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

October 1, 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 Ombuds Report on the investigation into the October 2019 suicide of an incarcerated individual at Peninsula Work Release Center completed by the Office of Corrections Ombuds.

The Department is concerned about missing details and would like to clarify several points upon review of the report published by the Office of Corrections Ombuds. Corrections also wishes to provide its actionable steps and plans and is appreciative of this opportunity.

Corrections found that the intake assessments conducted by intake and health services staff contained consistent results. The individual at the heart of the investigation presented as a low mental health risk after conversations with both intake and health services staff. Staff verified that the individual had been sober for many years, with the exception of the use of alcohol six months earlier that was noted and discussed, and additionally staff made note of his current positive prosocial relationships with individuals with whom he had become acquainted during the time of his treatment.

The incarcerated individual reported the noted suicide of the individual's loved one was 23 years prior to his intake assessment and the individuals had no current thoughts of suicide.

The Office of Corrections Ombuds implies there was a failure to communicate between staff in initiating a multi-disciplinary review. All proper communications did occur, and there was no need to initiate a multi-disciplinary review. The individual, as noted above, was properly assessed and notes were made by both assessments as to why the individual was not an immediate mental health risk.

There was not a delay in access to care for the individual. He came into the facility with no hearing aids or dentures in his possession. He also did not have dentures in the community and was not on any special diets due to this limitation. He made the request to acquire these devices and the process did begin. As a community supervision violator, he was in

Corrections' custody for a short period of time, restricting the department from being able to complete the process for these devices prior to his reclassification to work release. There is no evidence to indicate these items may have played a role in the individual's decision to commit suicide nor a statement by the individual indicating such thinking. The individual did not have these items prior to being brought into custody and had not made any mention that the absence of such was adding a negative impact to his mental health state.

The noted individual escaped from the work release facility 9 days before he was found by law enforcement. There is no way to know what the individual encountered after the individual escaped from the work release facility as there was no note left behind by him explaining his thinking at the time.

Recommendation	Response
Improve OCO access to a deceased I/I's medical and mental health records. Per OCO's statutory role in producing recommendations for the Governor and the Legislature to act upon, OCO recommends that it be given access to all records in DOC's possession related to an incarcerated individual.	An individual's federal protected rights, especially with regard to health records, do not end if an individual dies. There are legal remedies to pursue if an individual or government agency wishes to gain those protected records. State agencies are not beyond federal law. Corrections is working with the Ombuds to pursue appropriate legal venues as federal regulations allow.
Improve the existing Form 13-349 Intersystem/Restrictive Housing Mental Health Screening. This form should include all of the risk factors for suicide, so that the provider can accurately determine which patients are at risk and need mental health assessments.	The existing form 13-349 *Intersystem/Restrictive Housing Mental Health Screening* currently adheres to the NCCHC standards for section screening as well as complies with the recommendations put forth by Lindsay Hayes, a nationally recognized expert in suicide prevention efforts in correctional facilities. The Department was working with the Ombuds to jointly contract with Lindsay Hayes, a nationally recognized suicide analysis expert previously contracted with by Washington Corrections, to return to Washington and perform a follow-up

	analysis. The timeframe for his return is dependent on the current worldwide pandemic. These recommendations will be shared for his consideration in his analysis.
Increase the opportunity for cross-disciplinary communications. For example, requiring the medical provider to review results of the initial mental health screening as part of the intake History and Physical would ensure that all available information regarding an I/Is health status is analyzed when making decisions on whether an I/I needs a mental health assessment.	While reviewing the facts of the incident, the department determined all proper communications did occur, and there was no need to initiate a multi-disciplinary team review. The department does agree that there is always room to improve communication strategies across disciplines. Leadership from Health Services and Prisons will continue to review this and implement improved communication tactics and processes to appropriately exchange information across disciplines.
Provide training to medical, mental health, and nursing providers on the risk factors for suicide. It is important for staff to remember that **all** I/Is already have at least one of the major risk factors for suicide – being in prison or jail. Becoming more aware of the risk factors for suicide will enable staff to be more attentive to the incarcerated persons under their care.	The department does require that all mental health and nursing providers maintain continuing education credits to ensure current licensure to perform duties in a correctional facility. In addition, corrections provides annual mental health training that conforms to the recommendations provided by Lindsay Hayes, a nationally recognized expert in suicide prevention efforts in correctional facilities. The suicide prevention training material will be reviewed starting in January 2021 for the following implementation period. Any additional identified suicide risk factors can be considered for addition to the training during said review period.

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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 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