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

August 13, 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 Washington State Penitentiary' completed by the Office of Corrections Ombuds.

Recommendation	**Response**
DOC should review and consider changing its policy related to permanent restrictions on communication with loved ones for any reason, including contraband conveyance. A better protocol would be to impose timeframes with clear pathways back to communication.	The Department has implemented a new agency-wide visitation service pathway where a visitor who has applied for visitation and been denied, may request video visitation which will then be reviewed for consideration by the visitation unit. At each point in the pathway, the department will conduct an assessment and provide a recommendation for remaining at the level of the model currently being practiced, moving further in the model, or returning to the prior step in or before the model.
DOC should implement a process to ensure collection of information related to, at a minimum, suicide risk factors from transferring jails.	The Department of Corrections actively worked to create a form that would assist in collecting information related to suicide factors when transferring from jails. The department distributed and requested usage of the form by each transferring jail. Based on a lack of a legal means to enforce the usage of the form, the department cannot enforce use of the form and has seen little response to cooperate with the request.

	See attachment A.
WSP staff should ensure that the camera times accurately match real time to better enable accurate timelines and accountability following an incident.	After starting to record, staff announce the date and time of the incident. If for any reason the recording stops, when restarted, staff announce the date, time and reason camera recording turned off. Ensuring camera times are accurate is not always possible as cameras may be used infrequently and staff may not be experienced with, or have the time before using a camera to adjust the settings.
DOC should review any internal policies or protocols that dictate response times to unresponsive individuals to ensure immediate response.	Per DOC policy 890.620 Emergency Medical Treatment, a four-minute response time is specified for health care staff to reach a patient during emergency response. The policy is scheduled for review. As an action item that was created from a mortality review committee meeting, the Department is actively working on a program to enhance code response drills to prepare for more efficient team immediate responses within the Washington correctional facilities.
All DOC staff that distribute and/or carry radios should ensure that the batteries are charged and the radio is in good working order before shifts begin.	The Department of Corrections believes this was a singular incident, and doesn't view this as a systemic occurrence. This is already a requirement per local facility processes and is included in training for individuals in CORE. The radios have a feature that alerts the user of a low battery, and this feature is used as part of the pass down/equipment exchange process. Further, the battery chargers in use clearly indicate the status of a battery in the charger.
DOC should take into consideration the impact a suicide in custody can have on the mental health of the population within a housing unit. This consideration should include a minimum of providing mental	The Department of Corrections currently practices an enhanced mental health staff presence in a unit when a large incident occurs, to include a suicide event. Per recent updates to policy 630.550 Suicide

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health support resources to other individuals who lived or worked in the unit.	Prevention and Response, a plan for providing support resources to incarcerated individuals involved in a suicide incident are established at each local facility and an evaluation of mental health presence is required following a significant attempt or death by suicide.
DOC should implement a trauma-informed approach to informing family members of the death of an incarcerated person. OCO recommends at least a letter from the facility or DOC leadership expressing condolences, providing any immediate information that can be released, identifying a person at the facility with whom they can speak or in the alternative notifying them that all critical incidents such as suicides are reviewed and that they can receive a copy of the report through public disclosure, and including a full inventory of the person's property with information on how to obtain it. Letters left by the deceased person addressed to family members should be expedited for review and released to all identified persons, as feasible.	The Department understands if there is a perceived lack of an appropriate level of sympathy or empathy in this instance, and the department regrets any instance where it is perceived as a lack of appropriate sensitivity. The Department values the impacts on those we serve and believes that overall correctional staff approach this type of communication with an appropriate level of empathy and discretion. When a staff member contacts a loved one to inform of the death of an incarcerated individual, the expectation is to use a compassionate, trauma-informed approach and to offer assistance with the steps that will be taken following the notification. The Department of Corrections is working to establish a process that will ensure a letter of information is distributed to an identified loved one following the death of an incarcerated individual to include lists of property, any investigations pending, and any documents that were left addressed to an individual. These items will be available to the individual once all agency processes have been completed and a point of contact will be established.

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.

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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