washington state. Bueno was sent to Coyote Ridge after violating a protection order in Kitsap County, when he wrote a letter to his ex-wife. He denied he wrote this letter in a petition to the Washington State Court of Appeals. They declined to overturn his conviction.

Bueno was housed in the Medium Security Complex and was scheduled to be released in September. He died on June 17.

“The Department of Corrections is saddened by this loss,” said Corrections Secretary Stephen Sinclair, in a prepared statement. “The health and safety of the incarcerated individuals, the community and our staff remains our top priority.”

That same day, prison officials said they would increase coronavirus testing to include all Coyote Ridge staff and inmates that live within the Medium Security Complex. Five days later, there was a second Coyote Ridge inmate death.

On June 22, William Bryant, 72, died at a local medical facility after contracting Covid-19. Bryant was serving a 68-month sentence for first-degree child molestation out of Grays Harbor County. He was transported from Coyote Ridge for outside medical treatment on June 13, where he remained until he

collect nasal specimens from the more than 1,800 inmates within the Medium Security Complex, according to the same letter from from Superintendent Uttecht.

Test results will take three to five days and staff and inmates will be notified of their results. Depending on these results, inmates may be moved to a different area within Coyote Ridge, Uttecht wrote.

Covid-positive inmates would be housed together, and those who test negative will be retested. Inmates who test negative a second time will be housed together. Inmates who refuse testing will be placed in a separate isolation area.

Before this plan, Coyote Ridge would only test inmates who were showing symptoms of coronavirus. At least one inmate who submitted a written request to be tested, after being exposed to someone who tested positive, was denied testing. The inmate did not show any symptoms.

For more than a month, the Office for the Corrections Ombuds recommended universal testing for all inmates and staff at all Washington state prisons. In the very least, the office pushed for targeted testing for vulnerable inmates who have had close contact with a positive person -- especially at a facility like Coyote Ridge, with a known outbreak.

Instead, Coyote Ridge officials opted to place inmates in the Medium Security Complex on restricted movement on June 11. That has kept inmates confined to their cells, some of which had no toilets or running water, for more than 23 hours a day.

"Restricted movement provides an additional level of protection against the spread of the virus by reducing the number of incarcerated individuals out of their cells at any given time and increasing the ability to practice social distancing," said a Department of Corrections spokesperson, by email.

At first, inmates would only be allowed outside their cell for 20 minutes every other day, according to a report by the Office of the Corrections Ombuds. This was later increased to 30 minutes per day.

Inmates in cells without toilets resorted to peeing in bottles because they were not let out to use the restroom in time. Karlina Tasker, who lives in New Mexico, told KUOW last week that her husband, who is incarcerated at Coyote Ridge, waited two and a half hours to use the bathroom.

“I had to pee in a bottle ... I couldn’t hold it anymore,” Tasker's husband said in an electronic note to her.

State Supreme Court to consider new evidence, in a lawsuit against Gov. Jay Inslee and Stephen Sinclair, secretary for the state's Department of Corrections.

Governor Jay Inslee's office did not immediately respond to requests for comment on the new motion. A spokesperson with the Office of the Governor said the motion was "under review by legal."

The lawsuit, originally filed in late March, was an attempt to protect inmates from exposure to Covid-19, and asked for the release of thousands of vulnerable inmates. In late April, the State Supreme Court denied the inmates' petition.

The justices wrote that the petitioners failed to show how state officials were failing to perform "a mandatory, non-discretionary duty in addressing the Covid-19 risk at the Department of Corrections facilities, nor shown other constitutional or statutory grounds for the relief they request."

Inslee and Sinclair, following the lawsuit, released an emergency plan that allowed more than 1,000 nonviolent offenders to either serve the remainder of their sentences at home with ankle monitors, be released on work furlough, or be granted commuted sentences.

"It can be difficult to maintain proper physical distancing in our correctional institutions, and because of that, it makes sense to release certain individuals who may be at particularly high-risk during this outbreak," Inslee said in April.

But inmates and their loved ones argued that this move, which was a reduction of about 6% of the state's incarcerated population, wasn't enough to protect the thousands of inmates who remained in prison from Covid-19.

At the time that the Supreme Court denied the inmates' petition, there were 12 coronavirus cases within state prisons and work release facilities — but no cases yet at Coyote Ridge. Since then, the number of confirmed cases at Coyote Ridge has ballooned to nearly 150 inmate and staff cases combined.

The new motion argues that given the increase in cases, deaths, the expanded ability to test people, and an increase in the Department of Corrections' positive test rate to 19.2%— three times higher than the positive test rate of the Washington state general population — the courts should reevaluate its decision, said Nick Allen, Deputy Director of Advocacy at Columbia Legal Services.

