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

August 25, 2020

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 'OCO investigation into the suicide of an incarcerated individual at the Monroe Correctional Complex' completed by the Office of Corrections Ombuds.

Recommendation	**Response**
Combat compassion fatigue. OCO believes this is an urgent need at DOC. The Incarcerated Individual's case demonstrates a recurring finding from other OCO investigations and incident reviews: a diminished ability of many DOC staff – at the facilities and at the Headquarters level – to empathize or feel compassion for the incarcerated individuals in their care. DOC should provide training for staff on ways to manage compassion fatigue. DOC should also prioritize the filling of all vacant positions with qualified employee or contract staff, to avoid excessive overtime or the need to use less experienced staff for cross-coverage.	Burnout, sometimes known as compassion fatigue, is a potential consequence of working in prisons and can be seen in all public safety professions especially among first responders and those serving in a helping capacity while still managing and balancing the safety and security needs for the population. That said, the department has recognized and, successive to March 2019, is taking steps to assist staff in managing the effects of all the stressors that exist today. Our team of psychologists, who assist our staff, have been coordinating with Communications to send out messages and articles related to managing the side effects of stress. They also have created a series of guided self-care practice videos which will be rolling out through DOC in the near future. We have two hours of training in new employee orientation that was implemented in January 2020 on building skills related to stress and resiliency. Our agency's staff psychologists are connecting with individual staff across the state one on one and with work units. The agency has Critical Incident Stress Management (CISM) teams around the state on rolling deployments with walkabouts, check-ins, and coffee carts throughout our

	correctional facilities. The Department is also rebuilding the CISM academy curriculum to an entirely online delivery to train new members and expand efforts statewide. For several years prior to the pandemic, the department was offering a Corrections Fatigue to Fulfillment (CF2F) all-day course that allows some time for employees to increase their own resilience and growth and assist others in gaining these abilities. The ultimate goal of the CF2F course is to provide staff the tools they need to maintain wellness on the job, which increases safety, well-being, and enhances positive performance. The course includes the following components: 1. Definition and exploration of inherent wellness-related challenges of corrections work. 2. Examination of strategies to counter or prevent Corrections Fatigue and its effects both individually and organizationally. 3. Identification of individual and organizational strategies to pursue positive growth and professional satisfaction, and to increase resilience and even post-traumatic growth in the midst of often persistent adversity encountered in corrections work. We will look at offering the course again and assessing how the training can be delivered within the protocols established for the pandemic response. The department invites the Ombuds to meet with the Executive Strategy Team (EST) to detail their observations so that EST can better

	understand specifics behind the finding of diminished compassion. The EST is open to additional evidence-based suggestions and ideas. Prior to the pandemic-required hiring freeze, the Department of Corrections filled vacant positions as quickly as the department was able to find qualifying candidates. If possible, the department will always revert away from overtime hours, but due to unforeseen circumstances, this is not always a feasible option.
Develop additional methods and resources to reduce the risk of suicide in the incarcerated population. DOC should review the overall therapeutic environment for all patients, particularly those at risk for suicide. Suicidal patients need to be surrounded by caring, empathetic staff who respond in a trauma-informed manner. DOC should consider using other incarcerated individuals as peer support to help with feelings of isolation. Providing books, a tablet, or other mentally-distracting activities may assist in redirecting a person's thoughts.	In 2015, the Department requested and received an independent analysis of suicide prevention efforts in the state's correctional facilities. Prior to the pandemic, the Department was in the final stages of contracting with the same nationally recognized expert, Lindsay Hayes, to return to re-analyze the previously taken actions based on his recommendations and make any further recommendations on actionable methods and resources. That reanalysis is still wanted by the Department but is on hold for the near future due to the ongoing pandemic. In the specific case being investigated, the incarcerated individual was not placed under care of the mental health staff, and was not provided access to activities such as books, a tablet or other mentally-distracting activities. The department is working to ensure that correct placement of individuals with mental health concerns takes place and appropriate care can be provided. Additionally, the department has been distributing activities such as books, puzzles, and mentally distracting activities to redirect thoughts and provide meaningful distraction.
Promote continuity of care by developing policies and processes unique to the violator	Beginning during the pandemic, the Department worked to reduce the number of

