STATE OF WASHINGTON

OFFICE OF THE CORRECTIONS OMBUDS

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April 27, 2020

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 uses of force and treatment of an incarcerated individual with mental illness, as well as restraint use and staff conduct at the Monroe Correctional Complex. We appreciate the opportunity to raise concerns regarding treatment of the incarcerated population, uses of force, and the need for improved staff training. We look forward to working with DOC to amend current policies and practices to better ensure that all incarcerated persons' health, safety, 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 CHRISTY KUNA, ASSISTANT OMBUDS – WESTERN DIVISION

Summary of Complaint/Concern

Between December 11, 2018 and March 18 2019, the Office of the Corrections Ombuds (OCO) received several complaints, which alleged the following:

- On or around December 11, 2018 a complaint was filed on behalf of an incarcerated individual residing at Monroe Correctional Complex (MCC) which stated that on December 5, 2018 a DOC correctional officer had used excessive force against and incarcerated individual during a use of force. The complainant reported that an officer who was wearing a hard helmet had head butted and punched an incarcerated individual in the face while the individual was seated in a restraint chair, under control of restraints and other officers who were involved in the a use of force. The reporter also stated that the same officer had reportedly been "taunting, teasing and harassing" the incarcerated individual on the same day, prior to the use of force.

- During the open investigation on or about March 12, 2019, the complainant reported an additional concern related to use of force. The complainant stated that on February 18, 2019 while at Monroe Correctional Complex (MCC) a correctional officer had, "viciously punched him in the face" while he was seated in a restraint chair. The complainant reported that the officer who hit him had used an excessive amount of force.

- During the open investigation, on May 28, 2019, the complainant reported that DOC had used excessive force against him on multiple occasions. The complainant reported the dates to be reviewed as follows: 07/01/2018, 07/05/2018, 08/06/2018, 08/13/2018, 08/14/2018, 09/17/2018, 09/19/2018, 09/20/2018, 12/05/2018, and 2/18/2019. During a follow up call with the complainant additional details about the uses of force were obtained. The complainant reported that correctional officers would use excessive force against him while he was restrained in a restraint bed or restraint chair and caused him injury with "malicious intent". The complainant stated that correctional officers would throw urine and feces on him, and also leave him lying on his soiled linens while he was in restraints. He also reported that staff refused him food, walks, and other elements of care while he was in the restraint bed. The complainant reported that staff left him in a restraint bed for 91 days and during that time staff had humiliated him, tortured him and taunted him, called him names, made negative references to his crimes, and would "goad" him into behavioral outburst so they could engage in uses of force.

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 individuals, 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 individuals' health, safety, welfare, and rights.

OCO Investigative Actions

- As part of this investigation, OCO reviewed DOC policy outlining medical care for incarcerated persons as outlined in the Offender Health Plan, DOC Use of Force, DOC Use of Restraints, Restraint Chair and Multiple Restraint Bed, DOC Incident and Significant Event Reporting, and information related to the DOC Quick Response Strike Team (QRST) and policy governing DOC staff conduct expectations. OCO also reviewed related grievances, supporting documents and contacted incarcerated individuals, DOC staff, and reviewed medical reports created by external providers.

OCO Findings

This report will be broken into sections addressing the following concerns: (1) Use of Force Reviews, (2) Concerns regarding the Use of the Multiple Restraint Bed, and (3) Concerns regarding Grievances.

Use of Force Reviews

The following section covers specific uses of force that were reviewed based on information provided to OCO by the complainant. OCO reviewed 11 use of force incidents. In all but one incident, OCO found that the use of force was not excessive and was in line with policy. In one incident, OCO found a DOC custody staff engaged in what appeared to be an excessive use of force. OCO noted areas of concern in review of some uses of force upon video reviewed such as limited camera use and had questions related to injuries sustained by the II during force. (Note: Information available for review was at times hindered by the camera angles and therefore it was not clear if policy violations occurred.)

- A use of force dated 07/01/2018 was reviewed. OCO viewed the related use of force video as well as the use of force packet and all related policies.

    - The II did not appear to file a grievance related to the use of force.
    - It did not appear that this use of force was outside of DOC policy.
    - During debrief all custody staff reported the levels of force used and based on the review force was within policy.

