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On Thursday, February 16th, 2023, the Hawaii Correctional System Oversight Commission (the Commission, HCSOC) toured the Oahu Community Correctional Center (OCCC) collectively as a group. The tour included four of the five Commissioners – Mark Patterson (Chair), Martha Torney, Ted Sakai, and Ron Ibarra in addition to the Oversight Coordinator, Christin Johnson.

After touring OCCC, the Commissioners chose to have an additional public meeting outside of the normal monthly public meetings to address serious conditions found within the facility. This report encompasses notes from the Commissioners and will be discussed at a public meeting held on March 7th, 2023, at 2pm via Zoom.

FEBRUARY OCCC SITE TOUR OBSERVATIONS

Module 5 (Intake)

Module 5, Intake, was not crowded at the time the Commission visited as transports were completed earlier for the day. The most crowded times are on Mondays or after three-day weekends when defendants who are held in police cell blocks are brought in after their court bail hearings—as many as 50-60 at one time. The male side of the intake gets very crowded on those days. The female side of intake is separate from male side. Commissioners noted that filing appeared to be up to date (not a lot of loose documents were apparent) and a single Adult Corrections Officer (ACO) was entering data into the Department's database, OffenderTrak.

Commissioners were shown the interior of a van used to transport inmates to and from the facility. The van had a place for at least one separatee away from others being transported to prevent possible harm by others or collusion between defendants.

During the visit, neither of the sally port gates outside Module 5 were closed. There simply were too many vehicles parked within the sally port. It is important to note that escapes have occurred when sally port gates were not properly secured – one was from OCCC and one was from the First Circuit Court. Moreover, the Commission observed an even more egregious security violation: **inmates were disembarking from a van when the sally port gates were not secured**. This should never occur. *Please see Recommendation 1.*

Covid-19 Medical Isolation Unit

The Covid-19 Medical Isolation Unit is located in shipping containers outside of Module 5. Newly admitted inmates (male and female) are tested upon admission — if positive, they are moved to the shipping containers. If they are negative, they will be placed in New Admission housing. Any person testing positive post-admission are transferred to shipping containers. If two are placed in one cell, the bed frame is removed and both inmates sleep on mattresses on the floor.

On the day of the visit, two of the nine cells housed inmates. Each cell appeared to have enough space to house up to two inmates. Each cell was equipped with a bunk, had a toilet/sink combo and was air-conditioned. There was one shower outside of the cells. Inmates would have to be escorted to the shower by staff. There was no readily accessible space in the immediate vicinity in which the inmates could exercise. There was no shading provided above the top of the container which has contributed to hot conditions, even with functioning air conditioning.

There are three serious deficiencies that can cause significant risk to the health and safety of inmates who may be placed in these cells:

1) There is no communication system (e.g. intercom) within the cells. An inmate can communicate with staff only by calling out through the metal doors.
2) Because each door is individually keyed, an officer would have to go to each door to unlock it during an emergency.
3) On the day of the visit, there was no staff stationed in the immediate vicinity. Moreover, the key to the cell doors was held INSIDE the facility, in Module 5.

The Department places itself at considerable risk by not posting an ACO in the immediate vicinity whenever any of the cells is occupied. *Please see Recommendation 2.*

Module 19 (New Admissions)

Module 19 houses newly admitted males for assessment and placement determinations. Inmates who have tested negative for COVID-19 upon admission are quarantined in cells with others for at least five days, then retested before being permanently housed. When a new inmate is put in a cell, those already housed there will have their number of days extended to accommodate the new admission's five-day quarantine.

There are 36 cells in Module 19 with an operating capacity of 72, but the unit has held up to 120 inmates which implies all cells would house not less than three inmates, while the (slightly larger) corner cells hold up to five inmates. The cells are designed for one occupant and can hold two occupants under certain conditions.

There is only one bunk bed in each cell leaving the other inmates sleeping on the concrete floor next to the toilet and under a bunk. In the corner units, three inmates slept on mattresses on the floor. The inmates reported that they had very little out of cell time. They even ate meals in their cells, creating the potential for sanitation issues.

