Use of Force & Restrictive Housing Policy Violations at Washington Corrections Center for Women

June 2025

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Summary

During an OCO monitoring visit at the Washington Corrections Center for Women (WCCW) in September 2024, an individual housed in the restrictive housing unit alerted OCO staff to multiple concerns regarding staff conduct, including policy and procedure violations, excessive use of force, and unfair practices. This prompted the OCO to open an investigation into the treatment of individuals living in the restrictive housing unit at WCCW.

The OCO conducted an extensive records review related to these allegations. The evidence reviewed included emails, Teams messages, logbooks, critical incident reviews, use of force packets, mental health records, surveillance videos, and handheld video recordings of multiple uses of force. Additionally, between September and December 2024, the OCO visited WCCW on 12 occasions to observe operations and conduct interviews with staff and the incarcerated population. OCO staff continued to observe and gather information onsite weekly throughout January to April 2025.

The OCO identified violations of multiple policies, including:

- **DOC 410.200 Use of Force** (Restricted)
  - Misuse of oleoresin capsicum (OC) spray in breach of the manufacturer's safety requirements
  - Delayed decontamination process
  - Incorrect use of restraint devices
  - Lack of proper equipment

- **DOC 320.255 Restrictive Housing**
  - Inappropriate use of conditions of confinement

- **DOC 420.370 Security Inspections** (Restricted)
  - Failure to conduct tier checks

- **DOC 890.600 Bloodborne Pathogen Protection and Exposure Response**
  - Unauthorized blood testing

- **DOC 590.500 Legal Access for Incarcerated Individuals**
  - Denied access to the law library

Additionally, evidence suggests the possibility that WCCW leadership may have violated DOC 850.030 Relationship/Contacts with Individuals. However, the OCO was not able to definitively substantiate this allegation.

Use of Force Observations

Between September 2024 and April 2025, the OCO reviewed numerous incidents involving staff use of force on four women incarcerated at WCCW. Below are summaries of some of the incidents.

Individual A

In September 2024, Individual A, who was housed in restrictive housing, refused to return to her cell because she wanted to shower. While sitting at a dayroom table in waist and wrist restraints, she slipped out of her wrist restraints. The unit supervisor then ordered unit staff to go "hands-on" with her, meaning that staff were authorized to move her physically. At that time, Individual A swung her fist at an officer's upper body, but he successfully deflected the strikes. Staff then positioned Individual A face down on the table. When facility staff had gained physical control, restraining her with her hands behind her back, two additional facility staff members approached and deployed OC spray[1] directly into both of her eyes, within inches of her face. Individual A screamed that she could not breathe and vomited. During the decontamination process, facility staff used a hose with a nozzle that had forced pressure. On video, some staff can be heard asking for the pressure to be turned down at multiple points during decontamination. Still, staff continued to tell Individual A to open her eyes and keep them open, although the high pressure of the water made it difficult and potentially unsafe for her to do so.

OCO Concerns Regarding September 2024 Incident

- Deploying OC at close range violates the manufacturer's safety protocol, which states that cans of MK-4[2] OC spray should be used at a minimum of three feet away. The distance of the dissemination and the amount of OC used in this instance also violates DOC's training and procedures for the use of OC.
- Facility leadership indicated in their use of force report that this was an emergent use of force. However, facility staff conversed with this individual in the pod for over fifteen minutes prior to the use of force occurring. After that much time without de-escalation, it should be considered a pre-planned use of force.
- On camera, the unit supervisor can be heard telling the facility staff to spray Individual A if she gets up; however, the facility staff had not set up decontamination stations, and the facility staff did not wear respirators.

[1] Oleoresin capsaicin, commonly called pepper spray, is a non-lethal solution used by law enforcement to neutralize a threat.
[2] MK-4 is a small can of aerosol OC spray. The system utilizes a stream delivery method, providing a target, specific stream.

