STATE OF WASHINGTON

OFFICE OF THE CORRECTIONS OMBUDS

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

January 13, 2021

Steve Sinclair, Secretary
Department of Corrections (DOC)

Office of the Corrections Ombuds (OCO) Investigative Report

Attached is the official report regarding the OCO investigation into the use of emergency restraints on an incarcerated individual at Airway Heights Corrections Center. We look forward to working with DOC to amend current policies and practices to better ensure that all incarcerated persons' health, safety, welfare, and rights are protected while they are within state confinement.

Any member of the public who wishes to report a concern to OCO is welcome to contact the office at (360) 664-4749 or at the address above. All concerns are logged into the OCO database and used as part of its overall reporting to policymakers and analysis of issues within DOC.

Sincerely,

Joanna Carns

Joanna Carns
Director

cc: Governor Inslee

OCO INVESTIGATION
INVESTIGATION CONDUCTED BY MATTHIAS GYDÉ, ASSISTANT OMBUDS – WESTERN DIVISION

Summary of Complaint/Concern

On December 2, 2019, the Office of the Corrections Ombuds (OCO) received a complaint which alleged the following:

- The complainant alleged that on September 3, 2019, while he was housed at Airway Heights Corrections Center (AHCC), a use of force was executed against him to carry out a non-consensual blood draw. He further alleged that the staff "blew out" his veins six times.

OCO Statutory Authority

- Per RCW 43.06C.005, OCO was created to assist in strengthening procedures and practices that lessen the possibility of actions occurring within DOC that may adversely impact the health, safety, welfare, and rehabilitation of incarcerated persons, and that will effectively reduce the exposure of DOC to litigation.

- Per RCW 43.06C.040, OCO has the authority to receive, investigate, and resolve complaints related to incarcerated persons' health, safety, welfare, and rights.

OCO Investigative Actions

- As part of this investigation, OCO reviewed DOC policy 420.250 Use of Restraints, DOC policy 420.255 Emergency Restraint Chair and Multiple Restraint Bed, DOC policy 620.020 Non-Consensual Blood Draw, DOC policy 410.200 Use of Force, DOC policy 610.010 Consent for Health Care, and DOC policy 620.100 Force Feeding. In addition, OCO reviewed the Emergency Management System Manual, DOC incident reports, corrections officers' statements, and the full use of force packet including the Superintendent Use of Force Assessment. In addition, OCO interviewed the incarcerated person involved, American Medical Response (AMR) management, and reviewed video evidence of the incident.

Summary of Event

The incarcerated person, a white male, was received at AHCC on August 28, 2019 and was placed in segregation on August 29, 2019. On August 30, 2019, a note is made in the incarcerated person's electronic file stating that since he was placed in segregation on the 29th he had been refusing meals. According to the incarcerated individual, he initiated a hunger strike due to missing property that resulted from several facility transfers.[1] On September 9, 2019, after

[1] Allegedly, 20 items of his property were missing when he arrived at AHCC, including such items as hairbrush, cable splitter, headphones, extension cord, hotpot, photo album, television cable, tweezers, hair pick, playing cards, soap dish, bowl, and nail clippers.

missing nineteen meals, the Facility Medical Director (FMD) ordered an involuntary blood draw due to "concerns for his medical wellbeing." The incarcerated person stated clearly that he would not consent to the blood draw, but that he would not resist. A multi-person "strike team" in helmets and protective gear secured the individual in the emergency restraint chair. Medical staff attempted at least four times to insert an IV to conduct the blood draw and were unsuccessful. At that point, the FMD made the decision to call in the Airway Heights Fire Department to initiate the IV. Upon arrival, the paramedics were able to secure an IV line, but only after his arm was repositioned in the restraint chair. While the IV was inserted, not only was a blood draw conducted, but two liters of fluid were also administered.

The incarcerated person spent three hours and forty-nine minutes secured in an Emergency Restraint Chair (ERC). The person was compliant at all times during the incident. OCO finds numerous policy violations with the incident and is concerned about the use of Airway Heights' Fire Department.

OCO Findings

The findings portion of this report will be broken into sections addressing the following concerns: 1) DOC does not classify the use of restraints as a use of force; 2) violations of policy 420.250; 3) violations of policy 420.255; 4) violations of policy 410.200; 5) violations of policy 610.010; 6) violations of policy 620.100; 7) concerns regarding the use of Airway Heights Fire Department; and 8) additional concerns.

