OFFICE OF FINANCIAL MANAGEMENT

STATE OF WASHINGTON

LOSS PREVENTION REVIEW TEAM

ASSESSMENT OF DEPARTMENT OF CORRECTIONS INCIDENTS INVOLVING SUPERVISED OFFENDERS

REPORT TO THE DIRECTOR OF THE OFFICE OF FINANCIAL MANAGEMENT

JANUARY 2005

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http://www.ofm.wa.gov.rmd/lprt/loss.htm

OFFICE OF FINANCIAL MANAGEMENT
LOSS PREVENTION REVIEW TEAM REPORT

DEPARTMENT OF CORRECTIONS
Offenders Re-offending While on Community Supervision

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Office of Financial Management
Loss Prevention Review Team Report

Assessment of Department of Corrections Incidents Involving Supervised Offenders

SECTION 1 - EXECUTIVE SUMMARY

CONTEXT

Under the Loss Prevention Review program, state agencies report to the Office of Financial Management (OFM) the "death of a person, serious injury to a person, or other substantial loss…alleged or suspected to be caused at least in part by the actions of a state agency" (RCW 43.41.370 (1)). OFM assesses these incidents, and in some cases, a review team is appointed to evaluate the incident to identify risk reduction and elimination strategies the reporting agency may adopt. The Department of Corrections (DOC) reports incidents to OFM, and the OFM Director selected two incidents involving three offenders from 2003 for such a focused, independent review.

THE INCIDENTS

In compliance with RCW 43.41.370 (4), DOC reported two incidents involving three offenders to the Office of Financial Management in January and March of 2003. The offenders were on supervision, and while on supervision, were arrested and charged with murder. The Director of OFM, pursuant to RCW 43.41.370(1), determined that these incidents merited review and appointed a team to conduct the review.

SUMMARY OF CONCLUSIONS

It is the team's basic conclusion that systemic problems were more to blame for the incidents reviewed than any individual acts of corrections employees. Prevention of criminal behavior is a complex task that is the collective responsibility of numerous government organizations, political bodies and persons, including taxpayers. Although responsibility for managing offenders has, in large part, been delegated to DOC, successful assessment and management of offender risk actually requires the participation of all. Agencies such as DOC cannot do this task alone. Any 'system' that wishes to reduce re-offending, or recidivism – and this broad definition of 'system' includes the various social systems that impact the lives of offenders -- must come to grips with this fundamental reality of shared responsibility.

In addition, any system that has as its aim the reduction of harm or loss associated with criminal recidivism must take into account two interlocking components of the task: (a) risk assessment, and (b) risk management. Risks cannot be managed unless they are first identified. Thus, any risk management system is first a risk detection system. Our ability to perform both tasks is limited by how much contemporary science knows about recidivism risk and by the resources available to accomplish them.

Careful review of the two incident cases before the Loss Prevention Review Team (LPRT) identified some serious, but correctable problems in Washington's offender risk assessment/risk management system. The team's conclusions are more fully discussed in the body of this report.

SUMMARY OF RECOMMENDATIONS

1. *Culture Adaptation*: The team recommends that DOC be even more proactive than it currently is in assessing the Offender Accountability Act's (OAA) performance in relation to its stated goals, and requesting needed amendments from the Legislature. (Recommendation 2)

2. *Supervision and Staffing:* The team recommends that DOC closely examine the actual activities of supervisors and staff, and take steps to adjust job descriptions, examine policies and procedures, and follow-through on current employee management and job assignment policies so that the work of the Community Correctional Officers (CCOs) is more closely aligned to the goals of the OAA, providing a greater likelihood of achieving those goals for offenders and the community. (Recommendations 3, 4, 5, 12, 13,14, and 15)

3. *Hearing Process:* The team recommends that certain aspects of the hearing process be critically examined, based on the conclusions reached by the team during these case studies. The critical examination should focus on the ability of the system to respond to offender behavior, the effectiveness of available sanctions, and assessing whether the post-sentencing administration of managing offender violations through hearings within DOC, rather than through the courts, achieves the planned outcomes contemplated when the hearing process was moved under DOC's control. (Recommendations 10 and 11)

4. *Risk Assessment Process:* Evaluate the risk assessment process in terms of whether the risk assessment should also be performed prior to sentencing, and adjust the post-sentencing risk assessment process to include reassessment both periodically and after an obvious change in the offender's circumstance. Based on its work, the team concluded that more effective sentencing would occur if judges had a risk assessment available prior to imposing sentence. (Recommendations 7, 8 and 9)

5. *Information Technology and Other Resources:* Provide CCOs with current technology devices, such as Personal Digital Assistants (PDAs), to offer them critical information while they are still in the field, and the opportunity to enter information about offenders into the system on a real-time basis. Semi-automate assessment tools so that reports are available and can be forwarded to the judge, providing the court with the most up-to-date evaluation. Expand the available ancillary services in rural areas. (Recommendations 1, 6 and 16)

SECTION 2 - REVIEW PROCESS

General Process

OFM selected these incidents for review because they are of a type that DOC reported to OFM on a recurring basis. Review team members, subject matter experts in relevant fields, are asked to analyze the incidents with a focus on causal factors and on preventative measures for DOC to consider for future implementation. As part of the process, the team interviewed DOC employees involved in the incidents and in the programs related to the incident, reviewed documents provided by DOC, and evaluated other relevant records.

This report presents the team's findings and recommendations based on this case study. Using the information provided, agencies receiving a review team report then evaluate the case study conclusions and recommendations, and develop an implementation plan regarding the recommendations, which it provides to the Loss Prevention Review program within 120 days after it receives the report.

The review expressly excluded formulation and expression of opinions on the performance of specific DOC personnel.

Methodology

The Loss Prevention Review Team interviewed DOC employees who were involved with the incidents, DOC managers and supervisors familiar with agency policy and procedure related to the incidents. The team met seven times and reviewed documents provided by DOC at the team's request, as well as other documents researched by the team. Appendix D contains the logs of the interviews and of the documents reviewed by the team.

Prior to report publication, DOC representatives met with OFM after reviewing the conclusions and recommendations. DOC provided comments to the team and additional information. The team then finalized the report, and, pursuant to RCW 43.41.380, the report was delivered to the Director of OFM and made public.

Team Members

Review team members were selected for specific subject-matter expertise. Full biographies appear in Appendix B.

They were:

a) Dayle Crane, Director, Kitsap County District Court Probation Department;

b) Gregg J. Gagliardi, Ph.D., Clinical Associate Professor, the Washington Institute, Western Branch, University of Washington Department of Psychiatry and Behavioral Sciences, Division of Public Behavioral Health & Justice Policy;

c) Michael Olivero, Department of Law and Justice Central Washington University; and

d) Phil Stanley, Corrections Consultant and part-time college instructor in Criminal Justice at Central Washington University.

SECTION 3 - FACTS RELATING TO INCIDENTS UNDER REVIEW

Two incidents were selected for review. One of them involved two offenders who committed the crime together. Therefore, the report addresses three examples of community supervision that ended in recidivism.

DANIEL HAGGARTY AND ANTHONY SHIRIHAMA

INCIDENT THAT OCCURRED WHILE UNDER DOC SUPERVISION

On January 13, 2003, Daniel Haggerty had not been making payments on his legal fees and Woods, his Community Corrections Officer (CCO) threatened to lodge a violation. At this point, the case supervision was only monetary. Woods was informed on January 21, 2003, that Haggerty had been charged with murder.