population. Medical records for the violator population should be maintained in a single folder or binder, so that information from prior incarcerations is readily available for assigned staff. In addition, a dedicated medical practitioner and mental health provider should be assigned to the Violator Unit, and they should be responsible for collaborating in the care of each patient – from intake through transfer or discharge.	violators being housed with the Department's facilities. Additionally, the Department is working through policy-level discussions to construct potential legislation that would reform violator laws and provide more permanency of reduced number of violators in the state's correctional facilities. The Department is designed to house longer custody individuals and prepare them for reentry, not to serve as a short-term holding facility. However, the Department continues to work within the existing laws and budget to house individuals, as needed, to serve their short-term custody stints, including providing health services as needed during those time-limited stays. To better afford necessary health services for violators, two medical assistants who work with the intake processing of custody violation individuals brought to Monroe have been trained since February 2020 to scan associated records to an online database for ready access in the event of return to the system. While current NCCHC (National Commission on Correctional Healthcare) guidelines do not consider it essential to necessarily establish a complete health record for every individual in custody, DOC does provide for access to information on prior treatment within our system via online pharmacy and clinical dashboard records. Even with making resources, such as the database and other records, available and pushing to expand these resources, it should be noted that the Department does not know when or where a violator will enter the system, and it is unmanageable to have these paper records readily available for all violators.

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	The agency is working to improve the intake process for violators to ensure these individuals are properly assessed and housed in the safest unit for their mental and physical health needs. The Department of Corrections agrees that investing in staff well-being with adequate staffing models and training is of an utmost importance and would welcome any assistance that can be provided to obtain additional resources to follow this recommendation.
Provide training to mental health, medical, nursing, and custody staff to understand suicide risk. Include refresher training on DOC 630.550 Suicide Prevention Response and Suicide Risk Assessments. Intake nursing staff should also be educated on the assignment of initial mental health PULHES "S" codes and suicidal risk "R" codes per DOC 610.640 Health Screenings and Assessments. "S" codes must no longer be down-coded due to housing limitations.	All Prisons and Health Services staff are required to participate in an annual in-service training on suicide risks and Policy 630.550 Suicide Prevention and Response associated with referring people of concern to the Mental Health staff. All licensed Health Services staff are required by the Washington Department of Health (DOH) to fulfill training requirements on the assessment and treatment of suicide risk. DOC has developed and deployed a specific training that meets the DOH requirement for Mental Health staff. The DOH requirement calls for this six-hour course to be refreshed every six years for mental health providers. Nurses are not in an appropriate mental health position to make determinations of "S" or "R" codes. If they receive any information of concern, based on their aforementioned training, they should refer the person to mental health staff. Based on the accompanying report, the Department does not see evidence that an "S" code was "down-coded" in this case and does not understand the reason for this recommendation. "S" codes are not "down-coded" due to housing limitations.

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Revise DOC policy to require the elevation of persistent declaration of medical emergencies by the incarcerated individual to the facility medical practitioner on duty for additional accountability and oversight.	The Department is working on training and processing to ensure appropriate escalation of care to practitioners and linkage to appropriate follow up after nursing encounters.
Change the emergency call system to modify or eliminate cords. More than 70% of inpatient suicides occur by hanging, which increases the potential danger posed by emergency pull cords.	The Department of Corrections does have a separate, cordless emergency call system for the housing units that are dedicated to house individuals who are being watched for suicide risks. The department understands a suicide risk assessment was not completed in this case, which resulted in the individual being housed in a unit that normally would not have been selected due to the suicide risk, giving the individual access to the emergency calling system cord. The agency is working to improve the intake process for violators to ensure these individuals are properly assessed and housed in the safest unit for their mental and physical health needs.
Ensure ready access to rescue tools in the officer booth on each floor.	The Assistant Secretary for Prisons sent direction to all facilities superintendents to ensure that there are emergency rescue tools in the officer booths in all housing units for quick accessibility in the event that it is needed.

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.

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Sincerely,

Steve Sinclair, Secretary
Washington Department of Corrections