NIC Review Team Report

Washington Department of Corrections
Monroe Correctional Complex
Washington State Reformatory

Incident Review of Death of Correctional Officer Jayme Biendl
January 29, 2011

March 2011

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Executive Summary

Eldon Vail, Secretary, Washington Department of Corrections (WDOC) submitted a request for the National Institute of Corrections (NIC) to conduct an independent review of Monroe Correctional Complex/Washington State Reformatory into pertinent systems and policies surrounding the policies and procedures relative to the death of Correctional Officer Jayme Biendl which occurred on January 29, 2011.

The Review Team consisted of NIC consultants, Joan Palmateer, Lead Consultant, James Upchurch, and Michelle Elzie. The Review Team was on site at the Monroe Correctional Complex (MCC), Washington State Reformatory (WSR) in Washington February 27, 2011 - March 4, 2011.

The report identifies systems, policies, practices, protocol, and technology within MCC/WRS which would reasonably have been connected to factors surrounding safety and security for staff and others within that compound.

It is important to note that the Review Team did not have access to the Chapel of the facility because it was still considered a crime scene and active for the criminal investigation. We did review the schematic of the entire chapel area to include camera placement or lack thereof.

The research, review of documents, interviews, and work formulating our conclusion and recommendations are in our opinion as Corrections Professionals opportunities to mitigate safety and security vulnerabilities. *There were numerous documents which could not be viewed due to the ongoing criminal investigation*. The recommendations may not only impact Monroe Correctional Complex, but the entire Washington Department of Corrections. Policies reviewed were generally department wide policies. It may be noted that beyond the department policy, there are often varying interpretations of how policy is carried out within each specific facility. There are reasons this occurs: physical plant differences in each facility, inmate visibility, inconsistent practices based on shift or supervisor expectations, security or custody levels, staffing accommodations, or even correctional staff interpretation of policy.

Complacency can exist among corrections staff at every level which may lull them into a false sense of security. Recognizing that complacency occurs periodically in all correctional environments is important.

Change of policy or processes will require considerations not limited to: communication, budget, and training. The consideration for how fast these changes occur should be accomplished based on prioritization from most critical to those with less risk factors associated.

We want to make special note that balancing programs with safety and security can still be accomplished. Every medium custody institution must have rehabilitation or reformation programs, and activities to provide opportunities for those inmates who will eventually return to the community. The balance is a delicate one; however, if the security and safety systems are designed to mitigate the risks associated with these programs/activities there can be enhanced security within the correctional environment. The "how" we accomplish those systems and practice safe operational protocol is what determines the safety level within the correctional environment. We also recognize there is no perfect system with all the answers on how to protect everyone, all the time, everyplace. We work in an environment which is inherently more dangerous than the average job.

The culture of an institution and how all staff responds to the entire operation and each other is as integral as the written policies and procedures.

Pre-Planning Meeting / Draft-February 11, 2011

Joan Palmateer met with Secretary Eldon Vail, Director of Prisons, Bernie Warner, and Deputy Secretary, Dan Pacholke on Friday February 11, 2011 for pre-planning for review request.

Briefing

Central Office staff and Monroe Correctional Complex staff.

Tour

- Monroe Correctional Complex/ Washington State Reformatory
- Chapel (specifically)

Review Chronology of Events:

- Time Inmate Schref arrives in Chapel
- Time Officer Jayme Biendl arrives in Chapel
- Last radio communication with Officer Jayme Biendl
- Last staff contact with Officer Jayme Biendl
- Count time (inmate discovered missing)
- Time of key and radio check from previous shift
- Inmate movement logs for day of incident
- Time of Officer Death
- Notification to shift management and Central office
- Notification to Medical Examiner
- Notification to police
- Securing of the Crime Scene
- Notification to other staff on shift
- Employee Assistance for staff affected

Security Policy/Protocol Review:

- Count
- Inmate Work Assignments
- Inmate Movement

- Emergency Plans
- Classification
- Chapel supervision schedule
- Communication equipment (radios, alarms etc.) (mandatory call-ins)
- Key Control
- Accounting for staff (shift to shift)
- Available logs, records pertaining to day's activities
- Camera placement and monitoring process from Chapel
- Specific officer safety training
- Personal body alarm system that may have been considered/available and/or any panic alarm,
- Procedure requirement for 30 minute security/safety/alertness calls to control, response requirements

Debriefing:

- Last day on site with Central Office, and Monroe staff

Written Review Report to be submitted by March 19, 2011 for review to BeLinda Watson, Chief, Prisons Division, NIC and Eldon Vail, Secretary, Washington Department of Corrections.

On Site Review: February 28-March 4, 2011

Documents

Inmate Byron Scherf - Hard file
WDOC Official Memos on Staff Member's Death
MCC Facility Information 2010
Published News Reports on Incident
Emergency Management Assessment 2010
Operations Inspection Report 7/2010
DOC Human Resource Management Report
WSR Demographics and Data
Training Program Information
2009 Employee Satisfaction Survey Briefing
Prison Management Expectations
Classification and Custody Policies
Risk and Needs Assessment
Incident and Specific Event Reporting
Post Orders and Post Logs
Radio System Operation and Acquisition
Counts
Callout Systems and Rosters
Searches of Offenders
Security Inspections
Key Control
Religious Programs

Work Programs
Escape Preparedness
Facility Lockdown Procedure
MCC Custody Post Audit
Chapel Schedule
Recent Directive Changes incorporated since incident
Various other logs, documents, forms, memos and policies

Staff Interviews

It should be noted that we interviewed many staff for specific information and understanding relating to policy and operational practice at MCC/WSR. Some staff did not to be identified by name.