DOC Does Not Classify the Use of Emergency Restraints[2] as a Use of Force

- Currently, DOC does not classify the use of restraints as a use of force and was not open to that recommendation in discussions with OCO. The overall concern that OCO has with this decision is that not only do restraints meet the definition of use of force, uses of force receive a higher level of investigation, documentation, review, and scrutiny, which OCO believes should also apply to the use of the non-routine, immobilizing, extended restraints, such as the emergency restraint chair, bed, and WRAP.

    - As defined in the DOC Emergency Management System Manual, a use of force is the "physical use of any weapon, implement, or body movement to cause an [incarcerated individual] to respond to employee orders." As the incarcerated person was physically and completely restrained in a chair upon the orders of the FMD to conduct a blood draw, OCO believes that this incident does in fact meet the definition of a use of force.

    - For the incident in this case, DOC activated a six person "strike team" in full protective gear and otherwise treated it as though it was a pre-planned use of

[2] For the purposes of this report, OCO considers emergency restraints to be emergency restraint chair, emergency restraint bed, or the WRAP in which a person is fully immobilized for an extended period of time. OCO is not including within its discussion of restraints items such as handcuffs, belly chains, or other temporary restraints used during routine movements.

force. It was only afterwards that staff decided that it was not a use of force because the person did not resist.

- Further, the paperwork itself indicates that staff considered it a use of force. The OMNI incident report classifies the "Incident Type" as a use of force. A use of force packet was partially completed that included a Shift Commander/Unit Supervisor Use of Force Report and a Use of Force checklist. In addition, all healthcare staff classified it as a use of force in their incident reports.

- An OCO volunteer[3] conducted research into other states' policies related to uses of force and restraints. Most states do not publicly post their use of force policies online; for the 20 that she was able to locate, 12 mentioned restraints as a use of force. [4]
  - Within these states, there are only five states that reference restraints for medical use.[5] Delaware states that, while restraints can be used for medical reasons, it should only be as a last resort.[6] Florida states that restraint can be used under the supervision of a physician when treatment is necessary to protect the incarcerated person from self-injury, death, or to protect others.[7] Maryland specifically states that a person can be restrained using the minimum amount of force necessary in order to draw blood for a DNA sample.[8] Minnesota has an entire section dedicated to the use of restraints for medical care (included in the other document).[9] Lastly, North Carolina states that restraints can be used in medical situations to prevent self-harm.[10]

Violations of Policy 420.250 Use of Restraints

- Policy 420.250 states, "The circumstances of the situation and behavior of the [incarcerated individual] will be considered when determining the type of restraints and number of restraint points to use." In this case, as noted in the DOC Incident Report, the person was compliant with all directives. Despite this, DOC staff used the maximum number of restraints possible, including a restraint for each wrist and ankle, one at the waist and two straps criss-crossed over his chest. DOC staff did not appear to take into consideration the compliant behavior of the person and did not limit the type and number of restraint points to use.

Violations of Policy 420.255 Emergency Restraint Chair and Multiple Restraint Bed

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[3] OCO thanks Rose Boughton for her time and research.
[4] Florida, Georgia, Maryland, Massachusetts, Minnesota, Montana, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island
[5] Delaware, Florida, Maryland, Minnesota, North Carolina
[6] https://doc.delaware.gov/assets/documents/policies/policy_11-G-01.pdf
[7] https://www.flrules.org/gateway/ruleNo.asp?id=33-602.210
[8] https://itcd.dpscs.state.md.us/PIA/ShowFile.aspx?fileID=80
[9] http://www.doc.state.mn.us/DocPolicy2/html/DPW_Display_TOC.asp?Opt=301.081.htm
[10] https://files.nc.gov/ncdps/F.1500_03_26_18.pdf

- Section III of Policy 420.255 states, "The emergency restraint chair and multiple restraint bed will only be used for the minimum amount of time necessary to ensure security and the safe control and/or compliance of the [incarcerated individual]." **OCO fundamentally questions the decision to utilize the ERC**. As noted above, the DOC Incident Report states the person was compliant with all directives. Thus, this portion of the policy was violated as no time in the ERC was necessary or appropriate.

- Further, the use of the restraints may have actually inhibited DOC staff from successfully starting an IV line. After DOC healthcare staff failed multiple times to establish an IV, the FMD made the decision to call the Airway Heights Fire Department for assistance. The fire department medics were only able to successfully start the IV after requesting that the patient's right arm be loosened from the ERC and repositioned.