- A use of force dated 07/05/2018 was reviewed. OCO viewed the related use of force video as well as the use of force packet and all related policies.

    - The II did not appear to file a grievance related to the use of force.
    - It did not appear that this use of force was outside of DOC policy.
    - During debrief all custody staff reported the levels of force used and based on the review force was within policy.

- A use of force dated 08/06/2018 was reviewed. OCO viewed the related use of force video as well as the use of force packet and all related policies.

    - The II did not appear to file a grievance related to this use of force.
    - While it did not appear that this use of force was outside policy, the II stated on video that he thought there was OC spray dispersed on the lexan-shield and that he was experiencing burning sensations to his face and breathing issues as a result. Custody staff deny that there was any OC spray on the shield or that it had been dispersed. Medical did wipe down the II's face per his request but medical staff did not note any effects from OC present during their medical evaluation. OCO cannot confirm or deny if there was OC spray on the shield during this use of force. DOC staff noted that all shields and other equipment are wiped down following uses of force.
    - During debrief all custody staff reported the levels of force used and based on the review force was within policy.

- A use of force dated August 13, 2018 was reviewed. OCO viewed the related use of force video as well as the use of force packet and all related policies.

    - On August 15, 2018, the II did file an excessive use of force grievance in relation to this incident. DOC conducted a full investigation into this use of force which concluded October 15, 2018. The claim of excessive force was refuted by DOC during the investigative process. The custody staff was found to have delivered appropriate levels of force and staff were found to have acted with policy and procedure during the incident.
    - At the time of the use of force, medical staff completed an evaluation of the zip ties and restraints and then again after additional restraints had to be added and reevaluated. Medical noted no apparent additional injuries to the II.
    - During video review, due to limited camera angles, it was hard to determine the force actions that took place or if they were within policy. The II's resistance, attempts to self-harm, exhibited aggression and assaultive nature also complicate the use of force and staff resort to use of force through control tactics and joint manipulation to gain compliance.
    - During debrief all custody staff reported the levels of force used, and based on the review force was within policy.
    - The use of force packet was reviewed by multiple DOC staff and DOC determined that there was no excessive use of force.

- A use of force dated 08/14/2018 was reviewed. OCO viewed the related use of force video and all related policies.

    - The II did not appear to file a grievance related to the use of force.
    - Due to limited camera angles in the video, resistant and aggressive behavior of the II, OCO cannot determine if there was force used that would be considered inappropriate or excessive but what was able to be reviewed on the video did not appear to be outside of DOC policy.

- During debrief all custody staff reported the levels of force used and based on the review force was within policy.
- DOC reviewed this use of force packet and found that the force was within DOC policy.

- A use of force dated September 17, 2018 was reviewed. OCO viewed the related use of force video as well as the use of force packet and all related policies.

  - The II did not appear to enter a grievance related to this use of force.
  - Incident narrative supports that staff utilized small joint manipulation on the left ring and pinky fingers of the II and a "gooseneck hold" on the left wrist was applied by two different staff during static and aggressive resistance and vocal refusal to be compliant to staff directives. Custody staff reported that the II was assaultive towards staff during this use of force. They document that staff were struck by the II on their inner thigh and hand, had their fingers and groin grabbed and held onto by the II and he refused directives to let go. Video review supports these actions as occurring.
  - Directly following the use of force, the II complained of hand pain. Medical staff did a short evaluation immediately following the force. It was noted that the II was having difficulty moving two fingers on his left hand. Medical staff then conducted medical follow up.
  - Medical records show that the II complained of left hand/finger pain and on September 18, 2018 x-rays and medical evaluations determined that the incarcerated had a fractured 4th metacarpal and that the left hand was mildly displaced at mid-shaft. The individual was medically treated for this injury. The reason documented is, "recent trauma".
  - Based on limited camera angles in the video, resistant and aggressive behavior of the II, and information in the use of force packet OCO cannot determine if there was force used that would be considered inappropriate or excessive.
  - During debrief all custody staff reported the levels of force used and based on the review force was within policy.

- A use of force dated 09/19/2018 was reviewed. OCO viewed the related use of force video as well as the use of force packet and all related policies.

