STATE OF WASHINGTON

OFFICE OF CORRECTIONS OMBUDS

PO Box 43113 • Olympia, Washington 98504-3113 • (360) 664-4749

September 24, 2019

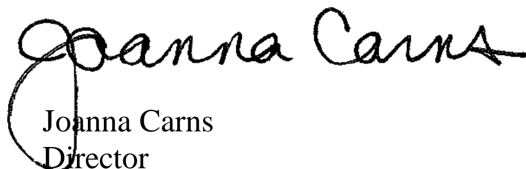
Steve Sinclair, Secretary
Department of Corrections (DOC)

Office of Corrections Ombuds (OCO) Investigative Report

Attached is the official report regarding the OCO joint investigation with DOC into the medical care and staff response to a threat to a person incarcerated at the Washington Corrections Center for Women (WCCW) in the Treatment and Evaluation Center (TEC). We appreciate the opportunity to work collaboratively 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
Director

cc: Governor Inslee

OCO INVESTIGATION
REPORT PREPARED BY JOANNA CARNS, OCO DIRECTOR

Summary of Complaint/Concern

On January 28, 2019, OCO received a complaint that alleged the following:

- The complainant was eight months pregnant and brought to the mental health unit at WCCW in October 2018. While there, another incarcerated person was mentally decompensating and threatening her. The complainant alerted staff but they did nothing. The next day, the decompensating incarcerated person boiled a jug of water in the microwave and threw it on the complainant's back. The complainant was badly burned and immediately started experiencing contractions. She wanted to go to outside medical care but was denied and brought to the facility clinic instead where she was not treated for 45 minutes. It was a Sunday, so there was only one nurse on staff, who said that it looked like a sunburn and dismissed the complainant's fear of early labor. Complainant was seen by the doctor the next day, who said instead that the burn appeared to be second or third degree. She was prescribed Silvadene cream, which was applied for several days. Then the complainant noticed that the cream contained a warning indicating that it was unsafe for use in third trimester due to high risk of bilirubin levels in the fetus. The complainant alerted medical staff, who discontinued use immediately. One week after the burn attack, the complainant gave birth to a child who reportedly was not breathing and to stay in the NICU for three days due to high bilirubin levels. The complainant attempted to grieve both the medical issue and staff's failure to respond to her safety concern and received limited assistance.

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

OCO Investigative Actions

- OCO decided to initiate a joint investigation with DOC staff to better address the gravity of the situation. Most of the issues were clearly documented, so a joint investigation allowed for greater internal buy-in and more immediate solutions.

OCO Findings

The following report will be broken into sections based on the following allegations: (1) staff failure to address the complainant's safety concern; (2) medical error and failure to treat; and (3) failure of the grievance procedure to take corrective action.

Staff Failure to Address Safety Concerns

OCO Assistant Ombuds – Gender Equity and Vulnerable Populations Riley Hewko and DOC staff Lieutenant Maria Hall conducted an investigation that involved interviews of five incarcerated individuals, including the complainant, and four DOC staff. They made the following findings:

Related to Staff Response to Safety Concern:

- The complainant's allegation of reporting a concern to a booth officer and being ignored could not be substantiated. The one incarcerated individual who remembered seeing the complainant go to the officer's booth to report the issue stated that she" could not remember" the officers responding. Although multiple incarcerated individuals interviewed made comments to the effect that they are often ignored or neglected by officers on the Treatment and Evaluation Center (TEC), which is a unit specifically for individuals experiencing elevated mental health needs, all but one person interviewed either denied or could not recall the specific alleged action occurring.

- The current process to notify staff of an issue is to raise the issue to officers conducting tier checks, which occur hourly or every half hour. If individuals need help between those tier checks, they can notify the officers in the both by pressing an intercom button.

- The staff person answering the call button on the day in question was on overtime and was not usually an officer at TEC.

- The staff person on duty that evening was interviewed and could not recall an effort to get his attention, but did make a comment stating a generalization that with the type of people in these mental health units, you know when there is an emergency that they would bang on the door and would not stop until they had your attention. The staff person also stated that if there was a lot of traffic and the call button was being used often, he would have notated that.

    - Copies of the logbook for the date in question were requested. WCCW reported at first that the log book could not be found. The log book was later retrieved after the investigation was completed.[1] The log book did not show a notation regarding the alleged incident. It also did not include notations that would substantiate whether other staff were available on the unit as unit staff log in only once when they come on shift and then activities are noted, such as rounds. DOC staff

[1] WCCW staff reported that it had been pulled for the investigation and then placed on a cabinet instead of being forwarded to the Captain's office.

reviewing the logbook indicated that the amount of documentation on the day in question was lighter than what might normally be expected.