- DOC also violated its own policy related to timeframes. Policy 420.255 further states, "The use of the emergency restraint chair will be limited to a maximum of 2 hours…If an [incarcerated individual] requires prolonged restraint for more than 2 hours, s/he may be placed in the multiple restraint bed." In this incident, the incarcerated man was in the ERC for three hours and forty-nine minutes. It is documented that just prior to the incarcerated man being in the ERC for two hours, the superintendent authorized a two-hour extension of the time the incarcerated man could be kept in the chair. OCO cannot locate a DOC policy that allows a superintendent, or anyone else, to override the two-hour time limit and the transfer to a multiple restraint bed.

- Had DOC transferred the person to the emergency restraint bed, as required by policy, the person would have been subject to mandatory limb rotations for at least two minutes every two hours. As the incarcerated man involved was never moved to the multiple restraint bed as he should have been, he was left in the ERC for almost four hours without the opportunity to stretch or move his limbs through their full range of motion. The portion of the policy that governs the ERC makes no provision for this removal of restraints and stretching, as a person is supposed to be removed from the ERC at two hours.

- Policy 420.255 also requires:

    - A health care provider will medically assess the [incarcerated individual] as follows, which will be documented on DOC 13-418 Restrained Patient Assessment and in the [incarcerated individual] health record:
        - Upon initial placement
        - At least every 15 minutes for the first hour
        - Upon removal

    Form DOC 13-418 was not completed and does not exist in the patient's chart. The only mention of this incident in the patient's chart appears two days after the incident and is noted by a psychology associate as having taken place.

- The policy further requires, "Upon authorization for the use of the emergency restraint chair or multiple restraint bed for medical/mental health reasons, a health care or mental health provider will document any less restrictive measures attempted and the result of those attempts on DOC 13-435 Primary Encounter Report and in the patient record." This form was also not completed, no documentation was made in the patient's record, and no less restrictive measures were attempted.

Violations of Policy 610.010 "Consent for Health Care"

- Policy 610.010 states, "Whenever an [incarcerated individual] refuses health care specifically recommended or previously consented to, health care employees/contract staff will make an entry on DOC 13-435 Primary Encounter Report…" This is the second policy applicable to this incident that requires this form be completed, which did not occur.

- Policy 610.010 further states, "When written consent for the service was or would normally have been obtained, or when the risk of refusal is significant, the primary care practitioner/or other designated health care practitioner must complete DOC 13-048 Refusal of Medical, Dental, Mental Health, and/or Surgical Treatment." OCO believes the FMD viewed the risk of refusal of this blood draw to be significant, as a use of force was authorized to carry it out. Therefore, DOC 13-048 should have been completed, which did not occur.

Violations of Policy 620.100 "Force Feeding"

- Policy 620.100 mandates the following:

  If efforts to encourage the [incarcerated individual] to eat and/or drink voluntarily are not successful and/or the [incarcerated individual]'s medical condition indicates serious deterioration in his/her health, the assigned practitioner will:

  - Make a written determination, based upon medical criteria, whether the [incarcerated individual]'s life or health is immediately threatened by continued refusal to eat and/or drink.
  - Immediately notify the Health Authority and the Superintendent if the criteria are met and recommend that the [incarcerated individual] either:
    - Remain in the facility and be force fed using recognized medical procedure deemed appropriate by medical employees/contract staff (eg., nasogastric tube, intravenous feeding), or
    - Be placed in a medical facility better able to treat the [incarcerated individual]'s medical condition (eg., facility infirmary, community hospital).

  As already stated, the healthcare team made no notes in the patient chart regarding this incident aside from a psychology associate who mentions it briefly after the fact. During this use of force, in addition to the non-consensual blood draw, DOC introduced two

liters of IV fluid into the man's body. No documentation exists relating to the decision to force IV fluids into the incarcerated man's body. Also, as there is no documentation from the medical team, it is not possible to ascertain if the Health Authority was notified as per policy.

Concerns Regarding the Use of Airway Heights Fire Department

- OCO has serious concerns regarding the decision to call the Airway Heights Fire Department to perform a medical procedure on this patient. As stated before, the patient did not consent to these procedures. DOC has policies and procedures in place to force compliance; however, AMR, the ambulance company for the fire department, does not. AMR policy requires a court order and documentation to prove the order before they will perform a procedure on a patient who does not consent. AMR informed OCO they were not notified of the lack of consent as they would not have proceeded without a court order had they known.