  - The II did not appear to file a grievance related to this use of force.
  - A small laceration happened to the base of the II's right thumb during this use of force, but this did not appear to be done maliciously or by a use of force that would be outside of policy. The medical staff did evaluate this, a photo was taken and the injury was cleaned.
  - There were control techniques applied to the left fingers of the II during this use of force. The II claims that custody staff failed to follow a medical directive to not touch this hand. OCO did look into this concern but there was not medical directive located that stated custody staff were prohibited from physically contacting the II's left hand.
  - It did not appear that this use of force was outside of DOC policy.
  - During debrief all custody staff reported the levels of force used and based on the review force was within policy.

- A use of force dated 09/20/2018 was reviewed. OCO viewed the related use of force video as well as the use of force packet and all related policies.

    - The II did not appear to file a grievance related to this use of force.
    - It did not appear that this use of force was outside of DOC policy but there were issues related to the camera not being operated properly according to policy. This is addressed appropriately in the Use of Force review packet done by DOC and prior to OCO involvement. DOC made the decision to make sure the camera is deployed in a timely manner, and that it is held during a use of force to maintain optimal coverage of the use of force.
    - During debrief all custody staff reported the levels of force used and based on the review force was within policy.

- On December 5, 2018 two separate uses of force occurred with the II on two separate shifts. While there were no reported concerns related to the first use of force the complainant did express concern related to the second use of force on this date. A review of the second use of force was conducted and concern regarding an unnecessary use of force and policy and procedure violation was noted by OCO during review.

    - The first use of force took place in response to the II opening up a bleeding wound on his forehead by self-harming inside his cell. Staff are seen speaking with the II at cell front and explaining that he needs to go back into the restraint chair to have medical treat and dress the self-inflicted wound. The conversation appears fairly calm.

    - OCO reviewed the second December 5, 2018 use of force and found the following concerns with the use of force:

        1. The custody staff who used questionable force during the second use of force on December 5, 2018 had been purposefully removed from the QRST team earlier in the day due to poor interactions with the II. It was documented that the custody staff was intentionally removed from the QRST since the II had been focused on the custody staff in question and there had been poor interactions between the II and the custody staff. The custody staff was nevertheless told to suit up for the second use of force.

        2. The custody staff while wearing a hard protective helmet was poorly positioned and within striking zone of the II. The II tells the custody staff he is “lucky” the II does not head butt him. The II then asked the lead QRST staff to tell the custody staff to move his head, which he does not do. The II then threatens to head butt the custody staff, but the custody staff still does not move away from the II. The II then head butts the custody staff who is wearing a hard protective helmet. The custody staff responds by headbutting the II in return. It is unclear why this custody staff who is wearing a hard protective helmet decided to head butt the II versus simply moving out of the strike zone. This not only happens once, but this occurs two separate times in a matter of minutes. This custody staff was warned to move back by the II and the II asked the QRST lead to direct the custody staff to move back.

3. The custody staff in question reported that he utilized a forward and downward pressure to pin the II's head during assaultive behavior by the II. However the video clearly shows a striking motion was made by the head of this staff while he was wearing the hard protective helmet and then contact being made with the II's facial area on both occurrences of head butting the II in the facial region. The II was not wearing any protective gear. Also, the II was in restraints in the restraint chair and also being controlled by several other custody staff who were part of the QRST team.

- At the request of OCO, the SOU Superintendent obtained a second expert review by a DOC HQ subject matter expert (SME) of defensive tactics. In this review of the use of force, the SME provided several examples to why there is reason to have concern that the force used by the custody officer was inappropriate and/or excessive. The SME states that DOC needs to determine why the custody staff in question chose to head butt the II two separate times in the face with clear striking motion when the II was in a restraint chair with four other custody officers engaged in controlling and restraining the II. The SME also questions why the custody officer chose to keep his helmet in the close proximity of the II even after being warned that he is within range of being assaulted. He points out that neither head butt by the custody staff was in a pinning motion as stated by the custody officer in his use of force report. The SME points out that the actions on video do not meet the custody staff's debrief information and that the force is not what he considers to be reasonable. The SME also points out that the video clearly shows the custody officer took a small step back from the II and then moves toward the II for what appeared to be a way to generate more energy for each impact to the II's face and then he notes that the custody staff immediately returns to his original position after the impact and makes no adjustment to avoid further engagement by the II.

