STATE OF WASHINGTON

OFFICE OF THE CORRECTIONS OMBUDS

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

June 8, 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 the suicide of an incarcerated individual at the Washington State Penitentiary. We appreciate the opportunity to raise concerns related to the incident. We look forward to working with DOC to amend current policies and practices to better ensure that all incarcerated persons' health, safety, welfare, and rights are protected while they are within state confinement.

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

Joanna Carns

Joanna Carns
Director

cc: Governor Inslee

OCO INVESTIGATION AND REPORT BY MATTHIAS GYDÉ, ASSISTANT OMBUDS—WESTERN DIVISION AND CELESTE FOX KUMP, OCO INTERN

Summary of Complaint/Concern

On September 18, 2019, the Office of the Corrections Ombuds (OCO) received a complaint, on behalf of a deceased incarcerated individual, which alleged the following:

- On September 13, 2019, a 27 year old incarcerated individual at Washington State Penitentiary (WSP) committed suicide. The complainant alleged that the incarcerated person had recently been infracted and his sanctions included no contact with his significant other. The complainant further alleged that the incarcerated individual owed drug debts to other incarcerated people at WSP, he was afraid to be housed there, and he was fearful of losing his Drug Offender Sentencing Alternative (DOSA) granted by the courts.

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 Process

As part of this investigation, OCO reviewed Department of Corrections (DOC) policies governing suicide prevention, response, and assessment, the "Offender Health Plan," medical records of the individual concerned, the Critical Incident Review Report, video evidence, and photographs. OCO also contacted a number of individuals, including DOC staff, incarcerated persons, and loved ones of the deceased.

Summary

- The incarcerated person involved was remanded to DOC custody on June 6, 2019. He was housed at Washington Corrections Center (WCC) until August 21, 2019, at which time he was transferred to WSP. Upon arrival at WSP he was infracted for allegedly attempting to introduce contraband, in the form of drugs, into WCC while he was housed there. A hearing was conducted on September 6, 2019. He was found guilty of the infraction and was sanctioned, which included the permanent termination of visitation with his fiance. The suicide note left by the incarcerated individual attributes his final actions to what he feels are overly harsh sanctions by DOC in response to the infraction, feeling persecuted for having a drug problem, and the loss of communication with his loved ones on the outside. On September 13, 2019, the incarcerated person committed suicide by hanging.

Timeline

6/6/2019	Individual remanded to DOC custody. Sent to Washington Corrections Center.
7/2/2019	WCC Mailroom intercepts mail addressed to the incarcerated individual that contains suboxone.
8/12/2019	WCC Mailroom intercepts second piece of mail addressed to the incarcerated individual that contains suboxone.
8/21/2019	Individual transferred to the Washington State Penitentiary-MSC (medium).
9/6/2019	Disciplinary hearing for 603 infraction – Introducing or transferring any unauthorized drug or drug paraphernalia, a Category A violation carrying a mandatory 20 classification point reduction. In addition to standard sanctions imposed, the sanctions included permanent loss of all communication with his significant other, including written correspondence.
9/10/2019	Individual demoted to close custody. Asks for override to stay in medium unit and is told that that is unlikely.
9/11/2019	Individual transferred to close custody unit.
9/13/2019	Individual committed suicide by hanging.

OCO Findings

- OCO finds that all requisite DOC mental health screenings were completed; however, the lack of information from the county jail to DOC resulted in a failure of knowledge of the person's depressive condition.

    - According to documentation from the Chelan County Jail, the person was assessed as being mildly anxious/depressive, although he denied thoughts of self-harm. The jail staff prescribed the person doxipen (an antidepressant) that was later discontinued because the person was found to be cheeking it. There does not appear to have been any communication of this information to DOC upon transfer.

    - Upon intake to WCC, the incarcerated person was assessed by mental health and assigned an "S" code of 1[1]. At this time he signed a Refusal of Medical, Dental, Mental Health, and/or Surgical Treatment form specifically refusing, "Mental Health Appraisal including an evaluation for referral to psychiatry to continue/ begin psychiatric medications."

[1] An "S" code is used within DOC to indicate an individual's level of mental health requirements with 1 being the lowest assessed need.

- The intake and screening forms that were completed upon his admission at WSP appear to be in line with policy and were done within the required timeframes. The screening reflects that the incarcerated individual denied having any suicidal thoughts or ideations and denied having attempted suicide in the past.