Five of the 36 cells were in need of repair and could not be occupied which forced serious crowding in the remaining cells. At least two of the corner cells had five inmates living in them whereas other cells had four. When asked how they decide who gets to sleep on a bunk versus the floor, one inmate replied, "the biggest." *Please see Recommendation 9 and Recommendation 10.*

Medical Unit/Infirmary

The inadequacy of the medical unit has been discussed previously during Commission meetings. Two things seem especially serious and need to be handled as emergencies, and assistance sought from outside the Department:

1) The infirmary is seriously overcrowded, with inmate-patients sleeping in beds in the common space. The nurse reported that at times inmate-patients have to sleep on mattresses on the floor.
2) The lack of electronic health records is a source of serious strain from an already over-burdened staff.

The Medical Unit was very crowded and very small with little space for staff to work. There was a lack of ability to separate patients from one another and *complete lack of privacy* for medical practitioners who interview and examine inmates. Other clerical staff members are able to hear what should be confidential medical communication. The staff pointed out that an enclosed area is needed and that they have made the request for an enclosed area several times. Additionally, the bed space is inadequate as the maximum bed capacity is 5-6 beds. Because the beds are squeezed in the space, the privacy curtains around each bed cannot be used. This infirmary is in a 1,000+ inmate population jail.

The Electronic Medical Records (EMR) system has been down since June 2022, forcing staff to rely 100% on paper records (manually creating and updating medical records). The records area was cram packed with documents, including records for current inmates and those discharged. The Records Clerk is making an effort to scan records that should be archived, but it appears to be a near impossible job. This contributed to a space problem not to mention the inefficiency of such a system. There were files in boxes and on carts.

The infirmary bathrooms are not ADA compliant. ADA patients are housed in Module 2. *Please see Recommendation 3.*

Module 1 (Male Unit for Mental Health/Suicide Watch)
Module 1, a male unit, is for those in need of mental health evaluations and services, and who are on suicide watch. Even those on suicide watch are placed in small cells with one or two others. An ACO is stationed directly across from a bank of suicide cells to provide the regular checks required by policy. In one suicide cell there were only two mattresses but three inmates. The inmate without a mattress informed the Commission that he did not want one.

Suicide Watch cells appear to be extremely punitive. The cells have one large rectangular slab of concrete in the center of the cell to be used as a bed. The cells are full of graffiti and lack any type of therapeutic design for those in a crisis state. *Please see Recommendation 4.*

Module 3 (Female Unit)
Module 3 houses females. Most, if not all, cells had very limited natural light as the windows were covered externally with wood to prevent communication between the women and men who use an outside recreation yard adjacent to Module 3.

Additionally, several areas needed maintenance. A shower in the female quarantine module was not in operation because the light was out. The Commissioners were told this problem was there for a while. There were leaking showers which were inoperable. Commissioners noticed water leakages, inoperable toilets, and graffiti in cells. *Please see Recommendation 5 and Recommendation 9.*

Module 11 (Male Unit)
Module 11, a male unit, had serious water damage in the shower area rendering one of the four showers unusable. The Commissioners were unable to determine the extent of mold damage, but the problem appeared to be in the wall versus the plumbing chase, making access for repairs very difficult. Windows were covered with wood, allowing only minimal (if any) natural daylight into cells. *Please see Recommendation 5 and Recommendation 9.*

Holding Unit
The Holding Unit, built in 1936, did not appear to be overcrowded (Commissioners only observed the first of the three floors). Assigned inmates are allowed one hour of outdoor recreation which takes place in cages about as small as the cells, not allowing for meaningful large muscle movement.