- It should be noted that on video after the use of force and during a medical procedure, the II spoke to the QRST team about the concerns related to the custody staff in question. He stated that he had been complaining for months about the interactions with this particular custody staff. The II stated that during the incident earlier in the day, staff did remove this particular custody staff to avoid incident. The II points out how he had requested that custody staff be removed from the vicinity and staff indicate that the II "will not dictate what staff are around".

- A use of force dated February 18, 2019 was reviewed. OCO viewed the related use of force video as well as the use of force packet and all related policies.

  - The complainant reported to OCO that custody staff had "viciously punched" the II in the face while he was in restraints.

  - On March 12, 2019, the II submitted a grievance about excessive use of force, reporting that staff had punched him several times in the face during this use of force. DOC conducted a full investigation into this use of force which concluded April 5, 2019. DOC determined that the force used was appropriate. The custody staff was found to have delivered two approved tactical hammer strikes to the II's head in order to stop assaultive behavior and regain control of the II's head. The force used was deemed as reasonable

and necessary given the assault against staff and the resulting serious injury received by the staff who used the force. The custody officer was found to have used reasonable and necessary force to cease the aggressive assaultive behavior and re-gain control during the use of force prior to being relieved by staff so he could get himself medical attention for the injury. The custody staff had broken skin on two fingers, bleeding and bone fractures as a result of this assault.

- OCO review of this use of force found that based on the aggressive actions of the II, the assault and serious injury sustained by staff, the immediate force and type of force used to stop the assaultive behavior and regain control of the II in this case was within DOC policy. Staff are trained and qualified to utilize strikes in the event that there is an imminent threat of serious bodily injury to themselves or others. Per DOC policy staff may use any available means to stop the action in the most reasonable manner possible where there is a threat of serious bodily injury to themselves or others. In this instance the staff was being seriously bitten by the II and the staff utilized immediate hammer strikes to stop assault behavior and regain control of the II. As soon as the staff is relieved, you can see him move away and reveal his injury to the camera as he walks past. The staff then removes himself from the scene and does not return. The staff required medical attention after sustaining skin tears and bone fractures. Self-defense is allowed in emergent situations and staff are authorized to use the amount of force reasonably necessary without prior approval.

- During debrief all custody staff reported the levels of force used and based on the review force was within policy.

Concerns Related to Use of the Multiple Restraint Bed (MRB)

The allegation of misuse of the Multiple Restraint Bed was reviewed by OCO. OCO found that much of the time in question is within policy; however, OCO notes several concerns regarding (1) inappropriate use of the MRB that may have exacerbated the individual's mental health conditions, (2) lack of video, and (3) failure to conduct necessary limb rotations.

- DOC policy shows that DOC has established guidelines for the authorization and use of the MRB to ensure the safety and security of DOC employees and IIs. Based on policy, DOC can utilize the MRB for documented medical and mental health needs. Per policy, the MRB may be used to control an aggressively disruptive/resistive incarcerated person, to prevent self-injury or injury to others, medical and mental health related reasons; and/or when continued prolonged restraint is necessary and other means have failed or are not appropriate.

- Between June 25, 2018 and October 4, 2018, the Incarcerated Individual (II) had been restrained through the use of MRBs and had been housed in various cells in the MCC SOU/Infirmary/WSRU during this timeframe. The II was moved into the MRB due to continued attempts of self-harm by removing staples/sutures from his abdominal surgical incision and causing additional self-inflicted wounds to his incision site. Self-harm behavior was also prolonging the healing time of the incision and there was valid concern related to potential infection. DOC's documented goal with use of the MRB was to allow for the

surgical incision to heal and to avoid re-injury or infection through self-harm activities by the II.