- DOC 410.200 Use of Force states that there should be free-flowing water during decontamination. The facility staff can be seen asking for the pressure to be turned down at multiple points during decontamination. Still, facility staff continued to tell Individual A to open her eyes and keep them open. The high pressure of the water made it difficult and potentially unsafe for her to keep her eyes open.
- The OCO requested the use of force packet[3] in November 2024 and was told it had still not been reviewed by the superintendent. Once the use of force packet had been completed, the lieutenant and captain found that staff had acted in accordance with all department policies, and the associate superintendent found that the force was reasonable and necessary. The interim superintendent[4] reviewed the video in January 2025 and asked for a DOC Headquarters review.

In December 2024, Individual A was moved from restrictive housing to the close observation area. She was in leg, waist, and wrist restraints. The individual tried to turn her head to look behind her and was physically redirected by facility staff. Individual A then became angry and accused the staff member of treating her like an animal. She stopped moving and became resistant. Staff began using control tactics (referred to as a gooseneck[5]) to move her forward. Individual A went to her knees, and the facility staff attempted to walk her forward. Facility staff ordered her to stand up and walk, but she was physically unable to comply because the gooseneck hold forced her head toward the ground. As staff continued to apply pain compliance, Individual A began screaming that staff had broken her wrist. Nonetheless, video evidence shows that facility staff continued to apply pressure to her wrists. Facility staff then attempted to apply a WRAP[6] restraint: video evidence shows five staff members holding down this individual while attempting to apply the WRAP. The WRAP was the wrong size, and she maneuvered out of it. Staff then held her down and put her in it again.

Two days later, the OCO visited the facility and learned that the individual had an injured left wrist and had not been taken to the hospital for imaging to rule out broken bones. OCO staff viewed the individual's wrists and observed that her left wrist was swollen and bruised. When the OCO expressed concern to nursing staff in the Intensive Patient Unit about Individual A's wrist, the OCO was told that Individual A had done this to herself. The OCO then contacted DOC

[3] In Washington DOC, a use of force packet consists of the use of force report, the underlying incident report, and all pertinent evidence. It is typically prepared by a lieutenant and reviewed by a captain, associate superintendent, and superintendent.
[4] The superintendent was assigned to DOC Headquarters during January 2025. An interim superintendent served in her place during that time.
[5] A gooseneck is a wrist manipulation technique used to control a subject. It involves rotating the subject's arm to gain control and cause pain compliance.
[6] The WRAP is a restraint system that positions an individual in an upright seated position to allow for safe transport.

Headquarters leadership and requested that she be seen for imaging. Facility staff then transported her to the emergency room, where they provided imaging and a wrist brace.

Four weeks after the incident, the OCO requested the emergency room medical records and verified that the individual had been referred to an orthopedic surgeon for further imaging. When the OCO asked the facility's health services staff if this appointment had been scheduled, the OCO was told that Individual A did not need to see an orthopedic doctor. Shortly later that day, the OCO learned that medical staff had taken the wrist brace from Individual A immediately after OCO contact. OCO later identified emails from custody staff asking facility health services to remove the HSR for the wrist brace. After the OCO alerted DOC Headquarters Health Services leadership about this concern, it was confirmed that Individual A would see an orthopedic doctor. In March 2025**,** during an OCO monitoring visit, this office met with Individual A, and she showed the OCO her left wrist. She had been involved in another use of force incident the day prior. The OCO observed that her left wrist was so swollen that the wrist restraints had to be moved up her arm to fit, as they could not close around her swollen wrist.

OCO Concerns Regarding December 2024 and Subsequent Incidents

- Incorrect use of control tactics by custody staff.
- Incorrect application of restraint device by custody staff.
- Inadequate medical assessment rendered to individual following a use of force.

Individual B

In September 2024, Individual B, who was housed in restrictive housing, refused to leave the dayroom after a disciplinary hearing and was able to slip off her waist restraints**.** Her hands were still restrained to the waist restraints, and the chains remained secured to the dayroom table. A crisis negotiator was brought in to de-escalate the situation and successfully negotiated with the individual, who agreed to go to her cell. After the negotiator left, the video shows facility staff speaking to Individual B. However, the recording of what was said was unclear. Facility staff involved in this incident reported to the OCO that other facility staff had made offensive comments to Individual B, which re-escalated the situation. At that point, video shows Individual B asking if she would be put in a restraint chair. Once the emergency response team entered the room, they began transitioning her from waist to wrist restraints. Individual B can be heard saying “ouch," and then became non-compliant by trying to stand up. An emergency response team member then deployed MK-9[7] OC in the individual's face. After the initial spray of OC, Individual B threatened the emergency response team members, who responded by

[7] MK-9 is a large can of aerosol OC spray typically used with a wand to deliver OC spray through a cuff port. It is ideal for forcing subjects from small rooms or confined areas and for crowd control.

spraying her a second time. The team then exited the room and left Individual B in the room without decontamination for 20 minutes. Facility staff involved in this use of force reported to the OCO that while writing the incident report for this incident, facility leadership asked them and other team members to omit information from the incident report.