We were not able to interview some staff because to do so may interfere with the criminal investigation. We did allow staff to discuss their concerns or issues if they thought there were security enhancements which may be needed. We have provided a synopsis of those issues at the end of this report.
Michelle Wood
Alma Kingstad
Chaplain H. Fisher
Marjorie Peterson
Anna Williams
Karen Portin
Robert Pittzenberger
David Bustanoby
John Padilla
Lindsey Robinson
Lesley Chu
Captain Hardina
Sgt. Knox
Officer Jensen
Jonathon Johnson
Officer Parker
Todd Brown
Mr. Claussen
Two female industries staff
PAB Officers
We also discussed security protocols with various custody staff at their duty stations

Briefing and Report-Out

Review team met with Monroe Correctional Complex Management team and Central Office Administrators February 28, 2011 to discuss how the week would progress. We were assigned a liaison from Central Office; Devon Schrum, to assist with

whatever needs we had from central office. Michelle Wood was assigned as our Monroe Correctional Complex liaison for the needs required from MCC/WSR.

Management team attending the briefing:
Dan Pacholke, Deputy Secretary
Bernie Warner, Director of Prisons
Scott Frakes, Superintendent
Karen Portin, Associate Superintendent
David Bustanoby, Associate Superintendent
Bryan Hardina, Captain
Kenneth Bratten, Captain
Annie Williams, Correctional Program Manager (CPM)
Michelle Wood, Correctional Program Manager (CPM)
Eric Harding, CMHMP
Marc Glaser, (recorder) CMHMS
Angela Loresch, Superintendent Support

Review Team Primary Areas of Critical Review
Joan Palmateer:

- Movement Call-outs passes, main line, unit control protocols, job accountability
- Change process/follow through on directives
- Change process, lack of presence, supervisor oversight
- Cameras, placement, visibility, needs
- Post Orders, conflicting information
- Visibility, building and “stuff” removal
- Security Audit from outside for all three complexes
- Gate 7 criteria for inmates assigned
- Inmate Scherf or other inmates as volunteer clerks

James Upchurch:

- Officer Safety training program
- Tower
- Staffing
- Radio
- Personal Body Alarms
- Chemical Agents

Michelle Elzie:

- Classification
- Accountability for all staff, contractors and volunteers inside compound at end of each shift, hours of work duty.

Findings and Recommendations

Sanitation
Finding

We were all most impressed with the sanitation level that we observed at MCC/WSR despite the fact that they had been in various stages of lock down since the incident prior to our arrival. A high level of sanitation in a correctional facility is indicative of the management and supervisors' ability to "get things done" through their staff as well as all of the staff's ability to require the inmates to regularly perform all the tasks associated with maintaining sanitation in a prison environment and to perform these tasks at a high level of proficiency. This speaks well for the overall health of the Washington State Reformatory (WSR).

Recommendation
None

Staff Assaults
Finding
We reviewed the staff assaults that have occurred at MCC/WSR since 2006 in order to make a determination of the relative frequency and severity of such incidents at WSR compared to other similar facilities in other jurisdictions with which we are familiar. It is important to point out that a staff assault as defined in most correctional jurisdictions today can range anywhere from such incidents, noted at WSR, as an inmate throwing his ID card into the chest of an officer to pushing an officer's hand away when he is retrieving contraband and to actually placing a staff member in a head lock when angered at a response. Our review revealed that staff assaults in general at MCC/WSR as reported to us have diminished significantly over the last five years. The frequency and overall seriousness of such incidents are not inconsistent with the level that would be expected in a facility such as MCC/WSR nor are they inconsistent with the level found in other jurisdictions with which we are familiar.

This is not to say that security operational practices cannot and should not be enhanced in areas relative to such an incident. It is a well known fact that working in corrections is always a career that you come into with an understanding of the ever present danger of working with sometimes violent offenders. As with the community, we never really know what goes on in the mind of other persons whether incarcerated or not.

Recommendation
None

Treatment/Program - Custody/Control Balance;
Finding

It is important that a balanced emphasis exist in a correctional institution, particularly a facility such as MCC/WSR that houses some 137 inmates sentenced to life without parole (LWOP) for a variety very serious, violent offenses. An environment that is conducive for effective program and treatment opportunities for inmates does not and should not be one devoid of structure, discipline and control. Inmates should be encouraged and given the opportunity to take personal responsibility for their behavior within an environment structured to the extent necessary to provide for order and safety for all. Adequate control and discipline must be exercised by the staff when inmates fail to follow the rules and must be applied in a fair, firm and consistent manner. Failure by the facility to provide the necessary level of control and discipline is detrimental to safety and security for everyone in the facility and also serves to the detriment of the appropriate and successful delivery of the programs.

Recommendation 1
It appears to us that to attain the appropriate balance at WSR some emphasis shift toward increased inmate accountability and control is indicated. Security staff concerns and issues should be carefully considered and implemented when determined to be legitimate and appropriate. If not implemented, the reason for not doing so should be thoroughly explained. Accommodation measures implemented solely for inmate preference, convenience and comfort should receive a low priority when considered in light of staffing limitations related to insuring that inmate movement and behavior is carefully monitored and controlled to maintain a safe and secure environment.