- Regarding the September incident, the II had been off-site at a hospital for a surgical procedure from September 11, 2018, with a return to the facility on September 17, 2018. Upon returning the II was notified by medical/mental health/custody staff that he would be placed into a MRB because he was, "On suicide watch, due to self-harm concerns". The II calmly articulated that his approved conditions of confinement (COC) had cleared use of the MRB prior to going off-site and that he had left for the hospital in normal clothing and had normal blankets and was without incident. The medical staff informed him that he would need to be placed into the MRB regardless and that he would have to display stable behavior for 24 hours at which time they would re-evaluate and possibly release him. The II states on video that he was not and had not been suicidal, that he had not self-harmed or had self-harm ideation and again stated that his COC had been clear of the use of a MRB. The II contested the fact that staff had already written the order for use of the MRB prior to completing an evaluation on him and directly upon his return to the facility. In response staff proclaimed that they "were right there" and having known him for eight years decided that the MRB would be used. The II became upset by this, agitated that he was not heard and stated that he did not want to go into the MRB. He then stated that he would refuse the directive and then force would have to be used to place him in the MRB. OCO questions whether the decision to use the MRB caused more harm and triggered the II into negative behaviors. Following this decision, the II had three days with uses of force and was unstable in his behaviors. The II also began to engage in self-harming behaviors following this incident.

- Video was not available for all hours of all days that the II was in restraints in the MRB. It is not a procedural expectation to capture video 24 hours a day while under restraints. Since there is not daily video, OCO had to rely on what video was available during this time frame. OCO also reviewed all available "Daily Report of Segregated Offender" documents, witness statements and medical documents as well as grievances filed by the II to gather information related to this concern.

- In a grievance written by the II on July 31, 2018, he stated that he was denied his every 2 hour limb rotation at 1140 on July 31, 2018 and as a result urinated in his bed. The II stated that staff then told him he would be moved to a different cell/MRB. The II reported that he was worried the new cell/MRB was unclean/contagious (claiming the former individual using these items reportedly has bed sores, open skin issues and dry flaking skin) and that he had overheard custody staff talking about how they knew he would refuse the move. The II stated that he felt custody staff offered this option purposefully so that II would refuse and have to lay in his own urine for longer. II states he did refuse to relocate to the dirty cell/MRB and then he was forced to lay in urine. Based on record documents, it appears the II remained in the urine until around 1430-1455.

    - Staff did miss limb rotations between 940 and 2330 hours on July 31, 2018 based on information documented on the "Continuous Observation Log". Policy states limb rotation are to take place every 2 hours while an II is in the MRB unless behavior prohibits. Another limb rotation is not documented on this day until 2330 hours. Based on

documentation, the II was behaving and allowed up for new linens and personal cleaning at around 1430-1455. It is unclear as to why the next limb rotation is not documented as taking place until 2330 hours. At one point custody staff was documented as telling the grievance coordinator that the move to the new MRB was considered limb rotation, but OCO does not believe this is within acceptable procedure as limb rotation is clearly defined in DOC policy.

- On August 6, 2018 during a use of force which was being video recorded, the II complained that he was laying in his own urine and that his sheets were soiled with it.

    - It is not clear how long he had been laying in urine prior to this use of force. This use of force took place at approximately 1440 hours, use of force documentation shows that after eating dinner and walking, the MRB was exchanged and the sheets were swapped for clean linens. Based on the "Daily Report of Segregated Offender", it appears the II had his meal at about 1745 hours and there was no documentation of his walk occurring at all. It is clear he was in his own urine for several hours but it is unclear how long and also it is unclear on how long he was considered a risk to safety following the use of force at 1440 hours.

- In a grievance written by the II on August 7, 2018, he stated that he should have had limb rotation at 1015 PM (2215 hours) but that it was missed by staff. During this time he had also told staff that he needed to urinate and since limb rotation was missed, he urinated on himself. The II was in a MRB during this timeframe. The grievance coordinator's response was, "…it is unknown at this time why the limb rotation was missed." And considered the complaint to have been "Resolved informally". No additional action appears to have been taken.

    - Per DOC policy, limb rotation is to take place every 2 hours unless there is a safety and security reason preventing the care. Typically during this time the urinal is available for use.