The Spokane Police Department officers responded to a call on January 19, 2003. A victim was found bleeding in a street. He was transported to a hospital where he later died. Anthony Shirihama and Daniel Haggerty were alleged to have bludgeoned the victim to death with a cane and a bat. He had received a broken arm, broken ribs, and nine major blows to the head.

Following transport of the victim to the hospital, police went to the victim's residence and forced themselves inside where they found and arrested Shirihama and Haggerty. Haggerty and Shirihama were charged with 1st degree murder. Shirihama and Haggerty provided the police with changing stories about what had happened and blamed the other as the principal aggressor and killer. Evidence was found indicating that the victim's wallet was taken and that there was an attempt to clean the blood in the apartment.

CRIMINAL HISTORY

Daniel Haggerty had a criminal history prior to his supervision by the DOC. His conviction (not arrests) record available through court documents to the community correctional officer included the following:

Convictions	Sentencing Date
Assault 3	08/14/1997
Malicious Mischief 2	09/08/1993
Taking Motor Vehicle Without Owner's Permission (TMVWOP)	04/30/1992
DWI	04/30/1992

SUPERVISION BY THE DEPARTMENT OF CORRECTIONS

Initial Sentencing: Daniel Haggerty came under the supervision of DOC subsequent to convictions for 2nd degree burglary and 3rd degree malicious mischief. On January 29, 1999, Haggerty pled guilty to 2nd degree burglary. The prosecutor agreed to recommend the low end of the standard sentencing range of four months, amended a charge of residential burglary to 2nd degree burglary, and dismissed a 4th degree assault and a 3rd degree malicious mischief charge. There was no pre-sentence investigation and the reason for this is not provided. He was sentenced to 12 months confinement at Geiger Correctional Center and ordered to pay legal financial obligations.

Supervision After Release: After release, he was to report to CCO Bruce Woods monthly in person, within the first three working days, or as directed. The conditions, requirements, and instructions form signed by Haggerty and Woods included a restraining order, participation in an alcohol program at Geiger Corrections Center, no use or possession of any non-prescribed controlled substances to be monitored by an agency approved at the discretion of the community correctional officer, and payment of his legal fees.

Additional Conviction and Sentence: Haggerty also pled guilty to 3rd degree malicious mischief on September 1, 1999, and was ordered into confinement for 12 months, to run consecutively with the conviction for 2nd degree burglary. In relation to this offense, he was ordered to enroll in some type of 12-step program such as Alcoholics Anonymous following his release from confinement, and he was to participate in drug/alcohol programs at Geiger Correctional Center. Following release he was also to submit to an alcohol/drug evaluation and be subject to additional treatment if the evaluation indicated that it was necessary.

SUPERVISION HISTORY

Woods assessed Haggerty using the LSI-R[1] and gave him a risk management classification as well. CCO Woods repeatedly assessed Haggerty using the LSI-R (the LSI-R scoring sheets were not made available to the LPRT). The following table shows the LSI-R assessments:

[1]The Level of Services Inventory-Revised (LSI-R) is a quantitative survey of attributes of offenders and their situations relevant to level of supervision and treatment decisions. Designed for ages 16 and older, the LSI-R inventory is designed to predict parole outcome, success in correctional halfway houses, institutional misconducts, and recidivism. The Washington State Institute for Public Policy (WSIPP) is presently conducting an empirical validation study of the LSI-R with Washington offenders as part of a larger study of the impact of the Offender Accountability Act that is mandated by RCW 72.09.610. (See WSIPP document number 03-12-1202.)

Date	Results
September 30, 1999	Woods reassessed Haggerty with the LSI-R. There is nothing in the record about a previous LSI-R. His percent chance to re-offend was 48.1.
October 12, 1999	Woods reassessed Haggerty with the LSI-R with the same results as previous.
May 2, 2000	Another LSI-R was performed by Woods with identical results as before.
June 21, 2001	Haggerty's risk management classification was completed and he was rated RM-C[2].

Several issues of importance distinguished Haggerty's supervision history, including: substance abuse or dependence and a failure to get into treatment and to maintain sobriety, ongoing criminal conduct, and a failure to abide by supervision requirements.

SUBSTANCE DEPENDENCE HISTORY

Throughout his period of supervision, CCO Woods attempted to get Haggerty treatment for substance abuse and dependence.

September 12, 1997 - Haggerty completed an intake with CCO Woods. Haggerty had an extensive criminal history and suggested that his conduct was the result of alcohol abuse. He claimed, "…at the time of sentencing he told the judge that he was an alcoholic. The condition imposed was 'not consume alcohol to excess, subject to monitoring for alcohol abuse.'" There is nothing in the written court documents that suggests that this was a condition imposed by the judge. The conditions imposed by the court are cited above.

Apparently, Woods took this assessment of Haggerty's needs on faith.

December 16, 1997 - Haggerty was arrested for two 4th degree assault charges. The victims were family members. Woods reported that Haggerty had been drinking at the time of the incident. However, this was not a violation because of what the judge asserted about drinking to excess. Woods wrote, "I requested a copy of the police report. If reports reveal he drank to 'excess' then a viol."

Woods repeatedly attempted to have Haggerty in treatment and to address his substance abuse issues.

[2] Risk management classification is the designated risk level for recidivism assigned as a result of completing the LSI-R. The scale identifies A as the highest risk, and D being the lowest risk for re-offending.

February 12, 1998 - Woods met with Haggerty in jail. Haggerty said that he was required to get an alcohol evaluation as the result of the assault charges. He admitted to being an alcoholic, but had not committed to treatment.

June 11, 1998 - Haggerty was placed in jail as the result of a warrant requested by Woods. Haggerty agreed to go to treatment for alcoholism, but had not "reached the point where he was fully committed to stop." He was directed to contact The Alternative to Street Crimes (TASC) if he wanted inpatient treatment.

August 13, 1998 - Haggerty was released from Geiger.

August 14, 1998 - Haggerty reported to Woods. Woods called and scheduled an appointment for Haggerty at TASC while Haggerty was in his office. He was scheduled for an intake on September 21, 1998.

October 12, 1998 - The record suggests that Haggerty went to his intake and was complying with treatment recommendations. It stated that he was submitting urine checks to TASC and had not been drinking.

October 26, 1998 - Haggerty was placed back in Greiger for failing to get treatment in a timely manner related to the assault charges.

December 10, 1998 - Haggerty was apparently out of jail. He told Woods that he was applying for the Alcohol and Drug Abuse Treatment and Support Act (ADATSA) funding in an effort to get outpatient treatment.

December 21, 1998 - Hearing scheduled on compliance with the assault charges conditions.

January 5, 1999 - Haggerty reported to Woods and said that he had an evaluation with ADN and applied for ADATSA funding.

April 17, 2000 -TASC reported that Haggerty had completed IOP and recommended AA/NA aftercare with a sponsor.

August 3, 2000 - Haggerty reported again and said that he had a sponsor.

October 5, 2000 - Haggerty was instructed by Woods to participate in AA/NA and to connect with a sponsor.

October 20, 2000 – Haggerty was instructed to do the same thing.