OCO Concerns Regarding September 2024 Incident

- DOC 410.200 Use of Force states that whenever OC is used, employees will ensure all affected individuals are removed from the area to fresh air and kept in an upright position until normal breathing returns.
- RCW 9A.16.010 defines "necessary" force, which may be used by DOC staff. According to this statutory definition, the initial dissemination of MK-9 was not "necessary" because MK-9 would only have been a reasonable choice for dissemination via a cuff port. Once the emergency response team entered the dayroom, MK-4 would have been a sensible option if OC was necessary. Additionally, the manufacturer's recommendations for using MK-9 state that the product is intended for "crowd control" or a multi-person situation.[8] In this instance, the facility staff deployed it at a one-foot distance despite the recommended distance being a minimum of six feet. The manufacturer's instructions state that failure to deploy from a safe distance could result in injury and overexposure.
- Facility staff did not wear respirators.
- Decontamination following the use of OC spray was delayed.

In October 2024, Individual B, housed in restrictive housing, attempted suicide by hanging. Records reveal that facility staff observed Individual B hanging in her cell, then left to retrieve MK-9 OC spray and a shield prior to entering the cell to render aid. Facility staff entered the cell minutes later with a shield and placed it in front of the individual before cutting her down from the ligature device. Facility staff reported that Individual B did not physically resist at any point during this incident. In addition, facility staff kept a shield in front of her while she was on her stomach on the ground until she was handcuffed.

OCO Concerns Related to October 2024 Incident

- Reports from the DOC staff during the critical incident review suggest that these actions may have increased the likelihood of positional asphyxia.
- Facility staff wore N95 masks, which are not authorized respirators for OC spray.

In December 2024, the OCO was onsite and witnessed a use of force on Individual B in restrictive housing. The individual had a disciplinary hearing in the dayroom. Individual B

[8] First Defense® 7% MK-9S HV Vapor OC Aerosol-NA

became upset after the hearing and broke a window in the dayroom. She was not in restraints, which was a violation of her security enhancement protocol.[9] Facility staff deployed OC spray to force her out of the dayroom and to her cell. After she returned to her cell, a crisis negotiator spoke with her and de-escalated the situation. Individual B agreed to come out of her cell for a strip search. As part of the negotiation, the lieutenant and sergeant had decided that everything would be removed from her cell except her legal work. The OCO verified this through video-recorded evidence. However, after the strip search was completed, the negotiation was overridden, and her legal work was taken anyway. This caused Individual B to re-escalate and refuse to return to her cell, which resulted in a hands-on physical use of force. The facility staff involved in this incident reported to the OCO that the superintendent overrode the decision to leave the legal work in the cell, breaching the negotiation. Individual B then refused to return to her cell, which resulted in spontaneous use of force against her. Additionally, the OCO review revealed that the Use of Force Report failed to describe the legal work negotiation and failed to provide this critical context for the subsequent spontaneous use of force.

OCO Concerns Related to December 2024 Incident

- DOC leadership said Individual B should have been strip-searched, and her cell should have been searched before she was taken back to her cell. Since this did not occur, the facility staff had to move her again after she was de-escalated.
- Incident reports did not describe the successful crisis negotiation, nor did it describe the negotiation being overridden by the superintendent.
- The superintendent overrode the terms of the crisis negotiation. This re-escalated the situation, resulting in the spontaneous use of force, placing staff and the incarcerated person at risk of injury. Additionally, it is possible that this override may have eroded Individual B's trust in future negotiations, rendering future attempts to de-escalate with negotiation ineffective.