    - A review of the "Daily Report of Segregated Offender" form for this day showed that limb rotation was documented by staff but no use of urinal was documented around this time. Urinal use is documented again on this day at 1540 showing 500 cc's of urine was collected. Several visits by medical staff, a grievance coordinator and custody staff is also documented on the log. Nothing OCO could find appeared to document the II urinating on himself or when/if he was cleaned.

- The II reported that there were times that staff had poured urine and or gotten feces on him, intentionally. OCO did not find any evidence to substantiate these allegations.

Concerns related to Grievances

In addition to the above concerns, OCO also notes concerns regarding the handling of the II's grievances reporting concerns.

- In the above-mentioned grievance written by the II on July 31, 2018, he stated that he was denied his every 2 hour limb rotation on July 31, 2018 and as a result urinated in his bed. The II stated that staff then told him to move to an cell/MRB which he worried was unclean/contagious (former II using these items reportedly has open bed sores, skin issues and dry flaking skin) and that II had overheard custody staff talking about how they offered this option purposefully so that II would refuse and have to lay in his own urine for longer. II states he did refuse to relocate to the dirty cell/MRB and then he was left to lay in urine. It appears he remained in the urine until around 1430-1455.

    - The grievance coordinator conducted a grievance investigation. In the response they recognized that mainline was late which caused the delay in limb rotation and that it was known that the II had urinated in his bed. Stated that the II had reportedly threatened that a use of force was needed to make him go to the other bed. Due to the behavior, no other limb rotations were done and meal and medications were late due to II's threatening behaviors. Response states the offered cell and second MRB had been cleaned per policy. It appears that the grievance coordinator never addressed the concern related to staff conduct or comments made about forcing the II to stay in his urine by offering up the perceived dirty MRB/cell.

- The II had filed a staff conduct grievance during the time he was in the MRB on July 31, 2018. The complainant reported that he did not feel safe in the MRB with "…staff who are intentionally out to cause me harm…" The II made it clear he was not grieving policy and that he was grieving staff conduct. The grievance coordinator responded that they had discussed the issue on August 7, 2018 and the issue had been resolved and the II stated he wanted to withdraw the complaint.

    - In conversation with OCO, the II denied that he had withdrawn this complaint. He stated that staff will, "Stall the process purposefully to the point that the II will give up or the issue is pointless since DOC doesn't care".

- The II had filed staff conduct grievance during the time he was in the MRB. On August 1, 2018. The complainant reported that a correctional staff had been "talking shit" about him outside his cell where he could be overheard and when told to stop by the II, custody staff tried to provoke him by making crying sounds as if the incarcerated person was a baby and asking, "Is that a threat?" He explained that the custody staff was trying to intentionally provoke him or push him to the point where he would become emotionally upset. DOC conducted a grievance investigation but determined it did not rise to the level of a staff conduct investigation. Staff and staff witnesses denied the allegations. The situation was considered "informally resolved".

- The II had filed staff conduct grievance on November 15, 2018 stating that custody staff had been threatening towards him. The grievance had been filed as an emergency but returned for a rewrite on the same day. The re write was due by November 26, 2018 but since it was not received the grievance coordinator closed the grievance. No follow up or conversation with the II took place.

- The II had filed an emergent staff conduct grievance noting staff blatantly ignoring him and citing fear of retaliation (following the use of force/staff assault from the day prior) on February 19, 2019. The grievance was returned for rewrite by the grievance coordinator and was to be returned in 5 working days suggesting there was a need for more information. Since there was no rewrite received it was "administratively withdrawn". The staff conduct was not looked into and the concern went unaddressed.

Outcomes

- DOC placed the custody staff on reassignment and opened an investigation into the use of force dated December 05, 2018. DOC found that the use of force dated December 5, 2018 was outside of the Use of Force policy and procedure and recommended additional training.

- DOC identified that on 12/05/2018 during the second use of force there were issues with the QRST leadership and also the procedures staff used when placing the II into the restraint chair and fastening the restraints. As a result DOC designed a new and updated video training that focuses on chair and bed restraint placement. The training video and a PowerPoint were specifically developed for Emergency Restraint Chair placement as well as bed placements. At this time the training has not been approved for statewide training yet but is currently under review with the goals of statewide implementation.