January 12, 2001 - Haggerty was released from jail and reported to Woods. He was directed to contact Interim Detox Services for treatment.

August 10, 2001 - Haggerty was arrested for unlawful imprisonment and had been consuming alcohol.

April 1, 2002 - Woods met with Haggerty and he agreed that he needed inpatient treatment.

June 10, 2002 - Haggerty reported that he had an appointment with ADN/HAS.

CRIMINAL CONDUCT

Haggerty was returned to jail or Geiger Correctional Center for several other offenses, many of which were alcohol related. It should be noted that Haggerty repeatedly was released from jail and CCO Woods would not find out about it until he committed another crime.

Haggerty was supervised for monetary obligations to his victim, which affected the level of supervision he received. During that time frame, Haggerty's criminal arrests included:

October 13, 2000 - arrested for stealing a truck and pleaded guilty to taking a motor vehicle without the permission of the owner. He was convicted and sentenced to three months confinement and to pay various costs.

November 2, 1997 - in jail for two misdemeanor assault charges.

March 12, 1998 - Woods was contacted by the Washington State Patrol indicating that Haggerty had been arrested on February 14, 1998, for taking a motor vehicle without permission.

June 16, 1998 - Woods also reports that Haggerty had disorderly conduct charges.

July 20, 1998 - The Washington State Patrol informed Woods that Haggerty was arrested for 2nd degree burglary on May 26, 1998.

March 11, 1999 – The Washington State Patrol reported that Haggerty was arrested for 3rd degree malicious mischief on January 15, 1999.

September 1, 1999 - Woods was contacted by the Washington State Patrol who said that Haggerty had been arrested on June 27,1999, for residential burglary.

December 6, 2000 - Woods found that Haggerty had been arrested on October 14, 2000, for TMVWOP in Benton County.

April 4, 2001 - Haggerty was arrested for a misdemeanor theft warrant.

August 10, 2001 - arrested for unlawful imprisonment and had been consuming alcohol.

February 19, 2002 - Woods found that Haggerty had been arrested on January 18, 2002 for 2nd degree assault and unlawful imprisonment.

Haggerty demonstrated evidence of troublesome adjustment to the community, as reflected by the following incidents. The level of response available to DOC is limited as well, despite the repeated number of sanctioned actions by the offender.

November 4, 1997 - Haggerty turned himself in at the jail for a warrant issued for failure to provide a blood test.

December 19, 1997 - Woods requested warrants for failure to report and to pay legal fees and on January 13, 1998, CCO Douglas reported that Haggerty was at Geiger WR with an unknown release date.

March 4, 1998 - Haggerty was in jail and agreed to serve 90 days on the violations and to report to Woods upon release.

June 11, 1998 - Haggerty was arrested on a warrant requested by Woods and an FTC for the two 4th degree assault charges. Haggerty agreed to serve 120 days for his supervision violations.

December 19, 2000 - Haggerty was brought to Spokane County jail where he agreed to serve 45 days for violating his supervision requirements.

April 4, 2001 - Haggerty was arrested for violation of his supervision requirements probation violation and a misdemeanor theft warrant. He agreed to serve 90 days.

April 1, 2002 - Woods met with Haggerty in jail and agreed to serve 60 days in jail for violation of his supervision requirements.

ANTHONY SHIRIHAMA

CRIMINAL HISTORY PRIOR TO DEPARTMENT OF CORRECTIONS SUPERVISION

Anthony Shirihama had a criminal history previous to his supervision by DOC. His conviction (not arrests) record available to the community correctional officer through court documents included the following:

Convictions	Sentencing Date
Assault 2	02/04/1987
TMVWOP	06/30/1986

SUPERVISION BY THE DEPARTMENT OF CORRECTIONS

Anthony Shirihama was charged with, and subsequently convicted on May 13, 2002, of 2nd degree assault and 1st degree malicious mischief. According to an officer from the

Spokane Police Department, he had gone through his neighbor's house, broken out all the windows, busted up doors and chased the homeowner around.

He was sentenced to less than a year in jail and to serve three months in confinement for each offense, to be served concurrently. He was to pay legal fees and was restrained from having contact with the victim. In addition, he was to serve 12 months in community custody with the DOC. There is nothing in court documents about substance dependence or abuse. A pre-sentence investigation was not performed.

Supervision History

On May 20, 2002, Shirihama reported to the DOC as directed and completed an offender report. He was instructed to contact the DOC in three weeks and did so.

An assessment by CCO Kinner on June 13, 2002, using the LSI-R concluded that his chance to re-offend was 76 percent with a Risk Management Classification of RM-A. CCO Schilling's assessment on June 13, 2002, with the LSI-R concluded that he had a 77 percent chance to re-offend. However, Schilling reported that Shirihama's Risk Management Classification was RM-D, rather than RM-A[3].

Shirihama reported on October 7, 2002, that he had obtained a chemical dependency evaluation and was on a waiting list for outpatient treatment. CCO Schilling encouraged Shirihama to attend AA meetings and to break ties with drinking/drugging associates. He remained on the waiting list and was directed to provide releases so that Schilling could speak with treatment providers. On December 4, 2002, Schilling reported that Shirihama was still not in treatment and had not signed releases so he was unable to confirm "if he is scamming me or still on the wait list as he claims."

Throughout his supervision his KIOSK Reporting Sessions Status was successful. During his supervision, Schilling counseled Shirihama on staying away from the victim, criminal peers, and familial relations. Shirihama was arrested on January 19, 2003, for 1st degree murder with Haggerty as described above.

Daniel Mario Rodriguez

Incident That Occurred While Under DOC Supervision

Daniel Rodriguez was arrested and charged with 1st degree murder for the death of Armando Perea on March 29, 2003.

[3] DOC informed the team that the CCO became aware of the error and corrected it in the system the same day. However, the existing computer technology precludes erasure of entries once entered, and therefore, the team could not tell from its records when the error was detected.

CRIMINAL HISTORY PRIOR TO DEPARTMENT OF CORRECTIONS SUPERVISION

Daniel Rodriguez had a criminal history prior to his supervision by DOC. His conviction (not arrests) record available through court documents to the community correctional officer included the following:

Convictions	Sentencing Date
Residential Burglary	10/16/1997
Second Degree Burglary	10/16/1997
VM/D Cont Substance	04/29/1998
Residential Burglary	02/19/1998
Residential Burglary	01/20/1999

SUPERVISION BY THE DEPARTMENT OF CORRECTIONS

Rodriguez was convicted of 2nd degree unlawful possession of a firearm on January 3, 2000. He was sentenced to six months confinement and 12 months community supervision with DOC. He was to pay legal fees, report to the DOC within 24 hours of release, not to possess any controlled substances, and to report to the DOC for urinalysis.

January 17, 2002 - he was convicted of 2nd degree possession of stolen property. He was sentenced to six months confinement and 12 months community supervision with the DOC. He was to pay legal fees and have no contact with victims. The boxes were checked on the Community Custody Order for abstinence from alcohol, no possession of a controlled substance, report for a urinalysis and not drive without insurance or a license and they were marked out and initialed by the judge apparently withdrawing them.

August 2, 2002 - Rodriguez was convicted of 3rd degree assault. He was sentenced to four months confinement and 12 months community supervision with the DOC and to pay legal fees.

No pre-sentence investigation was performed.