We note in the executive summary that to achieve that balance, the security and safety systems and practices must be enhanced to allow safe programs conducive to inmate reformation opportunities while still providing structure and control. Security is dynamic, and as such it is ever changing so as program needs change, so should the security policy and practices.

Communication and Alarm
Finding

There is no personal body alarm (PBA) system at the MCC/WSR. Uniformed staff must depend on direct verbal notification when possible, telephone and/or their assigned portable radio to alert control and other staff to an immediate need for assistance should they be assaulted or should the threat of assault be imminent.

The radio system does feature an alert capability in addition to the normal radio transmission capability associated with depressing the microphone key and communicating verbally the need for assistance, location and identity of the transmitting officer. This alert capability audibly signals the control room area where the radio control station is located and simultaneously keys the microphone on the portable radio ('hot mic') possessed by the officer to transmit for a prescribed time period and override all other radio traffic to allow control and other radios tuned to the same talk group to hear any verbal/audible activity that may be occurring in the immediate vicinity of the radio. This function is initiated by depressing a small red button just proximal to the antennae connection point to the body of the radio. These options in many cases are sufficient to allow an officer to acquire assistance when it is needed. There are, however, concerns with depending on these options alone that are addressed with the installation of a PBA system and discussed below. These concerns are magnified in the case of non-uniformed/custody staff who are not issued a portable two-way radio and must depend on the telephone and/or shouting or screaming for assistance.

Recommendation 2

We recommend the installation of a personal body alarm system that when activated automatically alerts the institution main control room and provides the name of the officer and the officer's location within the institution -the current capability associated with the radio system described in the finding above only alerts to the specific radio from which the alert was received and not the name of the staff member or the location from the which the alert emanated. If desired the system can be integrated with the radio system to immediately announce from the radio console the alert and associated information to all staff on the talk group being utilized.

There are several vendors that can provide such a system thus fostering a competitive procurement process to hold down costs. It is recommended that the system selected include only those features required to make it functional to accomplish only what is necessary to provide for enhanced staff safety. This would include that the system be self-monitoring in terms of alerting control room staff when transmitter battery strength is low and if, for any other reason, a transmitter or receiver becomes dysfunctional. The system with which we are most familiar alerts when either a button is depressed on the transmitter worn by the staff member or when a lanyard attached to both the transmitter and to the belt or clothing of the wearer is dislodged by an inmate pulling the transmitter away from the staff member in an effort to keep them from depressing the alert button.

There are systems that feature transmitters worn by the staff that alert when the orientation angle of the transmitter to perpendicular changes significantly indicating that the staff wearing it has fallen or been forced or knocked to the ground. The issue of false alarms has served to dissuade many users from this feature.

For cost containment purposes the agency may also consider location specificity of the PBA system be limited to general zones or areas such as designated living areas and/or zones/sectors within large buildings such as industries at MCCWSR. For example, as opposed to the expensive requirement that the PBA alert system provide the location of an officer needing assistance in a cell block to within a 15 foot area and/or distinguish which tier level he/she is located, it is sufficient that the system simply advise that the officer needs assistance in a block to allow response staff to locate him/her in that area. Similarly, instead of requiring that the system provide the specific office from which an alert is transmitted from the programs area building (PAB) at MCC/WSR, two area/zone locations encompassing the main hallways would be sufficient.

We are available to assist your department further in developing the specifications for a system that is effective while simultaneously cost efficient in recognition of the difficult fiscal times impacting all of us in state government.

Chemical Agents

Finding

Uniformed custody staff are not issued and subsequently do not carry on their person any force multiplier option for their own defense in case of imminent or actual physical assault or to rescue/defend fellow staff or inmates from such assaults. Staff currently must rely exclusively on physical, hands on force options in such cases when non-force options fail.

While it is certainly true that the training provided to staff annually on defensive tactics is beneficial, it is generally known that proficiency in the tactics taught cannot be achieved in the limited training time designated for this purpose. A review of the training curriculum provided to custody staff in the Washington State Department of Corrections would also appear to support this observation. Additionally, the absence of physical fitness requirements can result in poorly conditioned staff being pitted against physically superior inmates in situations where staff personal safety is in jeopardy.

Physical, hands on confrontation with inmates also has the additional risk associated with the well-established higher prevalence of communicable diseases such as HIV and hepatitis C within the inmate population cuts, abrasions, etc. that allow for contact with bodily fluids during a physical struggle with an inmate pose a significant risk to staff.

Staff physical injuries sustained in hands-on struggles with inmates also frequently result in extended medical leave requirements and expensive workmen’s compensation claims and medical expenses in addition to the associated pain and suffering such injuries can cause.

Recommendation 3
We recommend that all custody staff, be issued a 3-4 ounce OC/pepper spray canister.

- *A pilot with fewer staff carrying OC/pepper spray may be considered as an alternative to everyone receiving it. Issuance to Sergeants or supervisors or zones of control, and lone posts staff may be the first consideration.*

We further recommend that the canister be of law enforcement strength formulation. These canisters are sold by a number of vendors and utilized by numerous law enforcement and corrections agencies across the country. While it is certainly true that this additional tool provided to custody staff can be abused, the implementation of careful control, supervision and accountability procedures and narrowly limited parameters for its authorized use can serve to effectively mitigate these concerns to only very rare instances. As with many decisions considered in the corrections field, the questions to utilize the chemical agent or not becomes one involving a risk assessment – does the risk of abuse/misuse by staff when appropriate controls are put in place outweigh the benefits to be derived for the safety of staff and inmates? We contend that it does.