Individual C

As of May 2025, Individual C had been housed in the close observation area (COA) for four consecutive months. Individual C has severe mental illness and has an S5[10] PULHES code, indicating the highest possible need for mental health services. Symptoms associated with this

[9] A security enhancement plan is developed for individuals whose behavior warrants additional precautions to enhance staff safety. Plans focus on out-of-cell movement within the unit. DOC 320.255.

[10] An "S" PULHES code is used by DOC to track mental health service utilization. S-5 is defined as significant active symptoms in most or all areas, which may be a safety risk for self or others, cannot be safely managed in a GP setting, and require treatment in a specialized mental health setting.

person's mental health disability have led to staff assaults in the past. Staff have resorted to uses of force to gain Individual C's compliance multiple times since September 2024.

In October 2024, facility staff sprayed Individual C with OC when she was engaging in self-harm. In a review of video footage, none of the facility staff using OC spray were wearing respirators, and facility staff can be heard coughing throughout the video.

A Quick Response Strike Team (QRST) was called in to remove Individual C from her cell. Video evidence shows that the QRST lead was not wearing appropriate equipment or a respirator at the time the team entered the cell. As the QRST entered the cell, one team member pushed Individual C with a shield and turned her over to her stomach to apply restraints. The QRST member with the shield was still holding it against Individual C's body while other staff attempted to restrain her. The QRST lead can be seen grabbing the shield away from the staff member and throwing it on the ground outside the cell.

After Individual C was restrained, staff carried her out of her cell and placed her in a restraint chair. Staff had covered Individual C's head with a spit hood, and on video she can be heard coughing, likely because she had been sprayed with OC and had not yet had decontamination. In reviewing records, the OCO could not identify any history of this individual spitting on staff. Although the incident report stated that Individual C threatened to spit on staff, in reviewing the handheld video footage, the OCO could not identify any instance of Individual C speaking throughout the entire process.

In video footage taken when staff moved Individual C to the restraint chair, it appears that staff struggled to secure her into the restraint chair: two staff members can be seen leaning on Individual C's stomach with their knees to gain leverage to pull on the straps. Individual C can be heard moaning as this occurred.

Staff briefly removed the spit hood when Individual C was seen by health services but then replaced it. Individual C was then left in the restraint chair alone in the cell wearing the hood. Staff asked her if she wanted decontamination and she did not respond. Forty-five minutes later, according to logbooks, Individual C did ask for decontamination. However, another hour passed before staff removed her from the restraint chair. The logbook shows she received clean clothes, but the logbook did not have an entry for decontamination.

In April 2025, the OCO learned that Individual C had been placed in "medical seclusion." OCO investigation revealed that medical seclusion refers to a practice supposedly meant to be used to seclude individuals in their cells due to mental health concerns without having to confine them to the COA. However, further investigation revealed that the facility is using this practice on individuals in the COA, thereby restricting them from *any* out-of-cell time. A review of Individual C's COA records showed that medical seclusion was explicitly imposed on her "24

hours a day," with time out of cell only allowed for "needed medical intervention." Evidence suggests that this practice had been authorized by interim mental health leadership but was never official incorporated into DOC policy or protocol. The OCO verified that the DOC Director of Mental Health was unaware of "medical seclusion" as used at WCCW.

In April 2025, during a monitoring visit, the OCO was informed that Individual C had not had a shower in weeks due to medical seclusion. The OCO immediately contacted facility leadership and asked for this individual to be offered a shower. The OCO confirmed she was given a shower five days after the OCO's request. Three weeks had passed since her last shower.

OCO Concerns Related to October 2024 and April 2025 Incidents

- Incorrect use of control tactics by custody staff.
- Decontamination following the use of OC spray was delayed.
- The QRST lead did not wear a respirator or proper equipment.
- Use of practices outside of DOC policy or protocol.
- Further secluding an individual who is already living in an isolated environment in the close observation area.
- No access to shower for extended period of time.