SUPERVISION HISTORY

Rodriguez reported to DOC and CCO Mungia on January 28, 2000. He was assessed with the LSI-R and scored a 48.1 percent chance to re-offend (the LS-R scoring sheets were not made available to the CCO). He told Mungia that he had an extensive juvenile record, had been punished 30 times at Maple Lane (the juvenile institutional record was not available), had an 8th grade education, no income, came from an abusive household, had no pro-social friends, had a drug problem and preferred marijuana, and

displayed an attitude about not caring about going to jail. He was directed to sign up with the ABC program, to report monthly, submit random urine analysis and attend AA/NA as deemed necessary.

May 18, 2000 - CCO Elder asked for a warrant for failing to report, failure to change address, failure to pay financial obligations.

July 10, 2000 - CCO Elder reassessed with the LSI-R and gave Rodriguez a 57.3 percent chance to re-offend. He performed the LSI-R again on July 31, 2000, to reflect changes. The instrument provided identical results.

August 28, 2000 - Rodriguez was arrested on the warrant and for failing to obey a police officer. He agreed to serve 20 days in jail.

September 12, 2000 - Elder reminded Rodriguez to report within 24 hours of his release. He was released and failed to report on September 13, 2000, and disappeared. Elder went looking for him and could not find him. On September 19, 2000, Elder asked for a warrant for failure to report, pay and report his change of address.

December 6, 2000 - Elder met with Rodriguez in jail and told him to report within 24 hours of release. Rodriguez agreed to serve 40 days in jail.

January 25, 2001 - Elder reassessed with the LSI-R and Rodriquez scored a 76 percent chance to re-offend. His risk management classification was completed and set at RM-B.

February 9, 2001 - Rodriguez was released from jail and failed to report. Elder asked for a warrant on February 14, 2001, for failure to report.

October 1, 2001 - Rodriguez was in jail for the warrant, as well as a charge of residential burglary and MIP. He agreed to serve 60 days and to report within 24 hours of his release. He was released from jail on December 6, 2001, and failed to report.

December 12, 2001 - Elder went searching for Rodriguez and could not find him. Elder asked for a warrant.

December 31, 2001 - Rodriguez was in jail for the warrant, as well as MIP and stolen property.

January 2, 2002 - Elder met with Rodriguez and directed him to meet with him 24 hours after release.

January 3, 2001 - Elder met with Rodriguez again and he would not agree to serve time without a hearing on the failures to comply. He also admitted that he had problems with alcohol and crack and wanted to get treatment.

January 30, 2001 – Rodriguez pleaded guilty to the failures to comply and received 80 days in jail.

April 13, 2002 - Rodriguez got out of jail and reported on April 15, 2002.

May 7, 2002 - Rodriguez reported as expected, but would not produce a urine specimen. He left the building saying that he was going for a soft drink and never returned. He then disappeared and Elder searched for him.

May 23, 2002 - Elder had warrants initiated.

June 11, 2002 - Rodriguez was arrested on warrants and 3rd degree assault on a police officer.

June 14, 2002 - Rodriguez agreed to serve 120 days in jail for failures to comply. This is an exception to the sanctions permitted to DOC by law and was imposed by the courts.

September 26, 2002 - Rodriguez reported as expected following release from jail. Rodriguez explained his living situation and admitted to being a gang member. He was directed to report in again on October 15, 2002.

October 15, 2002 – Rodriguez reported as required. He had an injured hand from a fight and denied any drug use. He provided a urine sample with negative results.

November 5, 2002 – Rodriguez reported as expected and his urine was positive for methamphetamine. He disappeared again and Elder searched for him. Elder secured another warrant and Rodriguez was arrested on January 2, 2003, for failures to comply.

January 7, 2003 - Rodriguez agreed to serve 30 days. He also received jail time for other issues and received a total of 150 days in jail.

March 28, 2003 - Rodriguez was released from jail.

March 29, 2003 – Rodriguez got into an altercation at a convenience store. He shot two people, killing one instantly and wounding the other. According to the information contained in the CCO's file, the incident might have been gang related.

March 31, 2003 - Rodriguez was arrested and charged with 1st degree murder and was later convicted for the offense.

SECTION 4 – ASSESSMENT AND ANALYSIS

BRIEF AGENCY HISTORY

The Department of Corrections came into existence in 1981 after having been a sub-agency within the Department of Social and Health Services. There had been riots and criticism of management of prisons in the late 1970s. For example, the Washington State Penitentiary in Walla Walla was reputed to be liberally run, with inmates having influence over its operation. There was an outcry about the "inmates running the prisons." As a separate agency, DOC received specific funding and throughout the 1980s and 1990s there was a building boom to house a growing number of prisoners. This additional population was driven by various "get tough" measures primarily in the form of sentencing reform.

In 1984, the Sentencing Reform Act did away with the Parole Board and for a brief time there was no post-release supervision ordered for sentenced felons. This reflected the then-prevailing theory that "if you do the crime, you do the time." After 1984, the Legislature gradually brought back post-release supervision for specific crimes, to the point where, at the present time, most prison-bound felons receive some type of post-release supervision. The supervision of these offenders, coupled with community custody supervision is labeled "community supervision." The Probation and Parole Officer staff providing the supervision of these offenders were renamed CCOs.

During most of the 1980s and 1990s, the "get tough" approach to sentencing was financed by healthy state revenues also used to build additional prisons and supervise larger number of offenders in the community. At the end of the 1990s, state revenues began to dwindle and new approaches were needed.

A national trend to deal with the "harm done" to the community by offenders resulted in various approaches, usually called restorative justice, reparation, or community justice. The Washington State version, the Offender Accountability Act (OAA), was passed in 1999 and became effective July 1, 2000. This legislation created a risk based model for addressing offender supervision, which includes community outreach and engaging the offender in restoring justice and requiring restoration for the harm done to the community.

As a result of this legislation, DOC was significantly reorganized, with increasing emphasis on supervision strategies for offenders in the community. A risk management tool, the LSI, was introduced to encourage supervision for the "riskiest" offenders. Other offenders not deemed to be a high risk were then managed administratively, for the most part. This reprioritization of CCO effort was done in recognition that the DOC did not receive substantial additional resources in the budget to implement the OAA.

CCOs were both encouraged and trained to do more outreach with the community, working with the police, treatment agencies and community groups to provide a "combined" effort to reintegrate the offender back into the community. The model for

this outreach had been pioneered in Washington in the “cop shops” in Spokane. This was the approach to case management being used at the time of these offenses and is still the approach today.

SENTENCING REFORM

Prior to 1984, community supervision for both probationers and parolees was fairly traditional. A probationer was a felon sentenced by a Superior Court to a period of probation supervision. A parolee was a felon sentenced by the Superior Court to prison, who served prison time, and parole supervision after release from prison was under the jurisdiction of the Board of Prison Terms and Parole.

With the advent of the Sentencing Reform Act, and subsequent revisions, periods of supervision and conditions of supervision have been legislatively mandated, rather than under the control of Superior Court judges and Parole Board members. The array of sentence structures has consistently been criticized by CCOs as difficult to decipher and manage within high caseloads. Since 1984, the Legislature has repeatedly added community supervision requirements to criminal statutes, resulting in a confusing number of implementation dates, jurisdictional dates, and supervision responsibilities. CCOs clearly describe the frustration of determining how each offender should be supervised based on varying sentence requirements.