Experience in jurisdictions where this tool has been put into place has been very positive with instances of abusive use by staff occurring very rarely. Benefits in terms of staff safety and reduction in staff and inmate physical injuries have also been observed. The added initial concern that the chemical agent canister will be taken from the staff by the inmates and used against them has also proved to be unfounded except in the rarest of incidents. Lastly, the concern that staff will resort to the use of the chemical agent before and instead of utilizing other non-force options including providing verbal direction and employing verbal de-escalation techniques has proven to be minimally problematic when standard use of force requirements are stressed and careful reviews of each occurrence are conducted to insure that parameters for use are not violated. These observations are not intended to say that there will not be infrequent incidents of staff misuse of the chemical agent just as there have historically always been such incidents involving hands-on physical force by a very small percentage of our staffs. Accountability is a must in either case and those staff who are abusive of the inmate population must be dealt with sternly and when indicated removed from employment and held criminally accountable when appropriate.

The use of the chemical agent canisters carried by staff on their person should be clearly limited to spontaneous incidents where immediate response to an actual assault or imminent threat of assault by an inmate(s) on themselves, another staff member or an inmate is required and either there are no other viable options or all other options have been exhausted. All other use of chemical agents including those issued to each officer should continue to require prior approval of institutional supervisory staff as currently prescribed.

It is recommended that a numbered seal be affixed to each chemical agent canister carrier in such a manner that the canister cannot be removed from the carrier without breaking the seal. All canisters in the carriers will be checked out at the beginning of each shift and checked back in at the shifts end. The shift supervisor should be charged with verifying the condition of the numbered seals and periodically weighing random canisters to insure that they have not been used without the required reports, etc. associated with the use of force.
It was noted during our visit to WSR that custody staffs currently receive training on the use of chemical agents. The provisions for use of the canisters discussed above should be included in this training. It should be strongly emphasized to staff that abuse or misuse of these canisters will likely result in the loss of this valuable tool being made available to them as a personal safety enhancement.

Training Enhancement
Finding

We did not note in the annual training curriculum for staff in the WSDC any specific course designation for officer/staff safety. There were certain courses that included various types of information on what officers/staff should do to insure their safety. As we all know, prisons are inherently dangerous places where continuing vigilance and an appropriate level of alertness are essential to everyone's safety. Despite this knowledge, staff frequently becomes complacent and too comfortable in this volatile environment. This fact results from the frequently routine nature of the day to day job responsibilities and the fact that while volatility and potential violence always exist, they exist beneath the surface and only become evident when, regrettably, it is often too late. Frequent reinforcement by supervisors and managers of the existence of this danger is imperative.

Recommendation 4
Consider as a part of efforts by managers to insure that staff are continually reminded of the hazardous nature of work they have chosen, we recommend that a training course be added to the annual mandatory training requirements that addresses specifically officer/staff safety. This course should be approximately two hours in duration and include real life scenarios to encourage discussion and personal recognition of various situations from which concerns may arise. It should also include refresher information on the use of all equipment and notification systems associated with insuring staff safety. Examples of basic safety principles that should be included, stressed and reinforced in the training are the following:

- Never confront a confrontational, agitated inmate alone when it can be avoided – in almost all cases time is on your side and the inmate is not going anywhere – call for back-up.

- Inmates respond better to redirection counseling, etc. when they are alone and do not feel pressure to save face as with confronting them in the presence of their peers.
- Always insure that other staff know where you are within the facility especially when you are away from your assigned area and that you are fully aware of your surroundings to include all available means of egress should you need to vacate the area quickly.
- Ask yourself the "what if" question frequently as a means to assess any situation and to have some plan for what you will do should a threat arise.
- When responding to another staff member's call for assistance or any other emergency situation always pause briefly/stage just outside the incident area before entering the situation to assess it and if part of a response team wait on other team members. A response team's effectiveness is significantly lessened if they enter the incident individually.
- Practice simulating the use of any emergency communication device or equipment that may be available to you e.g. quickly locating the emergency button on your two way radio or PBA.
  Remember the "Three Truths of Officer Safety":

    - Always expect the unexpected and have a plan! It can happen to you!
    - It is better to have mastered an officer safety skill that is never needed than to need a skill that isn't mastered!

Although certainly not all inclusive, these examples should set the tenor for the training and when combined with others along this same line and with Incident Command System principles and facility specific information should result in a compilation of information critical to staff survival in a prison environment.
Another way to emphasize the importance of the information contained in this training is to issue each staff member a pocket handbook to which they can refer as a refresher. The handbook should be a concise, abbreviated compilation of the information provided in the training. Individual elements of information contained in the handbook should be briefly referenced and discussed as necessary in roll call periods to provide a daily reminder of the importance of the concepts included in it. Upon your request, we will be willing to share staff safety curriculum developed in our jurisdictions as well as an officer safety handbook developed along the lines of that described above. We would only ask that you share with us anything that you may develop so that we can learn from each other in this critical area.