Four inmates requiring protective custody (PC) were held in the Holding Unit, in cells separate from inmates who were on disciplinary lockdown. The PC inmates were subject to the same conditions as the inmates on disciplinary segregation. That is, the PC inmates are held in lockdown with hardly any activity. The Commission knows of no professional standard under which this is acceptable. *Please see Recommendation 6.*

Work Line
The Industry area was closed for the day, but the Commissioners did talk with the supervisor. The Industry work line is responsible for responding to repair work orders generated by the various units. Civilian staffing shortage severely limits the Industry program's ability to make repairs. Getting the right fixtures for repairs is also an on-going problem, in a large part because most orders are to Mainland companies. *Please see recommendation 9.*

Kitchen
The kitchen was being cleaned by the inmate work line during the Commission's visit. For the most part, it appeared to be in good order. The supervisor shared the difficulties they experienced during the Pandemic as no inmates were assigned to the kitchen and paper products used to prevent the spread of COVID-19 were often in short supply. These issues have since been resolved.

The increased cost of some food items, such as eggs, affects the budget. One way the supervisor prepares for possible shortages is to monitor Mainland weather that many impact availability of produce and other foods—changes to the menu are made when these shortages occur.

During the visit to the food service area, meals were being plated for transport to the various living units. It appeared that the food was placed on plates directly from trays that were not on appropriate warmers. No one was observed taking the temperatures of the hot food in the trays, or of the food on the plates at appropriate intervals. This leaves OCCC at risk for a food-borne illness caused by food served at inappropriate temperatures. *Please see Recommendation 7.*

Visiting Area:
The visiting area allows for only non-contact visits, preventing any physical contact between inmates and their loved ones. Please see *Recommendation 8.*

Overall:
Morale: Overall, the staff and ACOs have a high morale considering their working conditions. They are doing the best they can with what they have. A concern is that after staffs' repeated requests for repairs or remedial actions are not addressed, the staff will "give up" and not make any requests.

Overcrowding: There is persistent overcrowding along with the need to keep inmates separated has caused OCCC management to resort to intolerable actions. There appears to be no immediate way to resolve this unacceptable situation. However, comments from staff indicate that a more assertive approach to population management is in order. The Acting Chief of Security described inmates who were held with low bail and who had serious medical or mental health issues who would be better placed in treatment facilities. A medical staff member stated that her "top-of-the-head" best guess was that 90 % of the new intakes are homeless, mentally ill, or active drug users, or any combination thereof. *Please see Recommendation 10.*

Recommendations to be considered by the Department of Public Safety:

1) **OCCC should ensure that vehicles are nor parked in the sally port unless in active use, and that the sally port gates are secured unless a vehicle is entering or leaving.**
The Commission found that the sally port gates were unsecured, even while inmates were being transported in and out of the facility. Sally ports are spaces that are most at-risk of having a security breach due to the direct access outside of the facility's perimeter fences. It is important to note that escapes have occurred when sally port gates were not properly secured – one was from OCCC and one was from the First Circuit Court. Sallyports should always be locked securely unless a vehicle if entering or leaving the applicable gate.

2) **The container units outside Module 5 used for quarantine/isolation should not be used unless there is staff in the immediate vicinity at all times.**
The Commission found that the containers outside of Module 5 did not have an ACO in the vicinity. The Department places itself at considerable risk by not posting an ACO in the immediate vicinity whenever any of the cells is occupied. The ACO should be required to make regular (not less than every half hour) security checks of each cell and document these checks along with their observations. This ACO should carry the key that opens each cell door. It is therefore recommended that OCCC not use these units unless it can post an ACO in the immediate area whenever any cell is occupied.

3) **The medical infirmary needs immediate attention by PSD leadership for various issues directly related to inhumane conditions.**
The Commission found that the infirmary is seriously overcrowded, with inmate-patients sleeping in beds in the common space which also contributes to a serious lack of privacy when discussing federally protected medical issues. The Commission also found that the lack of electronic health records is a source of serious strain from an already over-burdened staff. Lastly, the Commission found that the bathroom located in the infirmary is not ADA-compliant. It is therefore recommended the infirmary receive immediate attention from PSD leadership to find solutions to the:

a. lack of privacy;
b. lack of ADA compliance;
c. lack of appropriate bed space;
d. lack of basic humane conditions experienced by the most vulnerable and medically disabled individuals in the facility; and
e. lack of efficiency caused by a non-functioning medical record system and complete reliance on paper-based system.