The original intent of sentencing reform was to standardize sentencing and remove discretion from the hands of judges and parole board members due to perceived inconsistency. It was felt that this would be a fairer system. However, the constant tinkering with the sentence types and conditions have led to new questions of fairness and consistency. For example, there have been 35 changes in the standards since the first SRA was instituted in 1984.

The law requires courts to sentence offenders based on the statute in effect at the time of sentencing. This means that a confusing system of sentencing standards exist, since an offender may be supervised under more than one standard if more than one offense occurred, and it is difficult for CCOs to track which standards apply to their supervisees. Since it is unlikely that the sentence structures will be revised in the interest of simplifying the supervision parameters, it is essential that DOC develop extensive information for community correction staff about the types of sentences and the differences so that CCOs can be both knowledgeable and effective.

> ***Recommendation 1*:**
> *Make the type and terms of the offender’s sentence readily available to CCOs so that there is no confusion or ambiguity in the CCOs mind about what the offender is required to do.*

RESTORATIVE JUSTICE

As noted above, Washington State, through passage of the Offender Accountability Act, has joined the national trend of states that want their offenders to recognize the harm

they have done to the community. Taken to its ideal state, the community would actively engage the offender and the offender would, in some manner, repay the community for his/her transgression (the original crime). This was the original intent of the "accountability" aspect of the law. The ideal is difficult to achieve.

In many ways, supervision of offenders has not changed a great deal since the days of traditional probation and parole supervision. It remains basically the interaction between the CCO and the offender. The CCO needs to employ verbal coercion, persuasion, counseling, and other forms of influence to affect offender behavior. The law enforcement aspect of a CCOs role has been better realized through an improvement in the level of interaction with local law enforcement in most communities. But, the connection with the community "structure" has been more elusive. Community leaders are reluctant to consider reintegration of offenders as a high priority. Until significant changes can be made in this equation, supervision will still be primarily the business of CCOs and police to hold offenders "accountable" within the community.

DOC CULTURE AND STRUCTURE

Structure of the Agency: For most of the past twenty-five years, DOC has been structured much like most states corrections agencies across the country. That meant that a central office directed operations, dividing operational staff into a community corrections division and a division of prisons. Since 1997, DOC was reorganized to have just one operational division, the Office of Correctional Operations (there is also an Administrative division).

Of additional note, DOC staff have benefited from having stable leadership, with only three Secretaries of Corrections over its 24-year history. Compared with a national average of changes of directors every 2.5 years, this stability has provided a dependable organizational structure for staff to operate within.

Under this organization, prisons and community corrections were administered within five regions covering the state. It was felt that the divisional barriers between prisons and community corrections impeded the flow of communication and cooperation within DOC. The offender was viewed as the constant objective to be managed by prisons or community corrections, depending on sentence severity and treatment or supervision needs. The hope was that with improved communication the offender would benefit from more consistent intervention.

It is difficult, at this time, to assess whether the "barriers" have broken down. To some extent, community corrections staff and prison staff still feel that they are working opposite sides of the street. Some of this will always be true, since many of the offenders under DOC never go into a prison. The LPRT did not find that the organizational structure of DOC was a factor in these incidents.

> ***Recommendation:***
> *There is no recommendation for organizational change at this time.*

Culture of the Agency: The internal culture of DOC has been relatively stable for long stretches of time because of the longevity of the leadership tenure. Mirroring this, correctional staff are primarily committed to their work as a career, rather than as something to do until something better develops. As with any large bureaucracy, there are periods of instability or uncertainty about agency mission, but the upper level stability has ameliorated most significant issues.

At the same time, there is a realization that corrections is a stressful career. Most DOC staff feel that they work in an environment that they understand, but they feel the general public misunderstands their work. Correction's approaches to the management of offenders can be difficult to communicate to the public, leading to suspicion or simply to lack of information. One example of this is the public's lack of knowledge about the OAA.

DOC needs to continue its efforts to assess the various impacts of the OAA[4]. In presenting its account of the OAA to the public, as much practical research should be used as possible.

> ***Recommendation 2:***
> *DOC should continue its efforts to study how well the OAA is meeting its intended social goals and use the empirical outcome feedback to inform legislative changes that can keep the OAA on target and further refine it. This requires identifying key performance indicators for purposes of an evidence-based assessment.*

STAFF SUPERVISION

Within community corrections, the ratio of staff supervised by each supervisor is approximately one supervisor per 8 to 12 staff. Due to geography and distance, there can be variation of this ratio. As the LRPT talked to staff involved in these incidents, there was no direct criticism of supervisors by line officers. However, it was clear that the data or computer input function of an officer's workday was the primary criteria by which a supervisor managed their staff. The emphasis on data input is frustrating to most officers. They spoke about wanting to be in the community to a more extensive degree providing supervision, but the data input requirements precluded that.

Supervisors also felt that they were required to monitor the computer data input function of their officers as the primary tool for evaluation. There was no indication that line officers and supervisors spent significant time in case conferences regarding strategies to impact individual offenders. The LRPT felt that this is a significant dynamic that requires more discussion and change. The supervisor should be auditing cases and participating in case conferences as much as possible, and while this is a requirement in the Supervisor Manual, the team did not see any evidence of it occurring.

[4] The Legislature funded an evaluation of OAA by the Institute for Public Policy, and two reports have been published. There is no data yet on recidivism. This recommendation is directed toward a need for internal review and self-assessment.

While interviewing staff, there was reference made to a case approach that involved "peer coaching", which is a more recent aspect of the program since these incidents occurred. During interviews, staff referenced the concept of discussing cases with peers. While that type of case conference can be helpful, the supervisor is the voice of experience that should be leading these groups. More support for staff is needed in addition to this approach. The supervisors interviewed were very supportive of their staff, commenting on the liability concerns of supervising dangerous offenders.

> ***Recommendation 3:***
> *DOC needs to audit supervisor compliance with the Supervisor Manual standards, and institute changes to support supervisors in performing the case audits, and implementing the other aspects of CCO support envisioned by the manual's standards.*

CCOs Work Environment

Even with the utilization of a risk management tool such as the LSI, line officers are increasingly concerned with liability. As they have seen fellow officers sued, their general approach has grown more conservative. Yet, some of the traditional tools for offender management have continued to be restricted[5].

The interviews with officers indicated that the fear of liability prevents the creation of a strong foundation for officer effectiveness in the management of offenders. The team's interviews identified that officer's caseloads do not typically permit them to have more than 20 minutes to an hour of contact with each high-risk offender each month. DOC 2002 data and procedure indicates that the workload system in place gave two hours a month for a high-risk offender. Further, each of the offenders in the reviewed incidents had similar levels of risk assessment, but were supervised at different levels as a result in part of the actual workload time available to the CCO.

This leaves the offender with many hours to engage in negative behavior. The belief that an officer having an offender under supervision provides the community all the safety it requires is naïve at best. Even though this is a stressful work environment, line officers appear willing to meet the challenge, but there is hope they can be provided additional tools to maximize their effectiveness. The CCOs expressed that, and the team agrees, lifting the threat of tort action to them as individuals would go a long way toward improving the environment.