Individual D

In April 2025, during a monitoring visit in the close observation area, the OCO spoke to Individual D, who had several concerns about a use of force she had experienced the night before. After speaking with her, the OCO reviewed documentation and verified that Individual D had been told by staff that she would need to be seen for a mental health assessment. When she refused to leave her cell, facility staff spoke with her at her cell front and attempted to negotiate with her to come out. When that attempt was not successful, QRST was called to the unit for a potential cell extraction. While facility staff were waiting for the QRST to arrive, records indicate that a different facility staff member opened Individual D's cell door and threatened to "spray the shit out of her" if she did not comply. According to the incident report, Individual D became upset and questioned the staff person about his statement. Records state that the staff member then pushed another facility staff person out of the way, entered Individual D's cell alone, and sprayed an entire can of MK-4 OC spray into the cell. The incident report states that this staff person screamed for her to get on the ground as he sprayed her. According to the report, Individual D did not offer resistance and was on her bunk, coughing. After the OC spray was deployed, none of the facility staff entered the cell to attempt to restrain her or offer decontamination. Once the QRST members arrived at the cell front, they assisted Individual D and took her to COA. The incident report stated that Individual D was neither physically combative with staff nor physically resistant. DOC 410.200 Use of Force states

that all reasonable steps must be taken to de-escalate or prevent an incident that would likely result in using force, and resistance must be evident.

OCO Concerns Related to April 2025 Incident

- RCW 9A.16.010 defines "necessary" force, which may be used by DOC staff. According to this statutory definition, OC spray was unnecessary as a QRST team was on their way to assess the situation, and the individual was not a current danger to themselves or others.
- Facility staff did not wear respirators.
- Decontamination following the use of OC spray was delayed.

Additional Policy Violations

In addition to the use of force policy violations, this office identified violations of other DOC policies that occurred in restrictive housing at Washington Corrections Center for Women.

In October 2024, the OCO received complaints from Individual A and Individual B, both in restrictive housing, stating that they were denied access to the law library. They had no tablets, were on phone sanctions, and the restrictive housing law library computer was broken. Both individuals had active court cases with no way to do their legal work. The OCO verified with facility staff that the restrictive housing law library computer had been down for months. The OCO alerted facility leadership and learned that work was underway to address the problem; facility leadership stated they had been aware it had been down since late September. The OCO reviewed DOC IT tickets, showing that the computer had not been logged into for "up to two years."

This violated DOC 590.500 Legal Access for Incarcerated Individuals, which states that individuals will have access to a law library and/or resources of a law library and access to legal service contractors.

Also in October 2024, a disciplinary hearings officer designee conducted an infraction hearing at the cell front in restrictive housing, which is not common practice. Individual B became frustrated with the process and threw an 8-ounce Styrofoam cup of fluid out of the cuff port, landing on the staff member. It was never determined what fluid was in the cup, nor was it tested; Individual B has always maintained that it was water. This office reviewed the evidence and verified that the superintendent asked for a nonconsensual blood draw for a blood-borne pathogen test to be conducted on Individual B to test for HIV and Hepatitis B and C per DOC 620.020 Non-Consensual Blood Draws. The OCO reviewed messages between nursing staff who disagreed with this request, and DOC Headquarters Health Services leadership told the OCO staff that the DOC Infectious Disease Specialist had denied the request.

The following day, this individual attempted suicide and was taken to the hospital. DOC Headquarters staff reported to the OCO that she was asked if she would consent to a bloodborne pathogen test on her way to the hospital, and she said no. While at the emergency room, the DOC facility staff asked the hospital to perform a bloodborne pathogen test per DOC 890.600 Bloodborne Pathogen Protection and Exposure Response and submit the results to the facility. Upon further investigation, it was determined that the superintendent was never given authorization by the Chief Medical Officer to order this test, and that the superintendent had signed the DOC form 03-269 for approval herself.

This act violated DOC 890.600 Bloodborne Pathogen Protection and Exposure Response, which states that the superintendent may order bloodborne pathogen testing only if it is determined, per consultation with the Chief Medical Officer, that the exposure event created a risk to the exposed person. Any employee who discloses confidential information related to test results without authorization per this policy is subject to disciplinary action, civil liability, and/or criminal sanctions. The OCO verified that the superintendent never contacted the Chief Medical Officer for permission to test this individual. In addition, this office verified through email documentation that these test results were sent to the custody staff. Individual B was never told she was given a bloodborne pathogen test, nor was she ever given the test results.