- OCO could not locate a DOC policy that allows for a use of force or use of restraints by an external entity for medical reasons. OCO could not locate a DOC policy that provided any additional notice to the incarcerated individual regarding the use of an external entity. OCO is of the opinion that if DOC's healthcare team could not successfully perform the procedure, the incident should have been terminated.

Additional Concerns

- There are two places in the use of force packet, in separate narratives, that state the FMD informed the incarcerated man at the cell front, why the blood draw was necessary. While the video of the incident is choppy, the FMD's interaction with the incarcerated man is viewable. At the cell front, the FMD does not explain anything about the procedure or why it is necessary. The FMD says, "Mr. _____ I appreciate your willingness to cooperate," the incarcerated man interjects and the FMD states, "Okay, you're heard," and walks away. The video of the incident does not support the statements in the narratives.

- It should be noted that OCO was initially provided with two DVDs that contained the handheld video taken of the incident. The first disc that contained the initiation of the use of force and the first portion of the incident would not play. The second disk played as expected. OCO subsequently requested and received from DOC two more copies of the defective disk. Neither of these would play either. Eventually DOC provided OCO with the ability to view the video streaming from their servers; however, the streaming of the video is extremely choppy and does not provide a cohesive view of this portion of the incident.

- OCO received no documentation reflecting the initial authorization for a use of force.

Outcomes

- OCO is initiating a larger systemic review of DOC incidents involving the use of emergency restraint chairs, beds, and the WRAP in collaboration with DOC staff. Expected outcomes of this review include, but are not limited to, improvements in documentation and review, greater scrutiny and data collection, reduced time in emergency restraints, and greater de-escalation and other alternatives developed and implemented.

Recommendations

- The use of emergency restraints should be classified as a type of use of force and all use of force policies should be followed.

- DOC should thoroughly retrain staff, particularly all healthcare staff, on policies 420.250, 420.255, 910.010, and 620.100, surrounding the use of emergency restraints, assessment, and appropriate documentation. This may occur after the larger systemic review mentioned above and expected resulting changes.

- DOC policy should contain language that prohibits utilizing external persons to enforce the use of emergency restraints for the purposes of a medical procedure, absent exigent circumstances and a court order.

- DOC should asses and determine if any staff involved in this incident should receive disciplinary or other employment action.

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

January 27, 2021

Joanna Carns
Office of Corrections Ombuds
2700 Evergreen Parkway NW
Olympia, WA 98505

Dear Ms. Carns:

The Washington Department of Corrections appreciates the opportunity to respond to the OCO Report on the 'the investigation into the use of emergency restraints on an incarcerated individual at Airway Heights Corrections Center' completed by the Office of Corrections Ombuds.

Recommendation	Response
The use of emergency restraints should be classified as a type of use of force and all use of force policies should be followed.	The use of emergency restraints, the restraint chair, and multiple restraint bed are, by themselves, not a use of force. If the individual is compliant with placement in restraints, a use of force has not occurred.
DOC should thoroughly retrain staff, particularly all healthcare staff, on policies 420.250, 420.255, 610.010, and 620.100, surrounding the use of emergency restraints, assessment, and appropriate documentation. This may occur after the larger systemic review mentioned above and expected resulting changes.	The department will schedule refresher training with healthcare staff on emergency restraint use to include health care responsibilities related to protocols required to occur prior to and during the use of restraint bed or restraint chair.
DOC Policy should contain language that prohibits utilizing external persons to enforce the use of emergency restraints for the purposes of a medical procedure, absent exigent circumstances and a court order.	It is not practical or advisable to restrict external entities from using force, force options, and/or restraints they are trained to use given a lawful reason to do so. This situation was not a use of force, and no external entity used force or restraints (including for medical purposes).
DOC should assess and determine if any staff involved in this incident should receive disciplinary or other employment action.	The department assessed the situation and found that staff acted in accordance with policy requiring no disciplinary or other employment action.

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The information provided by the OCO was useful to ensure the Department of Corrections is doing everything it can to ensure an incarcerated person's time in the agency's facilities is a fair and safe space for all incarcerated individuals.

We also appreciate your team's understanding of the unique processes across facilities and the addition of policies and procedures being put in place to address them. We are working towards proactivity and improving quality assurance processes throughout the department. Moving forward, Washington Department of Corrections will continue to collaborate with the Office of the Corrections Ombuds to implement additional policies, procedures, and security measures to continue to improve the facility operations.

Sincerely,

Steve Sinclair, Secretary
Washington Department of Corrections