4) **Cells that hold individuals on suicide watch should be painted and reconfigured for a more therapeutic environment for those who are in crisis.**
The Commission found that suicide-watch cells were covered in graffiti in addition to having a large metal slab to be used as a bed. Inmates would place their mattresses on either side of the slab. The Commission recommends the slab be removed and the cells receive a fresh coat of paint.

5) **Those housed in Protective Custody status should be allowed all items usually authorized for general population inmates.**
The Commission found that the PC inmates were subject to the same conditions as the inmates on disciplinary segregation. That is, the PC inmates are held in lockdown with hardly any activity. Individuals who are in PC are vulnerable populations that should not be punished for requested additional safety precautions. Individuals on PC should be housed in the least restrictive environment practicable, in segregated housing only if necessary, and in no case in a setting that is used for disciplinary housing. Additionally, PS inmates should be allowed all of the items usually authorized for general population prisoners and provided opportunities to participate in programming and work. PC inmates, similar to general population inmates, should be provided the greatest practicable opportunities for out-of-cell time

6) **Housing unit windows which are covered by wood should be replaced with frosted windows to allow natural light.**
The Commission found at least two housing units where every cell that had a window facing outside had their windows blocked by a slab of wood. In accordance with American Correctional Association (ACA) Standard 4-ALDF-1A-16: *All inmate rooms/cells provide the occupants with access to natural light by means of at least three-square feet of transparent glazing, plus two additional square feet of transparent glazing per inmate in rooms/cells with three or more inmates.* Therefore, the Commission recommends to replace the wood with frosted windows to allow natural light.

7) **Food must be served at appropriate temperatures to prevent food-borne illness.**
The Commission found that the food was placed on plates directly from trays that were not on appropriate warmers. No one was observed taking the temperatures of the hot food in the trays, or of the food on the plates at appropriate intervals. This leaves OCCC at risk for a food-borne illness caused by food served at inappropriate temperatures.

8) **Contact visits should be restored.**
The Commission found that OCCC has not offered contact visits in at least three years due to Covid-19. Now that visitors can be tested for Covid-19 and required to wear masks, it is important to allow contact visits. There is extensive research that highlights the importance and rehabilitative factors of contact visits for those in custody. Contact visits allow inmates to feel closer to their loved ones and their community. Noncontact visits are inherently punitive and against therapeutic and rehabilitative practices.

9) **Maintenance should have a prioritized list of items or matters that require repairs and share that list with downtown leadership with specific timeframes of anticipated repair.**
The Commission found various areas where maintenance was needed. This is particularly meaningful for cells that were out of commission due to needed repairs. Given the immense overcrowding OCCC is experiencing, it is imperative that cell repairs happen quickly and efficiently. Staff had noted some areas of repair that had been out of commission for months or years. The Department of Public Safety leadership should be monitoring required repairs closely and ensure timely repairs.

10) **PSD should invite participants in the criminal justice system (police chief, prosecutor, defense bar, judges and the politicians) to visit the correctional facilities.**
The Commission found that much of OCCC's seriously overcrowding is linked to those with low bails, serious mental health issues, those experiencing homelessness, and others who will experience excessive trauma by being incarcerated. The Commission recognizes PSD does not get to choose who they receive, or who can be released. However, a greater effort can be made to work collectively with partners in the criminal justice system to find diversion options.

If PSD finds appropriate, HCSOC will assist in inviting, planning, and facilitating the tours with the support from facility staff for appropriate background checks, scheduling, and guiding the tours.

HCSOC will examine the efforts made by the Department to actively work with the Courts, other justice agencies, and the health and housing agencies to find alternative placements for inmates charged with non-violent crimes. It is noted that on February 13, 2023, 16 male inmates at OCCC were Sentenced Misdemeanants, 60 were Pre-Trial Misdemeanants, and 160 were Probation Violators. It is also noted that 58 of 127 women at OCCC were in these categories.