Custody Staffing

Finding

We reviewed the custody staffing level at WSR in order to determine relative sufficiency when compared to other jurisdictions with which we are familiar and to determine any recommendations for re-distribution of this scarce resource. We determined that there are 215 uniformed custody staff assigned to WSR. There is some additional custody staff assigned to the Monroe Corrections Center complex

who provide support in various areas as needed but, for the purpose of this assessment, only staff specifically assigned to WSR and the staff necessary to provide relief for them for their regular days off, vacation, sick leave, etc. are included. Considering that the current inmate capacity at WSR is 780 inmates, the staff to inmate ratio for the facility is approximately 1:3.6.

This ratio is indicative of a very adequate, if not very good, custody staffing allocation for WSR. In considering this ratio, it is important that we consider the design features of this old facility and the fact that 28 of the 215 total custody staff are assigned to various tower posts and, as such, are not available for direct supervision and management of the inmate population in the facility. All of this considered, it remains our belief that the institution is adequately staffed and no additional positions are necessary. There are a couple of recommendations to follow that could benefit the facility greatly and provide for enhanced safety and security and improved operation.

Recommendation 5
Particularly problematic to maintaining adequate staffing on site and on post at all times is the currently mandated 30 minute lunch break provided to all custody staff. Considering that this break begins and ends at the facility entrance/exit point, it frequently requires 45 minutes or more to actually complete and return to the assigned post. Additionally, the hours of the shift during which the break has to occur are also specified thus making the relief process all the more staff intensive and operationally disruptive. These breaks result in critical areas such as the cell blocks being posted at significantly reduced levels during high activity time periods. The result is an “artificial” staffing shortage that is disruptive and problematic. Discussions with custody staff at the WSR failed to produce anyone who was in favor of these breaks; in fact, the disfavor harbored for these breaks was a common thread vocalized in many of our interviews. We strongly recommend that this break process be revisited and revised with the custody staff working a schedule approximating the straight eight hour shifts previously utilized.

We further recommend that the operation of the numerous perimeter/wall towers be carefully evaluated. It appears that several of these towers operate primarily in order to operate and supervise gates located proximal to them. It may be that the staffing associated with at least one if not two of these towers can be can be utilized elsewhere at least on one or two shifts during which gate traffic can be disallowed. The wall at the facility constitutes a formidable barrier that can only be successfully breached with the aid of significant equipment items/tools/etc. and very inattentive staff. There are a number of options in terms of sensors that can be utilized on the wall to alert staff to any attempted breach. All of these considerations should be examined to possibly allow for the redistribution of some of the positions currently assigned to around the clock tower coverage to posts inside the facility with an emphasis on enhancing internal post coverage
We would encourage a review of how all posts are deployed so the staffing is based on peak activity areas and peak times of the day.

Single Officer Posts – Such posts are commonly found in all correctional jurisdictions with which we are familiar. In addition to the other officer safety strategies discussed in this report, the risks associated with such posts can be significantly mitigated by enhancing the inmate accountability practices associated with them. For example, inmates involved in any activity where security is provided by a single security officer should be counted into the area (checked off an approved attendance/movement list). This count should be conveyed to a control point such as tower 9 at WSR. At the conclusion of the activity the inmate participants should be grouped together and counted out prior to release back to the living area. Once released as a group, this count should again be called in to tower 9 from where the inmates can again be counted as they pass through the turnstiles already in place to facilitate this process. This insures that all inmates have left the area and returned to the living area.
It is important to remember and to have procedures in place to account for the fact that inmates in groups will almost never support individual, wanton violence by a member of their population. Experience has shown that their presence serves as a deterrent and that they will actually intervene themselves on behalf of a staff member in such instances.

The predatory inmate plans for opportunities to get a staff member alone in an isolated area. Preempting this opportunity is critical to the safety of officers assigned to single person posts. Controlled and organized group movement procedures such as that discussed are the key to mitigating the primary threat associated with these posts.

Post Orders

Finding

We did review a number of post orders which relate to the Chapel post order, and find there are discrepancies, and conflicting information in the Chapel post order.

It is apparent the post orders have been revised annually as required; however, this is accomplished by one or two supervisory staff.

The revision may require inclusion of a team of custody staff to assist in determining current practice, required practice, and conflicting information. It is difficult for one or two staff to revise without custody staff seeing information which may not be practiced or in effect any longer.
Examples of critical conflicting post order requirements and practice:

Chapel Officer P.O. states;

- "Daily, 2030 hours or when Chapel is secure, Report to the PAB, help officer clear and secure building". This has not occurred for a long time, if ever.

- "Daily, 2100 End of Shift, notify Shift Sgt. that you are leaving, turn in all equipment to control prior to leaving". This was also not occurring.

These statements (requirements) are also not in the Shift Sgt. Post order nor the PAB officers post order.

Recommendation 6

- Review and revise post orders to ensure clear, concise directives and expectations.
- Assure supervisors know and understand their subordinate's responsibilities and post order requirements.
- Assure supervisors are accountable for follow up and enforcement of post orders, and accomplish on the job training with staff at their posts on a frequent basis to mitigate complacency.
- Consider developing and implementing a supervisor handbook.

Inmate Movement/Call-outs/Passes

Finding

Inmate clerks in Chapel and Prison Activities Building (PAB) manage communications (kites) from inmates to access areas and programs, and screen communications (kites) to determine inmate eligibility for program; then place inmates on call-outs, (Offender Attendance Roster) for the programs.
The call-outs then get posted in housing units to alert the inmates if they are authorized to attend program.