In October 2024, Individual B attempted suicide while being housed in restrictive housing. Multiple violations of policy were found during the DOC critical incident review. **The review found that conditions of confinement were not followed, violating DOC 320.255 Restrictive Housing, and tier checks were not done appropriately, violating DOC 420.370.** The unit supervisor required that two staff members do tier checks together, which is not in DOC policy or post manual expectations and does not support the restrictive housing staffing model. In addition, the facility issued an infraction to Individual B for making the ligature out of her bed sheets. The OCO asked for this infraction to be removed; DOC Headquarters leadership agreed that it had been issued inappropriately and had it removed.

In December 2024, the OCO was provided documents indicating that over a decade ago, Individual B had assaulted a DOC staff person in a different state. The individual who provided these documents to the OCO believed the person who had been assaulted was related to the facility's superintendent. The OCO requested court and DOC records from that state, which verified that Individual B had been convicted of criminal charges for assaulting a corrections officer whose last name was the same as the WCCW superintendent’s last name. The OCO then learned that the superintendent has an immediate family member with the same first and last name as the person identified in the court and DOC records. This family member worked in that out-of-state prison at the same time as Individual B’s incarceration and staff assault. The OCO contacted DOC Headquarters to confirm that this information had been disclosed. The OCO was told by DOC that this disclosure had not been made.

Policy states that employees will report to their supervisor when they or an immediate family member has been a victim of an individual under the Department's jurisdiction. The OCO was unable to definitively determine whether the superintendent knew that this person was the same person who had assaulted her relative. However, in the four months following OCO's initial questioning about this situation, which would have at minimum revealed this relationship to the superintendent, official disclosure had not been made. **Failure to submit DOC 03-039 Report of Contact/Relationship after learning that a family member is a victim of someone in DOC custody violates DOC 850.030 Relationship/Contacts with Individuals.**

In January 2025, the OCO requested a confidential space to interview Individual B in the restrictive housing unit, who had an open investigation with this office. After the OCO left, that individual was told that her time speaking with the OCO was considered her dayroom out-of-cell time. When the OCO questioned the facility unit supervisor about this incident, the OCO was informed that facility staff were measuring all time spent outside the cell, including healthcare appointments and any activity outside the cell.

The OCO believes that it was unfair to force an individual living in restrictive housing to choose between dayroom time and speaking with the OCO. Moreover, the OCO believes that preventing an incarcerated person from having legitimate out-of-cell time after they have spoken to OCO staff could be construed as retaliatory behavior. **RCW 43.06C.070 prohibits "discriminatory, disciplinary, or retaliatory action" taken against an incarcerated person for any communication made, or information given or disclosed, to aid the office in carrying out its responsibilities."**

OCO Recommendations

Recommendation #1: The DOC should implement a timeline for the superintendent's review of DOC 410.200 Use of Force.

- **Since the policy does not include a timeline for staff to follow, use of force packets can be stalled and not reviewed by superintendents for months.**
  The policy states that the superintendent or designee will review all use of force incidents and document the review. The superintendent may identify possible further action, such as recommending a Headquarters review, training needs, or employee personnel actions. During this investigation, the OCO found that the superintendent did not review the use of force incidents until months after they occurred, with some not reviewed at all, which delayed the identification of training needs or employee personnel actions.

Recommendation #2: Provide immediate training for WCCW staff on the proper use of OC spray, restraint application, respirators, and decontamination stations per DOC 410.200 Use of Force.

- **The OCO identified that WCCW staff violated DOC 410.200 on multiple occasions.** According to DOC policy, the following criteria will be followed when the use of force is necessary: Resistance must be evident, and the amount of force used must be directly related to the level of resistance and/or perceived threat presented by the individual.
- **The OCO identified gaps in the DOC Use of Force training.** DOC should provide regular coaching and training refreshers on restraint applications, OC deployment, and use of force tactics at the facility level. The DOC Academy should also devote more time to training on restraint applications and the use of force tactics during initial onboarding and throughout a staff member's career. In addition, staff members should have formal training regarding de-escalation tactics. The OCO saw multiple opportunities for de-escalation tactics during the use of force incidents reviewed, but these were ignored.
- **The OCO identified that the lack of proper equipment and planning directly led to a delay in the decontamination process**.
  DOC 410.200 requires that all employees who might be exposed to OC in non-emergent situations wear respirators. For a pre-planned event, staff should be outfitted with proper respirators, and DOC policy and training require the decontamination process to begin as soon as possible.