[5] There was significant comment to the LPRT about the Offender Accountability Act hearing process, which will be discussed later. In general, officers feel that this hearing process does not support them when they feel that an offender poses community risk. At the same time, some of the treatment options in the community are difficult to access. Admitting offenders to mental health services and substance abuse treatment can be difficult. Offenders have few financial resources and these services typically admit those who have the resources over those who don't. These services are often operating over capacity and offenders can be difficult clients.

Sharing of responsibility for case decisions and case planning would lessen the overwhelming responsibility and concern for "liability" that the CCOs have. Team supervision efforts should be encouraged and responsibility for cases when there is an extended absence should be outlined in policy and supported by staffing resources. In the Anthony Shirahama case, it was evident to the LPRT that the CCOs were supervising this individual effectively, but, at a crucial juncture when Shirahama needed intervention, the CCOs were attending to family issues and were absent from the job. There was no system for "backup." DOC administratively has systems designed to provide backup, contained in the Supervisor Manual. In this instance, the CCO relayed to the team that no backup was available. This issue requires more discussion internally so that cases of high risk get the consistent attention required.

> ***Recommendation 4:***
> *Encourage team supervision efforts, and identify a standard process to use when a CCO is absent for an extended period of time, to ensure that supervision of offenders continues. This also relates to the need to reinforce supervisor activity that conforms to the Supervisor Manual.*

One suggestion that the LPRT heard consistently was that staff resources should be reprioritized. Because LPRT did not survey a statistically significant segment of the staff, the team believes there is more evaluation needed by DOC to validate this. However, this view was uniformly expressed, and the team bases its recommendation on that.

There is a sense that the basic mission of the department, providing protection to the community, is diluted by a number of "specialists" providing ancillary services. As examples, the team identified safety program specialists, community involvement specialists, risk management specialists involved in transition planning. DOC advised the team that as of January 1, 2005, transition-planning specialists will handle caseloads. Otherwise, these specialists don't carry caseloads but there was a sense that some of them could be pressed into case supervision activities to reduce the burden on the current CCOs. Given the burdens carried by CCOs, more effective supervision may be possible with smaller caseloads. This issue should be discussed at more length internally so that even if there is no reassignment of staff, at least the line staff have a better understanding of the role of specialists.

> ***Recommendation 5:***
> *Establish a series of mandatory internal workshops that discuss the "basics" of corrections under the OAA. The focus should include providing staff with a better understanding of the available DOC resources and the priorities of allocation of resources. One outcome would include developing plans for reprioritizing deployment of staff that includes a method of providing backup or team supervision to avoid supervision gaps. Overall, this should lead to better understanding by all staff of the finite resources of DOC staff. This could also lead to concrete suggestions for reprioritizing deployment of staff.*

PROBATION SUPERVISION TOOLS AND SERVICES

The OAA was implemented in 2000 to provide a method for individual planning for offenders. This act was to allow officers to impact an offender's sentence with conditions that would both address the offender's needs *and* provide the greatest protection to the community. Unfortunately, community support services available to offenders are not equal across the state. What is available in the larger, metropolitan areas (primarily western Washington) is not available in the smaller or rural areas (primarily eastern Washington). CCO's working in smaller areas have fewer community resources to offer their offenders and might be less likely to meet the offender's needs and affect the offenders recidivism.

> ***Recommendation 6:***
> *DOC should consider developing additional regional treatment services to provide more opportunities for offenders in smaller rural communities.*

Along with OAA, a risk assessment system was implemented, the LSI-R. While the tool existed prior to the OAA, DOC was not using it until the advent of the OAA. Specific scores are referenced in the statute in relation to the tool. When the DOC staff was interviewed two issues seemed clear: (1) this instrument takes significant time to administer and score, and (2) once the LSI-R is completed, it is only used internally because it is completed after the sentencing. The court never has the benefit of highly detailed information about the offender's potential risk to the community and their behavioral needs. This is not a problem caused by DOC, but impairs the agency's ability to most effectively use the tool.

Table 1 summarizes the risk assessment data for the three cases presented to the LPRT (DOC was unable to provide complete data for case 3). Ten of the eleven risk areas identified by the LSI-R[6] are presented along with:

(a) Whether the assessment identified a need for intervention,
(b) Whether that risk was addressed in the judge's judgment and sentence (J&S), and
(c) Whether that risk was a target for intervention in the offender's Offender Accountability Plan (OAP).

[6] DOC's Offender Accountability Plans do not include one LSI-R risk-needs score based on the offender's school history.

Pound signs (#) designate risk areas that DOC identified for intervention in the OAP.

	Case 1 Rodriguez			Case 2 Shirihama			Case 3[3] Haggerty		
LSI-R Risk Factor	Need	Targeted?		Need	Targeted?		Need	Targeted?	
		J&S[1]	OAP		J&S	OAP		J&S[2]	OAP
Criminal history	N/a			N/a					
Education/employment	High			High					
Financial	Med			Med					
Family/marital	High			High					
Accommodation	High			High					
Leisure/recreation	High			High					
Companions	High			High		#			
Alcohol/drugs	High		#	High		#			
Emotional/personal	N/a			High					
Attitudes/orientation	High			High					
LSI-R Total Score	44			43			31		

[1] “No sentence conditions found for this sentence” (p. 5, OAP)
[2] “No supervision ordered/monetary supervision only” (p. 1, conditions, requirement and instructions)
[3] LSI-R data was not provided to LPRT

As can be seen from inspection of the table, seven high-risk areas were identified for case 1 and eight for case 2. Yet, *these risks were not addressed as a supervision condition by the judge* in the judgment and sentence (J&S). Because of the differing standards in effect at the time of sentencing, the judge may not have had the ability to impose such conditions.

Only one risk was targeted for intervention in the OAP for case 1 (i.e., only 1 out of 7 risk needs) and only two areas of risk were targeted for case 2 (i.e., 2 out of 8 risk needs). In both cases, the total LSI-R score was extremely high (44 and 43). Under DOC Policy Directive 320.410, LSI-R scores of 41 or higher are considered evidence of high risk to re-offend, resulting in a risk management classification level of RM-A or at least RM-B. According to the Canadian test norms tabled in DOC’s “Offender Management Overview” (p. 16), these two offenders had a 76 percent or higher risk to re-offend.

The possible reasons that so few of the identified risk areas were addressed are worth considering. First, these risk findings were obtained <u>after</u> sentencing and, hence, they could not have been available to the prosecuting attorney during pre-trial negotiations (i.e., plea bargaining) or for the judge at the time of sentencing. For example, had they been made available earlier, it is possible that the judge could have targeted some of them as conditions of supervision. Indeed, given the magnitude of the LSI-R total scores, it is possible that the prosecuting attorney may have argued for a sentence at the high end of the range, or even for an exceptional sentence. The judge could have taken these scores into account in considering an exceptional sentence (see RCW 9.94A.390). Had the judge been able to order supervision conditions to address these areas of risk, this would have given DOC the authority necessary to provide

additional supervision of these offenders. The standards did not permit longer sentences or more comprehensive supervision that may have prevented two homicides.