Noor "witnessed unimaginable atrocities as a Somali civil war refugee" and described the current conditions at Coyote Ridge as "horrendous."

And because inmates are confined to their cells at Coyote Ridge, Noor once had to wait almost three hours before a staff member gave him permission to use the bathroom, Columbia Legal Services wrote.

"On other occasions, he has had to urinate in a small coffee bottle because of the long wait times to use the bathroom. As a result, [he] sometimes has soiled himself," the motion document reads. His cellmates, which include a man sick with cancer, have also soiled and defecated on themselves.

"When Mr. Noor soils himself, it impacts his ability to practice his religion. He is a devout Muslim and by obligation, must pray five times each day. As a Muslim, before presenting himself to God during his prayer ritual, he must be clean and wear good clothes ... This practice is impossible if he has soiled his clothes and lacks access to fresh water," the court document continues.

Allen said the measures taken by the Department of Corrections, to slow the spread of coronavirus, have been ineffective.

"I think the only thing accomplished through these measures is a deterioration in conditions, an increase of humiliation of people in prisons, and the DOC resorting to what we would categorize as an inhumane response to the virus," Allen said.

LATEST NEWSCAST: THURSDAY, JUL 2 Updated: 09:00 AM PT PRINT SCHEDULE

07 Stand with the Facts: How bots and trolls leverage a crisis
3 MINS

JUL 21 1:00 PM
Stand with the Facts: Community Solutions to Combat Misinformation

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Appendix XI

CN: 201601025138

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FILED

AUG 01 2018

Timothy W. Fitzgerald
SPOKANE COUNTY CLERK

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF SPOKANE

STATE OF WASHINGTON	)	CASE NO: [redacted]
	)	PA #:
Plaintiff,	)	RPT #:
	)	**CHARGES:**
V.	)	Count 1: 9A.60.020(1)(B) -
	)	FORGERY(POSSESS/UTTER/OFFER)
[redacted]	)	☒ **AMENDED**
	)	**RELEASE CONDITIONS PENDING TRIAL**
	)	**(CrR 3.2) (ADULT) (ORECRP)**
Defendant.	)	☐ **DEFENDANT TO BE BOOKED ON FTC WARRANT**

PROBABLE CAUSE:
☒ Probable cause has previously been determined.
☐ The court finds probable cause exists to believe the accused committed the offense(s) charged. CrR 3.2.1(e)(2).
☐ The court does not find probable cause exists for the offense(s) charged, but does find probable cause exists to believe the accused committed the offense of _____. CrR 3.2.1(e)(2).
☐ The court does not find probable cause to believe the accused committed any offense and the accused is ordered released without conditions. CrR 3.2.
☐ Probable cause statement not received from law enforcement and the accused is ordered released without conditions. CrR 3.2.
☐ Other: _____.

CUSTODY:
☒ 1. Defendant shall be in the custody of Spokane County Jail.
☒ Housing at Geiger is authorized if eligible and approved.
☒ Work Crew/Work Release authorized if eligible and approved.

☐ 2. Defendant shall be released on his/her own recognizance.

☒ 3. Defendant shall post a surety or cash bond in the sum of $2,500.00. ☐ Reserved ☒ Argued

☐ 4. No Bond shall be accepted. ☐ Reserved ☐ Argued

If released: Defendant shall remain: [redacted] Phone number: [redacted]

Further, defendant shall:
☒ Appear at all court dates;
☒ Remain in Spokane County and/or Yakima;
☐ No use or possession of non-prescribed controlled substances, legend drugs, or drug paraphernalia;
☒ Regularly contact her/his attorney;

ORIGINAL

SPOKANE COUNTY PROSECUTING ATTORNEY
COUNTY CITY PUBLIC SAFETY BUILDING
SPOKANE, WA 99260 (509) 477-3662

☐ The current offense and a prior qualified offense involve alcohol
  ☐ Defendant MUST install Ignition Interlock Device on ALL vehicles operated by him/her AND PROOF of installation must be filed within 5 days of the date of release
    ☐ with the Superior Court
  ☐ Defendant must comply with a 24/7 Sobriety Program Monitoring – if/when available
☒ Commit no criminal law violations; ☐ No contact with minors under the age of 18;
☐ No operating a motor vehicle without a valid driver's license and proof of insurance;
☒ Obey any and all court orders in effect and, if under supervision, obey all conditions of supervision;
☒ Other: Not use or possess any access device, credit/debit card, check, or identification not legally issued in his or her name, and financial or personal information not belonging to him/her .