Recommendation #3: The DOC should regularly audit use of force incidents at the Headquarters level.

- **Currently, DOC Headquarters typically reviews a use of force incident only if the superintendent submits it for review.** DOC Headquarters should regularly audit use of force incidents statewide to identify training needs and excessive uses of force.

Recommendation #4: The DOC should deploy more resources to WCCW to assist with facility staff training.

- **The OCO has found multiple violations of DOC policy in the restrictive housing and the close observation area.** The OCO urges that the DOC take immediate action by prioritizing resources to this facility to assist the staff in training on DOC policy, protocols, and procedures.

Conclusion

The OCO is committed to producing a timely public report regarding the findings and recommendations stemming from this investigation. The OCO also is aware of additional incidents involving excessive uses of force and other policy violations at WCCW that have occurred over the course of this investigation period. While the OCO is optimistic that DOC will address the concerns raised in this report, the OCO will continue to monitor uses of force and adherence to policy at WCCW.

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
OFFICE OF THE SECRETARY
P.O. Box 41101 • Olympia, Washington 98504-1101

June 5, 2025

Elisabeth Kingsbury, Director
Office of the Corrections Ombuds
128 10th Ave. SW
Olympia, WA 98501

Dear Director Kingsbury:

Last month we received a report from the Office of the Corrections Ombuds (OCO) entitled "Use of Force & Restrictive Housing Policy Violations at Washington Corrections Center for Women (WCCW)." The report details OCO findings relating to the treatment of four individuals in Department of Corrections (DOC or Department) care and custody at WCCW, along with recommendations to address the findings.

At the outset, please accept my appreciation for the work you and your staff do, including the work that went into the underlying investigation in this matter and detailed report. As I have expressed to DOC staff, your office makes our agency better, by helping ensure that we live up to our values of operating safe and humane correctional facilities.

Working in correctional settings can be difficult. We have thousands of dedicated employees who show up every day at facilities across the state ready to help incarcerated people better themselves. On good days the work can be rewarding. On bad days it can be dangerous.

We expect our employees to act professionally and in compliance with policy under all circumstances. Your report describes behavior that plainly does not meet this expectation.

It is important to me that the allegations in your report are investigated thoroughly. I therefore have directed DOC's Women's Prison Division (WPD) leadership to fully investigate the allegations set forth in the OCO report.

In addition, we have taken the following steps to date:

Pending Investigations:

On May 1, 2025, through standard operational incident review processes and before receiving the OCO report, three staff were placed on home assignments pending investigations for a recent use of force incident detailed in the report. The Department also initiated critical incident review

(CIR) for this incident. That review is ongoing.

After receiving and reviewing the OCO report, WPD Leadership initiated additional investigations and an expansive fact-finding review regarding the allegations in the report. Two additional staff have been reassigned pending investigation based on other operational reviews related to concerns in the report.

Training:

The WPD Assistant Secretary initiated mentorship and staff training at WCCW with experienced staff and leadership from other facilities, deployed our Department Incident Management Team (DIMT) to WCCW to assist with use of force training and best practices, and reviewed the incidents noted in the OCO report and others at the facility to identify opportunities for refining and implementing regular on-site use of force training for staff.

Medical Seclusion:

This issue was promptly elevated when brought to WPD leadership. A multidisciplinary leadership team reviewed the use of medical seclusion and directed removal of this as an operational practice. Health Services and WPD leadership have clarified with staff and WCCW executive management that this is not a DOC approved practice. Written direction has been sent to staff to clarify appropriate cell front rounding and direct staff to immediately stop the use of medical seclusion in facilities.

Setting Expectations:

Multiple levels of leadership at headquarters and at WCCW are re-affirming expectations for uses of force and deployment of oleoresin capsicum (OC). These expectations for WCCW include proper use of OC, appropriate use of force, documenting uses of force, and setting timelines for completing use of force packets within 21 days. Staff will be held accountable for not meeting these expectations going forward.