- Further, OCO finds that two issues clearly precipitated the individual's suicide, both of which were within DOC's control: (1) the individual was demoted to close custody and expressed concern over placement in the close custody units due to a drug debt and (2) one of the sanctions imposed for the conveyance of contraband was the complete loss of communication with his significant other.

    - The suicide note left by the incarcerated individual states, "I hope this is a pathway to changing DOC policy on taking peoples [sic] means of contacting their loved ones away and locking some one in a cell alone for simply being a drug addict. To place me in the same catigory [sic] as these inhuman heartless beings who live here and act out in violence and force others to do the same is a huge flaw in DOC. Are drugs truely [sic] a reason to close someone out and take away all contact with their loved ones? To ban me from receiving any things from my girlfriend when truely [sic] you don't know sent the suboxone to me. Change your policys! [sic] You should be about reconnecting not disconnecting people with the ones they love."

    - The individual was found guilty of a 603 infraction – Introducing or transferring any unauthorized drug or drug paraphernalia, a Category A violation carrying a mandatory 20 classification point reduction. The custody demotion to Close Custody was in line with DOC policy.

    - The first classification counselor who handled the individual stated that he reported being "somewhat stressed about going to Close Custody" due to a drug debt. The individual was then transferred to the caseload of a different classification counselor who held the individual's Facility Risk Management Team meeting, at which point the individual requested to not go to certain units, leaving only Fox unit. The request for Fox unit was approved. Both classification staff reported that the individual did not otherwise present any indicators of distress that warranted a mental health or other intervention. OCO notes that the individual committed suicide two days after his transfer to the close custody unit.

    - As noted above, in addition to the standard sanctions of 180 days loss of free recreation, 180 days loss of privileges, 75 days loss of good conduct time, 180 days suspension of visitation, 180 days restricted communication and correspondence, 180 days loss or restriction of store privileges, and one year denial of attendance at special events, the individual also suffered the permanent loss of all communication with his significant other. This too is generally standard in cases involving conveyance of contraband. **OCO believes that the permanent restriction of**

communication with loved ones is unnecessarily punitive, regardless of the attempt to convey contraband.

- OCO finds multiple discrepancies between what staff report as the timeline of events for the response to the suicide, and what the surveillance video indicates. The video request documented by DOC staff states that the "camera times are a little off," which may account for the difference. However, this impedes accountability and ensuring a true timeline of the incident. Examples of discrepancies are listed below:

    - The DOC IMRS (incident report) reports that the radio call notifying other DOC staff of the discovery of the unresponsive man was made at 4:59:00 PM. All individual staff statements regarding the incident refer to notification at 4:59 PM. However, both east and west booth logbooks note an emergency due to the unresponsive individual at 5:01 PM. Surveillance video indicates that no one was at the cell front until 5:08:18 PM and the radio call wasn't made until 5:08:41 PM.

    - The DOC IMRS states that paramedics arrived at 5:11:00 PM and entered the unit at 5:13:00 PM. The unit log indicates that paramedics enter at 5:16 PM. The video indicates that paramedics entered the unit at 5:24:31 PM.

- OCO staff note two concerns related to the DOC response: (1) The officer who made the discovery was unable to immediately make a radio call for help, as the batteries in his radio were dead. (2) Once the body is discovered, almost one minute thirty seconds pass before anyone enters the cell.

- Upon interviewing both staff and other incarcerated people who lived near the deceased in his unit, OCO discovered there were shared concerns regarding the aftermath of a suicide in custody. The staff that were interviewed relayed feelings of sadness and trauma associated with responding to a suicide and the death of the incarcerated person. Although the individual had only been on the unit for two days, other incarcerated people relayed experiencing the same feelings of sadness and trauma. While staff are offered support following an incident like this, the incarcerated population is not.

- In follow-up discussion with the mother and significant other of the deceased person, additional concerns were relayed regarding how information related to her son's death was relayed to the mother. Reportedly, a call was made from the coroner to the mother to let her know that her son's body was there, but no additional information related to the circumstances surrounding her son's death was relayed. The letter left by the person, quoted above, was sent to the mother a month afterwards and no copy was sent to the significant other, to whom the letter was also addressed.

OCO Recommendations

- 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.

- DOC should implement a process to ensure collection of information related to, at a minimum, suicide risk factors from transferring jails.

- WSP staff should ensure that the camera times accurately match real time to better enable accurate timelines and accountability following an incident.

- DOC should review any internal policies or protocols that dictate response times to unresponsive individuals to ensure immediate response.

- 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.

- 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 health support resources to other individuals who lived or worked in the unit.

- 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.

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

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