- Video footage did not exist because it is only retained for 30 days and it was not captured following the submission of the complainant's grievance (also separately addressed in the Grievance Procedure Failure section). Video, if captured, may not have assisted in the substantiation of the complaint.

OCO Assistant Ombuds Riley Hewko reviewed available documentation and made the following additional findings to accompany the investigation regarding DOC Headquarters staff failure to notice a potential new PREA allegation connected to a prior incident that had occurred at county jail:

- During the investigative interview, the complainant reported a PREA allegation on 5/29/18 regarding an incident that occurred while at Chelan County Jail. The complainant stated that she had reported the incident to WCCW staff upon her arrival and that the alleged perpetrator of the assault was also housed in RDC with her and had made new threats on 6/10/18 (PREA Incident Report 6/10/18).

    - The complainant claimed that she asked the first officer she reported the PREA incident to for a "keep separate" between the alleged perpetrator and herself. The alleged perpetrator was not yet at the facility, so no action could be taken at that time. A case was created for tracking purposes only, WCCW did not conduct an investigation into the allegation as it occurred at the county jail.

    - When the alleged perpetrator arrived to the facility, the complainant filed a report claiming that she was experiencing further harassment; however, there was confusion as to whether this was a new report and DOC staff assumed instead that it was a "re-report" of the original incident that had already been accounted for.

    - Once the PREA unit was made aware of the oversight, there is now an open investigation of the incident although both the complainant and alleged perpetrator have now released to community. DOC confirmed to OCO that the individuals were housed in separate pods in the receiving unit and that there is no interaction between those pods.

    - The oversight found in this incident led DOC to open an audit of all re-reports on file. To date, DOC staff have not identified any such oversight in any other re-reports.

- OCO confirmed that complainant was appropriately classified as a victim from the time of her report. While housed at TEC, she did not experience any further incidents or harm.

- OCO suggested developing a better reporting system between county jails and WCCW for PREA related incidents.

- DOC confirmed that it is standard for county jails to notify WCCW for ongoing and founded PREA allegations, however there is not a mechanism for notifying for any unfounded allegations, or where the police have refused to investigate.

- OCO will continue to monitor this issue to see if there is any further evidence of the need for improvements in communication between jails and prisons on PREA issues.

Medical Error

OCO Assistant Ombuds – Health Care Specialist Shelley Alden and DOC staff Dr. Patricia David conducted a joint investigation that included a review of the medical chart and interviews of both DOC medical staff and the complainant. The following findings and recommendations were made:

- The complainant's allegation that she was not treated for a period of time after the assault was substantiated in that the nurse reportedly conducted triage and decided to treat another incarcerated person involved in the assault who had a more serious burn, which is appropriate. The investigation found that the complainant received appropriate treatment – initial treatment with cool water compress, followed by Silvadene cream, analgesics, and admission to IPU for observation.

- The complainant's allegation that she was misdiagnosed by the triaging nurse could not be substantiated. According to the investigators, burns can evolve over time with regards to the depth of the injury. It is medically plausible that the burns could initially appear to be less serious at the beginning and more like a "sunburn" or first degree burn.

- The complainant's allegation of reporting contractions following the assault could not be substantiated by the medical documentation or interviews. However, DOC is in the process of finalizing a standardized labor assessment form for the evaluation of patients complaining of contractions.

- The complainant's allegation that she was treated with a cream that included a warning regarding use for a person in the third trimester is substantiated. Silvadene cream contains a warning due to the fact that no human studies have established its safety.[2] Under pre-2015 FDA pregnancy risk categories, Silvadene cream was grouped in the same category as Tylenol. However, the benefits and risks should have been explained to the patient prior to application, and allowed for her to accept or not. According to the medical record, the risk/benefit discussion was held by the WCCW clinician four days after the assault and the original application of the cream, and at that time the complainant did

[2] "A reproductive study has been performed in rabbits at doses up to three to ten times the concentration of silver sulfadiazine in Silvadene Cream 1% and has revealed no evidence of harm to the fetus due to silver sulfadiazine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly justified, especially in pregnant women approaching or at term."
https://www.accessdata.fda.gov/drugsatfda_docs/label/2013/017381s050lbl.pdf

accept the risks. As a result of this investigation, DOC is developing a process to assist nurses with discussing risks and benefits of medications being administered to patients when the prescribing clinician is not on-site.