I have also directed my leadership team to review the following policies for any necessary agency-wide updates considering the concerns identified in the OCO report:

- 320.255 Restrictive Housing
- 320.265 Close Observation Areas
- 400.100 Incident and Significant Event Reporting
- 400.420 Post Orders/Operations
- 410.200 Use of Force
- 420.250 Use of Restraints
- 420.255 Use of Restraint Chair and Multiple Restraint Bed
- 420.370 Security Inspections

Recommendations

Below are the Department's responses to the OCO recommendations identified in the report.[1] As you will see, we will be implementing all recommendations.

Recommendation #1: The DOC should implement a timeline for the superintendent's review of DOC 410.200 Use of Force.

DOC currently is reviewing the agency's Use of Force (UOF) policy. In the meantime, we have set an expected time frame for UOF packets at WCCW to ensure they are completed and reviewed in a timely manner. The expectation is that UOF packets now have a 21-day requirement for completion at WCCW, including review by the superintendent. Extensions must be approved by the WPD Assistant Secretary.

DOC also has set expectations for an appropriate designee process at WCCW to ensure that enough people are trained in the UOF packet process to assist with timely completion and review.

Recommendation #2: Provide immediate training for WCCW staff on the proper use of OC spray, restraint application, respirators, and decontamination stations per DOC 410.200 Use of Force.

The Department's Incident Management Team (DIMT) is being deployed in June to WCCW to begin retraining all staff on response tactics. The DIMT is a nationally respected team trained to manage incidents following the FEMA guidelines for Incident Command System training. This team has assisted during critical incidents in other states and has most recently provided support and training to the staff at the Department of Children and Youth Services' Green Hill School (GHS). DIMT members are DOC experts and trainers in the proper use of force, including use of OC.

In addition, beginning the second week of June, approximately 50 staff from WCCW will be deployed to Monroe Correctional Complex (MCC) to receive immediate training from a team of respected correctional professionals. This training will consist of working on team tactics, verbal skills, preparedness to assure the safety of all involved. The training will also include job shadowing staff at Sky River Treatment Center in real time so that WCCW staff can experience the verbal tactics used to gain compliance of individuals with mental health challenges.

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[1] *It is important to note that the WCCW superintendent mentioned in the report has accepted a position in a different state, and we have appointed new leadership to WCCW. This new superintendent is setting expectations, training staff to meet expectations, and is focused on ensuring gender responsivity and trauma-informed principles are being utilized within WCCW. When our response to your recommendations references a superintendent, we will be referencing WCCW's newly appointed superintendent.*

Recommendation #3: The DOC should regularly audit use of force incidents at the Headquarters level.

The WPD has initiated a headquarters WCCW UOF review team that will randomly review UOF incidents at WCCW, with an emphasis on reviewing uses of OC, force used in the close observation, treatment and evaluation, and/or restrictive housing units.

Recommendation #4: The DOC should deploy more resources to WCCW to assist with facility staff training.

WCCW's new superintendent has set expectations for facility staff to attend training at the Monroe Correctional Complex, as well as asked for emergency response and operational audits to be conducted this year to identify any additional concerns.

The DIMT team is being deployed in June to WCCW to provide on-site training and assistance. They will review incidents with the staff and walk through step by step with them, with a focus on team supervision during a planned or spontaneous use of force, how to talk to individuals to deescalate and gain compliance without force, using facility resources, and leadership training for duty officers and those who are doing reviews. This team, also referenced in recommendation two, is made up of DOC members from across the state, and they have been deployed to assist and train staff on-site in real time.

In closing, I appreciate the opportunity to review and respond to the WCCW report. It is unacceptable to provide anything less than a safe and humane environment in our state's prisons. We owe this to the individuals in our care and custody and our staff.

Moving forward, the Department will be intensely focused on ensuring WCCW staff receive appropriate training, are clear on DOC expectations for the humane treatment of people in our care and custody, and are held accountable, when necessary, for not adhering to policy, procedure, and expectations.

I am committed to collaborating with your office as we work to ensure safe and humane correctional facilities.

Sincerely,

Tim Lang
Secretary