Recommendations

- DOC should develop methods of trauma-informed care in their de-escalation practices and deploying mental health professionals for in-depth attempts at de-escalation prior to uses of force.

- DOC should implement the newly developed training on uses of force involving MRBs and restraint chairs and ensure that all staff who interact with seriously mentally ill individuals take it on at least a pass/fail basis.

- DOC policy 420.255 should be updated to include peri-care requirements and linen exchange expectations for IIs placed in the emergency restraint chair or MRB.

- DOC should ensure that all incidents involving the MRB and/or uses of force are captured on camera for accountability and quality assurance, which may require additional training for personnel holding the handheld cameras regarding best camera angles and for personnel responsible for immediately capturing static footage.

- DOC HQ should conduct a review of its use of the MRB with the II in September 2018 and in particular conduct its own review regarding the lack of limb rotations in all incidents cited in this report. Further training of staff is highly recommended.

- DOC should ensure all complaints related to staff misconduct are investigated, regardless of any perceived need for a "rewrite." Sensitivity, trauma-informed care and grievance response training is highly recommended for all grievance coordinators at specifically MCC.

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

June 19, 2020

Joanna Carns
Office of Corrections Ombuds
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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 uses of force and treatment of an incarcerated individual with mental illness, as well as restraint use and staff conduct at the Monroe Correctional Complex' completed by the Office of Corrections Ombuds.

Recommendation	Response
DOC should develop methods of trauma-informed care in their de-escalation practices and deploying mental health professionals for in-depth attempts at de-escalation prior to uses of force.	Attachment 3 of policy 410.200, *Use of Force Checklist,* requires staff to inquire with mental health staff prior to use of force efforts for assistance and recommendations on the individual circumstance, related to the incarcerated individual's mental health needs. The Department is working with the Training Development Unit to include additional trauma-informed care in existing de-escalation trainings. The expected time-frame for this training addition would be summer of 2021.
DOC should implement the newly developed training on uses of force involving MRBs and restraint chairs and ensure that all staff who interact with seriously mentally ill individuals take it on at least a pass/fail basis.	420.255 *Emergency Chair and Multiple Restraint Bed* requires identified employees will receive training on proper use. This training includes policy and procedures and practical applications. This annual training is required, and if these protocols are not used often by a facility, a biannual refresher training will be had.
DOC policy 420.255 should be updated to include peri-care requirements and linen exchange expectations for IIs placed in the emergency restraint chair or MRB.	The department is looking at including this recommendation in the position's Post Orders, which provides staff with specific information regarding the duties of a particular position. Policies are the guiding principles, and do not contain the level of detail found in a particular Post Order.
DOC should ensure that all incidents involving	Policy *410.200 Use of Force* requires that all

the MRB and/or uses of force are captured on camera for accountability and quality assurance, which may require additional training for personnel holding the handheld cameras regarding best camera angles and for personnel responsible for immediately capturing static footage.	preplanned use of force is required to be recorded. The department's current practice is that the shift commander would obtain the recording equipment in the event of an unplanned use of force attempt.
DOC HQ should conduct a review of its use of the MRB with the II in September 2018 and in particular conduct its own review regarding the lack of limb rotations in all incidents cited in this report. Further training of staff is highly recommended.	This incident has been reviewed at a local level and the events have been addressed with staff. Use of Force training is a requirement for all department staff before partaking in these efforts per policy *410.200 Use of Force.* This is a local issue where local staff refresher training should take place. Not a systemic issue to be addressed based on a single staff failure that has been addressed.
DOC should ensure all complaints related to staff misconduct are investigated, regardless of any perceived need for a "rewrite." Sensitivity, trauma-informed care and grievance response training is highly recommended for all grievance coordinators at specifically MCC.	The Department of Corrections implemented a mandatory grievance procedure training in March 2020. This training was extensive and included the new procedure for reviewing staff misconduct cases. For every staff misconduct review the Statewide Grievance Manager forwards the training and necessary documents to the investigator for review and reference during the investigation. The new process of conducting an investigation of all staff misconduct grievances regardless of any perceived need for a rewrite, is reminded to all grievance coordinators every week during the Statewide Grievance call. Please see the Attachment A.

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

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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

The full DOC response with the attachment is provided on OCO's website