  - Further, staff confirmed that the cream was incorrectly (too thickly) applied. As a result, the WCCW nursing staff have been provided education on the appropriate application amount and a new nursing protocol has been developed for WCCW regarding the use of Silvadene cream for pregnant patients, with an alternative treatment recommended.

- The complainant's allegation that the use of the Silvadene cream impacted her fetus could not be substantiated. The complainant's infant was born with a normal bilirubin level and had no evidence of jaundice or other signs at birth that would indicate an impact. The infant's bilirubin levels did subsequently increase, but a direct causal link could not be substantiated and it equally could be caused by the infant's pre-term status and normal physiologic process. Further, as relayed above, the risk presented by the use of Silvadene is unclear.

Grievance Procedure Failure

OCO Director Carns reviewed the complainant's grievance documents and DOC staff Grievance Program Manager Norm Caldwell conducted a separate review and investigation, including on-site interviews. The following findings were made:

- The complainant submitted a grievance on 10/19/18 that stated the following: "On 10-14-18 I was severely burned by offender [redacted] when she threw boiling water on me. The nurse who evaluated us stated that we had 1st degree burns and didn't need to go to the hospital! Upon later review by a Doctor we had second and third degree burns. Because of that nurses lack of knowledge we will have extensive scarring. We should have been evaluated by a Doctor NOT a nurse!" The typed response was as follows: "Please rewrite this and only write on your own behalf. You cannot write on the behalf of any other person." No additional action was taken. The complainant did not submit a re-write.

  - DOC staff's review found that the above response was appropriate. OCO disagrees. The above grievance presented a serious health and safety concern such that it should have been accepted and an investigation initiated. Since the time of this investigation and due to this and another OCO investigation, DOC made the administrative decision that grievances related to medical care can no longer be sent back for a rewrite without the approval of an Associate Superintendent.

- The complainant submitted a second grievance on 10/19/18 that stated the following: "On 10-14-2018 I was assaulted with boiling water by offender [redacted]. Prior to this incident on 10-13-18 around 6 pm I had tried to notify the booth officers about [redacted] threatening to punch me in the face but was ignored by officer [redacted] who instead of asking what I needed continued to eat pizza and pretend we didn't exist. This could have

been prevented if officers would of listened the night before. I will have permanent scarring now because of this." The response appropriately elevated the grievance to a Level II investigation and response.

- DOC review of the Level II investigation and response found the following concerns:

  - At least one potential witness was not interviewed;
  - Video evidence was not collected and the assigned grievance investigator indicated that she did not know how to collect it;
  - Possible pertinent questions were not asked of all interviewees;
  - Some of the investigation packet's forms were not signed/completed;
  - These issues were not caught or addressed by either the Grievance Coordinator or the signing Superintendent.

- Corrective action in the form of on-site education of the WCCW Grievance Coordinator immediately occurred in the process of this review. Further, DOC created and implemented a grievance investigation training for all Superintendents and Grievance Coordinators, which included immediately securing perishable evidence such as video footage and interviewing all relevant witnesses.

Outcomes

As noted throughout the report, the following actions were taken by DOC:

- Education to the WCCW nursing staff regarding appropriate application of Silvadene cream.

- Creation of a protocol regarding the use of Silvadene in pregnant patients, with an alternative treatment recommended.

- Creation of a standardized WCCW labor assessment form (still in process as of September 24, 2019).

- Creation of a process to assist nurses with educating patients on risks and benefits presented by medications when a clinician is not on-site.

- Grievance investigation training of all Superintendents and Grievance Coordinators.

- The incarcerated individuals reported that staff are now more present on unit at TEC Residential throughout the day in addition to tier checks.

- As previously stated, DOC initiated a review of all past PREA re-reports. They have also taken extra care to review re-reports in more detail to prevent future oversights.

Additional Recommendations

- DOC should ensure a procedure exists for the retention of video footage for incidents grieved that allege staff misconduct, when appropriate, and that all grievance investigators are trained on this procedure.

- DOC should assess whether a protocol for video retention should be added to DOC Policy 400.110 "Reporting and Reviewing Critical Incidents."

- DOC should consider requiring booth officers to log when an incarcerated person accesses the alert button for emergency issues and/or notifies officers regarding an alleged threat to their safety.

- DOC should ensure every person who may be given a grievance to investigate receives standardized training regarding how to conduct grievance investigations. Confirmation of receipt of this training should be required.