> ***Recommendation 7:***
> *Risk assessments need to be completed prior to sentencing so that the court can receive the benefit of the important information gathered in the process for use in determining appropriate sentencing conditions.*

Although LSI-Rs were originally to be re-administered on a regular schedule in the community to stay abreast of changes in risk (with additional event-driven administrations completed at the discretion of the CCO), more recently DOC has adopted a practice of limiting re-administrations to times when some significant event has occurred (e.g., failure to comply with a term of supervision). According to DOC personnel interviewed by the LPRT, this decision may have been motivated to conserve time and costs associated with repeat LSI-R administrations.

However, re-administering the LSI-R contingent on an offender's action assesses risk too late. It also leaves the impression that reassessment serves mainly as a post-hoc justification of the CCOs actions, or as a way to "cleanse the record" after the fact to give others an impression that responsible action was taken. Reinstituting the original vision of LSI-R use, where the tool is administered both on a regularly scheduled basis, as well as when events occur indicating a change would be the most efficacious procedure.

The process of reassessment needs to be sensitive to both reductions as well as increases in offender risk to be effective and efficient. Offenders who are showing by their behavior that they are making pro-social changes should be supervised less frequently, allowing the CCO to reallocate their time by focusing relatively more on those offenders who are struggling to adjust to the community.

> ***Recommendation 8:***
> *In addition to event-triggered reassessment, risk reassessments need to be done on a periodic basis according to the offender's current needs and level of risk.*

The LSI-R contains items and scales that are sensitive to risks that are both unchanging (static risk factors) and those that fluctuate over time and conditions (dynamic risk factors). Reassessments therefore involve attending mainly to dynamic factors, which compromise a smaller subset of LSI-R items and scales.

It would not be difficult to develop a set of brief dynamic risk factor scales from the LSI-R that would permit the CCOs to constantly monitor changes in offender dynamic risk while under supervision. The team is aware that DOC is seeking federal funding to develop a practical set of dynamic risk scales that CCOs can use in the field in the course of performing their normal duties, and supports this as a way of identifying predictor behaviors, on the premise that many crimes occur close in time to when they are conceived by the offender. The Bureau of Justice Assistance recently expressed

interest in funding research of this type at the meeting of the Association of State Correctional Administrators/Corrections Technology Association in Chicago, May 2-5, 2004. This is a grant DOC is currently working on.

Recommendation 9:
Adapt the LSI-R to create a set of brief dynamic risk scales to monitor changes in offender risk or design new scales to measure changes in offender risk. Seek expanded federal funding (in addition to the current grant being sought) from BJA to support development of a set of practical dynamic risk scales. Provision needs to be made for keeping this risk data readily accessible via the CCO's PDA.

DOC HEARING PROCESS

One of the changes the OAA made is to remove the violation hearing process from the court and vest it within the department. After 2000, DOC gradually began to administer the hearing process for all offenders under their jurisdiction.[7] Prior to this, probationers had been subject to a violation hearing process presided over by Superior Court judges. Offenders released from prison were subject to a set of standardized sanctions related to violation behavior. The hearing process administered by DOC was not standardized.

The team consistently heard from CCOs they interviewed that this process is not working[8], and that this additional assumption of responsibility has not served DOC well in a number of ways.

IMPACT ON CCO DECISION MAKING

Taking on the responsibility of hearings for the Superior Courts has essentially lifted the post-sentence responsibility from judge's shoulders. This has added significant "weight" to the decision making process for CCOs who must deal with the offender in the community. CCOs are less likely to use alternative sanctions such as treatment, when they feel the burden of "responsibility" for the decision and its outcomes.

The prospect of liability flowing from post-OAA litigation impacts the CCO decision making process in the area of sanctions. Judges have statutory immunity for their decisions; CCOs do not. A general concern for both the team and the staff interviewed centered on how decisions are made about the supervision of offenders. These decisions seem to be more liability driven than offender needs driven.

[7] DOC reports that the prosecutors and judges associations asked DOC to take over the hearings on sentence violations. DOC is aware that the current hearing system applied by DOC contains an inherent tension between the personnel administering the hearings and the CCOs. One benefit of the current system is that DOC has developed a high risk offender warrant system and can currently generate warrants in one day, which is much sooner than the time to process warrants through the court system.
[8] Statistically, the number of CCOs interviewed do not represent a majority of the CCOs employed by DOC. However, those interviewed were independently unanimous in their comments on this subject.

The duty of a probation officer to control a probationer she/he supervises proceed from the seminal Washington case regarding the duty of a parole officer to protect against the conduct of a parolee, *Taggart v. State*, 118 Wn.2d 195,822 P.2d 243 (1992). The court held that, “parole officers have a duty to protect others from reasonably foreseeable dangers engendered by parolees’ dangerous propensities.” Other cases quickly followed, *Bishop v. Miche*, 137 W.2d 518, 973 P.2d 465 (1999), and Hertog v. Seattle, 138 W.2d 265, 979 P.2d 400 (1999) that reinforced the scope of duty for CCOs.

These cases brought forward successful arguments that the probation officer had the absolute responsibility to protect the community and control the offender’s behavior. In some cases, probation officers took all the steps that we would ordinarily expect: frequent monitoring, reporting violations to the court, and recommending revocation of sentence. When the court took an alternative or no action and the offender committed another violent act, it was the probation officer (and the governmental body) who was found to be at fault.

Working within an environment where the probation officer is expected to “control the behavior of the probationer” without having the sole authority to change conditions of sentence or to take away freedoms places the officer in a difficult position. These and many other cases in Washington State focus the complete responsibility for an offender’s behavior squarely on the probation officer. The probation officer has much less ability compared to prosecutor and judges to definitively take action on the offender to changes conditions or limit freedom and who have much fewer protections from liability. This dynamic means that supervisors and line staff make decisions based in part on how they can protect themselves and the department when the lawsuit is filed.

EMPLOYEE MORALE AND EFFECTIVENESS OF EFFORTS TO SUPERVISE

As the LRPT interviewed DOC staff members, it was clear that CCOs were frustrated that bringing violation behavior to the attention of Hearing Officers resulted in “ineffective” sanctions for the offender (in their view). Internally, this issue is becoming a morale issue. Hearing Officers need to discuss line officer expectations of the hearing process, and at the same time, line officers must understand the restrictions that Hearing Officers work under. The team’s primary suggestion is to return probation violation hearings to the Superior Courts. Since it may be unlikely that DOC will give up this hearing process responsibility, it is recommended that there be more internal discussion and/or education for staff about the hearing process.

One aspect of the hearing process that begs for additional analysis is the understanding of how a Hearing Officer can apply stronger sanctions than those described in policy. The policy says that a hearing officer may only give stronger sanctions with concurrence of the Hearings Program Administrator. How often are exceptions granted? How often are they requested? Can the process be made easier? Can the sanction grid be strengthened or revised? If there is the possibility of revision, line CCOs should be involved to let them have some investment in the outcome.

Sanctions do not Provide Sufficient Deterrence

The process does not support the CCO by imposing sanctions that are deterrents to offenders. The hearing process within DOC basically pits one DOC staff member (the CCOs) against another DOC staff member (the Hearing Officer). In addition, CCOs feel that sanctions as a result of violation hearings are not strong enough to support their work with the offender in the community. The maximum period of jail time a hearing officer may impose is 60 days without getting approval for an exception from the Hearing Program Administrator. The program in place does not allow the CCO to increase the level of supervision despite the fact that the maximum 60-day sentences available did not modify his behavior. Hearing Officers are constrained by a sanctions grid as well as knowledge that negative consequences such as jail time are restricted by policy. This issue came into focus with the Daniel Rodriguez case.