The inmate clerks then make another list for the Chapel Officer called the Offender Attendance Roster (different format than unit rosters). When comparing the roster for the staff, and the one for the unit inmates, we discovered numerous discrepancies.

The *staff attendance* roster authorizes more inmates than are on the *call-out roster posted in the housing units*, and the inmate call-out contains some inmates not listed on the staff attendance roster. The staff use the one created for them; and many inmates came to chapel that evening that were not on the roster posted in units.

All these documents were created by an inmate clerk with no check by staff. Staff responsible for checking these documents stated that there was no time in the day to check all the work the clerk did.
There is no accountability on either end of the process for inmate movement.
The inmate clerks should never be involved in this process as it would be too easy to manipulate inmates authorized to go to an area for illegal or unauthorized activity. Though this did not have a direct impact on what occurred that evening; however, the system is flawed.

Inmate movement also occurs on a call-out basis through Offender Management Network Information (OMNI). This is a new system, and has not had the bugs

worked out to accommodate programs and activities. OMNI appears to cut the work load for staff when it comes to work assignments, but does not have the capability to manage a program that changes frequently. Manual input is required for the numerous daily changes for program and activity attendance. Upon discussion with staff who manage the OMNI call-out system, and other staff working within the MCC/WSR compound, it is clear the system is not accurate all the time, and the process still confusing.

The OMNI system can have one inmate scheduled for four different programs for the same time on the same day.

There is also great confusion among all staff on how the change in the call-out process is supposed to occur especially within the recent days while the inmates are coming off full lock-down.

The *pass system* is not workable, and does not account for inmates leaving and returning to units. The staff in housing units create a pass for an inmate; there is no carbon copy or log of the pass created, so if an inmate does not return to unit, and they find the inmate missing they have no point of reference of where the inmate was sent. This is an ineffective system at best.

Recommendation 7
The entire movement system for inmates for all work, activities program, passes should be reviewed, and a new system considered.
Inmate movement is a system which should be one of credibility and protects the integrity of safety within every facility.

We would also recommend a review of movement and call-outs in all WA facilities to assure whatever the process is used; it is as consistent as possible.

Consider a team of staff to be on a planning committee so custody staff and other department staff can add value to how the movement process works based on the fact that they are closest to the process. The practice of accounting for inmates is their responsibility on the ground working with the inmates.

If the system has no integrity, human nature is do what you believe is appropriate. This leads to complacency and vulnerability within the process.

Camera Placement and Visibility
Finding
We discovered upon reviewing the schematic of chapel locations, there are no cameras in the Chapel proper. There are cameras in corridors, and facing offices.

We recognize that technology is only as good as the staff that have the ability to monitor and observe those cameras; however, we also know that there is not enough staff to monitor all the cameras throughout a facility.

The monitors are all recorded at MCC, so if there is a camera, they can be used for investigating purposes. The monitors throughout MCC are of good quality and monitors were working during our visit.

The Industries area has cameras but the location of existing cameras was either nonexistent or were directed towards stationary material and not staff or inmate movement visibility.

Recommendation 8
There is a need for more cameras, redirections of lens, or relocation of them. We will discuss in the recommendation section immediately after this observation.
While we recognize budget cannot possibly allow for all cameras in all places; re-location and placement can make a huge difference.
As a matter of fact, the staff was working on relocation, and direction of cameras in the industries area the day after we spoke to them regarding this issue.

Recently there was a schematic of camera needs for MCC accomplished by maintenance staff; however, we recommend you consider using security staff and an electronics person to determine the location, placement, and direction of cameras to achieve the most appropriate, and effective coverage within the facility. The prioritization of new cameras should subsequently be based on high risk, limited staff supervision and budget considerations.
It may be noted that Prison Rape Elimination Act (PREA) also should be considered when identifying placement and camera needs.

Inmate Volunteers
Finding
Inmate Scherf was an inmate volunteer clerk for the Chapel. On the day of the incident he was on call-out for the Full Gospel program, yet according to the Chaplain he was in the clerk's office with Inmate Lindermood assisting him with a new call-out process.

The Chaplain did not know how he came to be a volunteer clerk. He thought perhaps he had been assigned or used as clerk by the previous Chaplain so continued the practice as routine. The Chaplain thought there may be a list in his office from the prior Chaplain but there is no access to the area since it is still a crime scene.
There are times when we all assume something is authorized and sanctioned, and it is not.

There is no policy or protocol written that relates to authorization for inmates to be "volunteer clerks". There is no screening process, or boundaries for inmates in this capacity to follow.

The paid inmate clerk for PAB has been working there for 40 years. There is a danger of crossing boundaries with inmates who are a position for such long periods of time because staff tend to have too much trust in them. Inmate clerks are relied on to complete tasks and do things we do not have time for. Staff refer to this particular inmate as “the go to guy”.

No inmate should be allowed to gain this much power in the correctional environment. This usually means we have no idea what they are doing on the computer or if they are manipulating the system. This leaves vulnerable to unauthorized or illegal activity by inmates.

Recommendation 9
It would be beneficial to review all inmates who have a capability to become an inmate volunteer clerk, and consider not having inmate clerks as volunteers unless a system is designed to accommodate such a practice.

We recommend you consider a time limit for inmates in work assignments to mitigate their power, and balance the boundaries so to speak.