- Non-TEC staff filling in on overtime duties should have a checklist they sign upon starting their shift in order to ensure they are reminded of any steps or protocol that may be different than other units.

- WCCW should hire a knowledgeable trainer for all line staff on cultural competency and sensitivity when working with individuals who suffer from severe mental illness within the next six months.

WA DOC Response to the OCO Investigation Report

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

October 23, 2019

Joanna Carns
Office of Corrections Ombuds
PO Box 43113
Olympia, WA 98504

Dear Ms. Carns:

The Washington Department of Corrections appreciates the opportunity to respond to the 'OCO Investigative Report' completed by the Office of Corrections Ombuds on September 24, 2019.

Recommendation	Response
DOC should ensure a procedure for the retention of video footage for incidents grieved that allege staff misconduct, when appropriate, and that all grievance investigators are trained on this procedure.	The Department of Corrections has revised the grievance manual language to reflect that "The grievance coordinator/assigned investigator will obtain and review video evidence, when available, and submit with completed grievance for retention." The Deputy Prisons Director – Command B distributed a directive on 10/9/19 to all prison staff with a hyperlink to the grievance training PowerPoint that is published on the iDOC site and added the grievance training PowerPoint to the shared drive as a resource for each Department of Corrections facility. Notice of the grievance manual update was provided within the same directive.
DOC should assess whether a protocol for video retention should be added to DOC Policy 400.110 "Reporting and Reviewing Critical Incidents."	The Department of Corrections has video retention listed as a requirement on Form 16-357 *Crime Scene Containment/ Preservation/Processing Checklist*, which is appropriately associated with Policy 470.300 "Special Investigative Services," the policy used for significant events, such as this incident. Policy 400.110 is a policy utilized after the investigation is already completed and is therefore not an appropriate policy to associate Form 16-357. Superintendent Wofford sent a memo to all Washington Corrections Center for Women (WCCW)

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	employees on 9/27/19 reminding staff that this is the procedure to be followed and explained how to use the video retention form when handling incidents.
DOC should consider requiring booth officers to log when an incarcerated person accesses the alert button for emergency issues and/or notifies officers regarding an alleged threat to their safety.	An urgent policy revision was sent by Assistant Secretary Herzog on 10/22/19 to all prison staff requiring employees to log when an incarcerated person accesses the alert button for emergency purposes.
DOC should ensure every person who may be given a grievance to investigate receives standardized training regarding how to conduct grievance investigations. Confirmation of receipt of this training should be required.	The Department has added the Grievance Investigation Training PowerPoint to the iDOC grievance webpage followed by a directive to all prison staff that they are to review the training. The grievance training was also put onto the shared drive at each facility and supervisors were reminded that this training should be sent to all new grievance investigators. The grievance workgroup that is co-chaired by DOC and the Ombuds will work on additional training, to include confirmation of training, to be used in supplementing current training efforts.
Non-TEC staff filling in on overtime duties should have a checklist they sign upon starting their shift in order to ensure they are reminded of any steps or protocol that may be different than other units.	Post orders are what the agency uses to communicate any uniqueness to a particular post. DOC Policy 400.200 states "Any time employees assume a new or unfamiliar post, they will review and sign the post order as part of the pass down process and review the post operations manual as needed for further clarification of their duties." Superintendent Wofford sent a memo on 10/20/19 to all Correctional Program Managers/Correctional Unit Supervisors outlining the process and expectations of log entries, clarifying the process that should be followed.
WCCW should hire a knowledgeable trainer for all line staff on cultural competency and sensitivity when working with individuals who	Superintendent Wofford has met with Dr. Rain Carei to put together a training plan that will be implemented at WCCW. Through the

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suffer from severe mental illness within the next six months.	PREA Advisory Council (PAC), Superintendent Wofford and Dr. Carei will put together the training that feature select subject matter experts presenting to all line staff. Within 60 days from the line staff training, the facility will expand the training to the relief staff and others who will potentially work in the unit. Funding dependent, the next step of this process would be to work with headquarters to have the American Correctional Association (ACA) provide the "Correctional Behavioral Health Training and Certification Program" at WCCW to include Training for Trainers so there is a permanent process in place.

The information provided by the OCO was useful to ensure the Department of Corrections is doing everything it can to keep incarcerated persons safe during their time in the agency's facilities.

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. Moving forward, Washington Department of Corrections will continue to implement additional policies, procedures, and security measures to continue to align with the Office of Corrections Ombuds recommendations.

Sincerely,

Steve Sinclair, Secretary
Washington Department of Corrections

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