THE COURT FINDS THAT THERE EXISTS a substantial danger that the defendant will commit a serious crime or that the defendant's physical condition is such to jeopardize his/her safety or that of others or that he/she will seek to intimidate witnesses, or otherwise unlawfully interfere with the administration of justice and, therefore:

☒ 1. Defendant shall not approach or communicate with (named victim) [redacted]
  ☒ or any others residing at the same residence
  ☒ or any immediate member of his/her family
  ☒ or any witness of the State, as listed in the police reports or witness lists

☒ 2. Defendant shall not go to the following (area) (premises) Any Moneytree
  ☐ the block of in Spokane County
  ☒ or any known location of any individual listed in number 1 of this order (e.g. school, work, residence, etc.)

☐ 3. Defendant shall not
  ☐ a. possess any dangerous weapons. ☐ b. engage in the activity of _____
  ☐ c. engage in the activity of sexual contact with minors under the age of 18
  ☐ d. use, possess or consume (intoxicating liquor) and/or (use or in possession of marijuana and/or products containing Tetrahydrocannabionnol (THC)) and/or (the following drugs _____)
  ☐ e. possess any pornographic material

☐ 4. Defendant shall report regularly and remain under the supervision of ☐ NEWTA or other Court approved facility. Defendant shall report within 24 hours of the entry of this order or release from custody.
  ☐ Reserved
  ☐ Other: _____

☐ 5. Defendant shall be detained until his/her physical condition permits his/her release.

☐ 6. Defendant is referred for assessment by Geiger/NEWTA.

☐ 7. Other: _____

DONE IN OPEN COURT this 1st day of August, 2018, in the presence of the defendant.

JUDGE JAMES M. TRIPLET

JUDGE

NOTICE TO DEFENDANT: Your attorney is required to advise the Court if you do not maintain

SPOKANE COUNTY PROSECUTING ATTORNEY
COUNTY CITY PUBLIC SAFETY BUILDING
SPOKANE, WA 99260 (509) 477-3662

regular contact with your lawyer. If you do not maintain regular contact with your lawyer, the Court may issue a bench warrant for your apprehension and incarceration in the Spokane County Jail. Failure to abide by any court ordered release condition is considered a violation and will be reported to the Court. A violation could result in a modification of release conditions, revocation of release, or the issuance of a bench warrant.

☐ **IF NO CHARGES ARE FILED BY AT , THE DEFENDANT SHALL BE RELEASED ON THIS CAUSE AND BOND SHALL BE EXONERATED.**

Presented by: Approved:

MARGARET J MACRAE for RICHARD REESE STERETT	ANDREW R. NONNENMACHER	[redacted]
Deputy Prosecuting Attorney	Attorney for Defendant	
WSBA # 50783	WSBA# 52571	

SPOKANE COUNTY PROSECUTING ATTORNEY
COUNTY CITY PUBLIC SAFETY BUILDING
SPOKANE, WA 99260 (509) 477-3662

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION THREE

STATE OF WASHINGTON,	)	
	)	
RESPONDENT,	)	
	)	
v.	)	NO. [redacted]
	)	
[redacted]	)	
	)	
APPELLANT.	)	

DECLARATION OF DOCUMENT FILING AND SERVICE

I, MARIA ARRANZA RILEY, STATE THAT ON THE 2ND DAY OF JULY, 2020, I CAUSED THE ORIGINAL **RENEWED MOTION TO STAY SENTENCE** TO BE FILED IN THE **COURT OF APPEALS – DIVISION THREE** AND A TRUE COPY OF THE SAME TO BE SERVED ON THE FOLLOWING IN THE MANNER INDICATED BELOW:

[X]	LARRY STEINMETZ, DPA [SCPAappeals@spokanecounty.org] [lsteinmetz@spokanecounty.org] SPOKANE COUNTY PROSECUTOR'S OFFICE 1100 W. MALLON AVENUE SPOKANE, WA 99260	( ) ( ) (X)	U.S. MAIL HAND DELIVERY E-SERVICE VIA PORTAL
[X]	[redacted] COYOTE RIDGE CORRECTIONS CENTER PO BOX 769 CONNELL, WA 99326-0769	(X) ( ) ( )	U.S. MAIL HAND DELIVERY _____

SIGNED IN SEATTLE, WASHINGTON THIS 2ND DAY OF JULY, 2020.

X_____

Washington Appellate Project
1511 Third Avenue, Suite 610
Seattle, Washington 98101
Phone (206) 587-2711
Fax (206) 587-2710

WASHINGTON APPELLATE PROJECT

July 02, 2020 - 4:16 PM

Transmittal Information

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Appellate Court Case Number:	[redacted]
Appellate Court Case Title:	State of Washington v. [redacted]
Superior Court Case Number:	[redacted]

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- greg@washapp.org
- lsteinmetz@spokanecounty.org
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