Industries, back complex inmate access (Gate 7, security checkpoint) for jobs, programs, and movement
Finding

The process for determining eligibility for inmate work assignments is accomplished through the Correctional Program Manager (CPM), and Investigation unit based on limited criteria: that being; infraction time span, classification, gang affiliation, and inmate conflict potential in the work area.

This review does NOT include inmates assigned to horticulture or anything other than work assignments in the area behind Gate 7, security checkpoint.
Gate 7 is not a magic end all for determining inmate access; there is the chapel, and other areas which are isolated for staff and volunteers (not behind Gate 7 checkpoint) where a criteria and more personal safety systems should be build into the system.

Recommendation 10
Consider reviewing criteria for life without parole inmates to work various areas, and what activities are necessary in high security areas.

Create a multi-disciplinary team to develop criteria and review LWOP, and dangerous inmates for any job or access to critical locations in the compound; especially if the areas are supervised by one staff or person. The multi-disciplinary team could consist of Security Staff, Counselor, Associate Superintendent, CPM and Investigator. The team should be balanced and have criteria other than infraction history, gang affiliation and conflicts.

If this is a difficult to manage process or the inmates would be unnecessarily limited freedom to accomplish programming necessary for their living environment, then consider placement in a facility that can accommodate those who require more freedom with necessary security precautions.

Visibility/ Safety

Finding

Tower 9 visibility is somewhat limited even with the camera system. There is a building immediately to the side of the Chapel not used for staff, programs or any activity at this time.
Industries areas have some limited visibility.

Recommendation 11

Consider removing that building to allow for a wider view of horticulture and other areas beyond Gate 7.

Continue the process of evaluating the cameras, monitors, and recording devices in the entire industries areas.

Security Audit

Finding

There are areas with tools, keys, computer use by inmates, and numerous other security systems which may not be as compliant as needed.

Recommendation 12

There are other security system issues which may benefit from an outside security audit for not only WSR but the other MCC complexes as well.

Current Change Process

Finding

Instructional Memorandums have gone out regarding operational change in movement and schedule for inmates, training on radio system acquisition and operation.

Follow through on change directives have been lacking by supervisors. Non-custody staff had never been told they would be trained on radio and alarms. This was told to us on 3-2-11, and the memo stated they would be trained by 3-1-11. Custody staff not involved in musters did not know of the training. It may be that they did not read the e-mail sent to staff; however, a better tracking system should be in place.

Operational Updates are e-mailed to staff as they come out. While these are comprehensive updates, it appears staff is very confused in many areas about how operations have changed and specifically going to occur.
It is possible that some staff do not read them because of volume or recognize the importance of the document, or cannot translate how the directions apply to their position responsibilities.

Recommendation 13
While confusion is quite normal during this type of change, especially when all staff are trying to heal and recover from this tragic incident, communication and follow up by supervisors and management is imperative. The paperwork and processes sometimes get in the way of what we need to accomplish.

This would be the perfect opportunity to lighten the supervisors' paperwork and allow management by walk around (MBWA) to field staff questions, train and support them as they manage their routine duties and help make those operational changes necessary.

It does appear the supervisors are spending much time in office rather than being out and on posts throughout facility. Follow-through, monitoring, and staff support should be a priority, especially at this time.

Classification Review – Inmate Scherf
Finding
Summary of Offenses
04-10-1978 - Assault 2nd Degree
05-05-1981 - Rape 1st Degree, Assault 1st Degree
10-06-1995 - Rape 1st Degree, Kidnapping 1st Degree, Unlawful Possession ofFirearm

Abbreviated Classification Chronology:
06-19-97 Initial Classification

Close Custody Designated
Finding

09-30-97 Classification Referral/Administrative Segregation
Inmate Scherf requested protective custody on 09-09-97 based on alleged threats. Committee decided that there was not any verified need for protection. Comment made in risk assessment: "Inmate has demonstrated that he will manipulate staff to get what he wants". Return to G/P

06-12-01 Classification Referral Annual
Information indicates that Inmate Scherf had been admitted to Administrative Segregation at MCC-SOU (Sex Offender Unit) after a "serious suicide attempt wherein he ingested 90 Tylenol tablets. He was determined to be stable and indication of a multidisciplinary mental health evaluation was noted for completion by July 200l. Decision to transfer to WSR, change custody from close to medium with LWOP override.

2001 Comprehensive (Multi-Disciplinary) Mental Health Report

Referral History Completed on 06-07-01
Included section (page 10 of 20) Alerts to Correctional Staff
“Inmate. Scherf has indicated previously that he would have problems with women supervising him while on parole supervision.” It is likely that this sort of difficulty would also present toward women in authority within the prison system.

Classification Policy WDOC 300.380 Effective Date 5-8-02
Section II E page 4,
“Any time there is new information regarding any of the categories in the CHS (Criminal History Summary), or ICD (Initial Custody Designation) scoring factors, or for offenders who have more than 4 years left to serve at the time of initial classification, the assigned counselor/staff will conduct an immediate review to determine if this information results in a change in custody level designation”.

06-18-01
Inmate Scherf transferred to WSR

07-26-01 Risk Management Identification Form Initial Assessment
Sex Offender Level III. Should be considered as such
In section titled, Override
Recommendation: No
Rationale: Inmate(P) is an LWOP case. P has a history of repeated sexual violence that has included threats to the lives of three women. P has serious issues with women and has stated that there would be problems with supervision by female staff.

Classification Policy DOC 300.380 Effective date 5-8-02
Section VI G page 12
The Department will make discretionary decisions regarding the placement and movement of offenders regarding the placement and movement of offenders to lower levels based on the outcome of risk assessments and evaluations for offenders convicted of offenses that can be registered.
Annual Facility Plans, and Classification Referrals were reviewed and it was noted that some were held in absentia, and recommendations were not consistently recorded and/or filed in master file, and were not filed in the master file, some were electronically stored.

When inmates are transferred to MSR, one on one interviews are conducted with the assigned counselor.
Psychological Reports are not a part of the one on one counseling. Facility Risk Management Team (FRMT) reviews was scheduled consistent with one year Initial classification review.

The Classification and Custody Facility Plan Review Policy DOC 300.380, Revision date 8-04-08 is more definitive and explanatory in directing classification procedures and establishes measurable controls for staff compliance.

“Sound corrections programs at all levels of government require a careful balance of community and institutional services that provide a range of effective, humane, and safe options for handling adult offenders. Corrections must provide classification systems for determining placement, degree of supervision, and programming that afford differential controls and services for adult offenders, thus maximizing opportunity for the largest number”.

The Classification process is the system upon which corrections professionals rely upon to evaluate inmates to determine what their needs are, where they can best be appropriately met, assignment of security and custody levels, risk assessments while meeting the requirement to provide public safety. In ensuring that these areas are addressed, a system of supervisory oversight is necessary to monitor staff compliance with directives. The Classification process is designed to be objective but by no means a perfect science.

Recommendation 14

- The review of all LWOPs will prove to be a vital process to enhance overall security of the facility. The aforementioned classification documents, if reviewed and considered in the classification referral process, or establishing different criteria for access within the facility with specific criteria above and beyond the classification process, may have more appropriately managed Inmate Scherf’s supervision level. Consider an enhanced process for inmate access to areas within the compound, and possibly other facilities.

- Validate and combine electronic Inmate Files with hard copy.

- Review all 137 LWOPs using current Classification Policy with added criteria based on hard file risk assessment criteria or revised criteria for work and activity access.

Staff Accountability

Finding

Correctional agencies have the responsibility to operate safe and secure facilities to ensure optimum public safety, safety of staff, contractors, volunteers and visitors who frequent their facilities. It is critical to have accurate accountability for all staff within for daily operations as well as emergency situations.

There currently exists at the Washington State Reformatory (WSR) musters for the day, swing, and graveyard shifts where oncoming staff are accounted for

There is no muster or centralized accounting system for staff assigned to different shifts nor non-custodial staff.

Recommendation 15

- Development of system and policy to accurately account for all staff, contractors and volunteers.

- Ensure that policies are disseminated, training conducted, and monitored for compliance.

Staff Comments

The comments noted made by staff are not all inclusive; however, there may be validity to many of the comments. Some staff preferred not to identify themselves but had comments. No staff displayed resentment while discussing issues with us, they appeared more frustrated than anything. This is also to be expected after an incident such Officer Biendl's death. You may note that some of the issues and concerns have been addressed through our review during the week.

Staff comments based on what they thought may be some security issues or concerns:

- Consider using the ID barcode to track and account for staff while inside the facility.
- Design an accountability process to know staff whereabouts to include all non-custody staff.
- Budget more staff so the units are not left with one officer during main line and peak hours of activity, especially since that is when a lot of staff are out for an hour for meals.
- Remove the glass plates from the microwaves in the units.
- Stop using inmates to repair cameras for yard and have staff doing this task.
- Do not pressure staff to join a joint inmate/staff choir.
- Stop using staff to water plants in the horticulture area. Inmates should be doing this.
- We need more cameras to detect what is going on in single posts and areas of limited visibility. Structure inmates daily activities. Too much movement too often.
- Line custody staff is not briefed on rules and policies that change. Make more time for us to understand.
- Some staff pencil whip logs and forms of importance, complacency.
- Tower 9 computer and monitors go down in the summer when hot, no cooling system installed.
- Inmates know operational changes before we do.
- Industries supervisors have to be in office up to 6 hours a day, that at numerous times has meant no one supervising the work in shops unless the custody officer makes the hourly check.

- The mattress factory behind industries building has trucks come in and park and no one is checking them or logs the driver in and out.
- Another count during the day instead of just start of shift would enable us to know if all inmates are accounted for.
- We don't see the Captain or Lieutenants often enough.
- The Tab shop has three keys for area, if two of the staff is not there and the TAB Shop supervisor needs to get out he cannot. Consider doing something for safety reasons.
- Female industries staff are concerned with cameras and being alone with numerous inmates and the inability to leave office often enough to supervise.
- Searches of industries area are "catch as you can". Never time to do this area in sufficient manner.
- The PAB can have as many as 102 volunteers and inmates at one time with up to 80 in one room. The rooms have not been capacity rated and we would like to see that happen.
- Housing Unit cell searches are supposed to be once every two months; however, this does not occur because of staffing shortages.
- Training is inadequate because they do not accomplish what they should in defensive tactics because they have too many injuries.
- Radio identification for staff is off in the numbering system, they need to correct that.
- Shift Sergeant, Lieutenants, and Captains need to get on same sheet of music. Some want policies followed to the letter, others want us to be flexible, but no one really know which ones are to be taken literally.

We wish to thank all staff for the open dialogue and discussion with us. We truly experienced hospitality form all we met within the Washington Department of Corrections.

End of Report