Daniel Rodriguez had been unsuccessful on community supervision, serving a number of short periods in jail for a string of probation violations. He was described as being able to do time "standing on his head" meaning that it did not have a negative effect on him in short bursts, such as 60 days in the county jail. The CCOs felt powerless to change Rodriguez's behavior unless he could be put into jail for a longer period of time.

The Hearing Officer duly found Rodriguez guilty of the charged violations and gave him the sanction outlined in policy. While it is uncertain that longer periods in jail would have prevented the murder that Rodriguez committed, at a minimum it would have further delayed or interrupted the destructive path that Rodriguez was traveling. Instead, he simply served his 60-day sentence, was released, failed to report or comply, was violated, and would serve another minimum jail sentence for each new violation. In short, the jail time had no effect on Rodriguez's behavior. When he admitted to having an alcohol/drug problem, the court or Hearings Examiner never ordered him to treatment. The team identified a cycle of offender behavior that repeated itself over the next two years, culminating in the incident being reviewed.

Recommendation 10*:*
Review the DOC hearing process to determine whether the agency should recommend amendment to either improve its ability to respond appropriately to offender's behavior by imposing more severe sanctions, return the process to the court, or some other solution to address the difficulty in creating effective sanctions for offender behavior.

Recommendation 11:
The current hearing process represents a significant negative morale issue within the internal culture of DOC. Discussion and possibly reorganization of the hearing process should occur very soon. All DOC staff need to understand the hearing process better. Hearing Officers need to better understand the frustrations of CCOs, and at the same time, CCOs need to better understand not only the role of Hearing Officers, but also the constraints they work under. It would be most desirable if the hearing process for probationers could return to the Superior Court. Sanctioning prison releasees by a separate agency may be

another solution. Providing the supervision and sanctioning of offenders within the same agency leads, as it currently does, to the potential for counterproductive conflict.

DOC STAFFING

Both line staff and first line supervisors were interviewed. Neither category of staff had any criticisms of the other. Two broad issues were identified from the interviews:

(1) The growing number of DOC staff who have no direct responsibility for the supervision of offenders, and
(2) The lack of direction provided to supervisors by DOC.

Line staff seemed frustrated by the growing number of "specialized" staff and units that provide support but no direct supervision of offenders. It was suggested that if even some of these positions were re-assigned to direct services, the staff to offender ratio could be improved without hiring any additional staff. The obvious result would be the closer supervision of more offenders and perhaps the expansion of services to again include Pre-sentence Investigation (PSI) reports for all sentencing.

Recommendation 12:
All categories of staff be reviewed, especially the financial obligation units, safety units, hearing examiners, and the large number of staff associated with the LSI-R function for possible reassignment to offender supervision.

It seemed apparent that there were gaps in both communications and responsibilities between line and supervisory staff. In the Shirihama case, the supervising CCO stated that he would have liked to see the offender actively supervised while he was on emergency leave. Insuring the availability of a staff person would provide a continuum of service to the offender and liability protection to the department.

Recommendation 13:
Use supervisors to provide coverage for line staff when line staff is not available to the offender for reporting.

Supervisors reported there was no specific policy about auditing line staff cases on either how often or how many files to audit. This seems to be an activity that while performed, is not well guided by DOC policy. Line staff expressed the fact that while supervisors are available for staffing, time spent discussing cases seems to be more crisis oriented. A pro-active approach envisions CCOs and their supervisors discussing a case strategy on a difficult offender before a crisis occurs. The LPRT felt that little case staffing time is spent developing resources and a case plan to impact a particular offender's behavior based on the needs identified in the LSI-R (e.g., see Table 1).

Recommendation 14:
As previously urged, the supervisor's role needs to be more clearly described in a consistent, measurable manner, to include timed and

defined case audits, expectations for in-house training, role of the supervisor as a backup for line staff, and clear expectations for the supervision of staff and the effective running of field offices.

A general overview also suggested that supervisors receive little initial training after promotion to a supervisory position and little or no ongoing, annually required training regarding the supervision of staff. The LPRT questioned whether supervisors had any specific training in areas of culture and diversity, which certainly were a factor in several of the cases the team reviewed. Supervisors confirmed they receive a week of training on these issues. More sensitivity in these areas might have produced different case management actions but this was an area that the team did not investigate in any great detail other than to question the way gang violence is discounted for purposes of assignment to a risk management level. The OAA as implemented by DOC assigns a higher level of risk to other acts of violence (e.g., when the victim is a stranger) but does not appear to recognize gang related acts of violence as "violence."

Recommendation 15:
The department provides more training and management development for supervisory staff, including areas of diversity and cultural awareness.

INFORMATION TECHNOLOGY AND TECHNICAL SERVICES

A clear theme that occurred throughout the interviews with both line staff and supervisors was that paperwork and computer input was taking more and more time. CCOs felt that they spent more time doing paperwork than monitoring their offenders and partnering with their resource and treatment community. Supervisors felt that they were expected to judge a CCOs performance based on data input and reports. The team identified high levels of frustration by both CCOs and supervisors over this performance measure, which affects the morale and buy-in to the department's mission of offender accountability and victim safety.

In addition, important information about offenders past history, potential risk to the community and needs are not always available to the court at sentencing. The Rodriguez case is an unfortunate example. With convictions of four residential burglaries, firearms, controlled substance and possession of stolen property, he was sentenced in August 2002 on 3rd Assault with no PSI information. The sentence was four months confinement and twelve months supervision. Eight months later he was back in custody for murder.

The Sentencing Reform Act, although originally intended to standardize sentencing has in fact created a number (17 cited by one CCO interviewed) of different categories of cases all carrying different sentence requirements. CCOs are on their own to determine the supervisory requirements on a case-by-case basis. This exercise of professional judgment contributes to the liability situation described previously. The CCOs interviewed all felt that this has created a situation that is time consuming, but more

concerning, has created so much confusion that cases might not be supervised and conditions might not be imposed correctly, which the LPRT felt might have been an issue in the Shirihama case.

Recommendation 16*:*
That automation and the electronic medium be used to:

- *Facilitate the creation of semi-automated Pre-sentence Sentence Investigations (PSIs) from the Offender Accountability Plan (OAP) for all offenders. The current semi-automated RAR could form the basis for such an instrument that goes to the judge. This is despite an assertion by DOC that the judges maintain they don't need that level of information.*

- *Allow CCOs to collect data on changes in offender dynamic risk via PDAs in the field. Create software that will permit the CCO to quickly use the PDA to ascertain the terms and conditions of the offender's sentence. Insure that the OAP and PSI are included on the PDA for each offender under the CCO's supervision.*

- *Create reports and generate statistics by importing standard language and offender ID information from file notes to eliminate repetitive, time-consuming data entry tasks.*

- *Automate reports by importing standard language and offender ID information from file notes. Generate statistics from file notes that mirror supervision goals and outcomes.*

- *Use WI-FI technology to allow CCOs to connect to network programs from the field.*

SECTION 5 - CONCLUSION

DOC has undergone a material change in policy and process since 2000, and such dynamic change can be expected to require a level of self-analysis and course correction along the way. The team identified issues surrounding supervising offenders after their release into the community reflecting some of the impacts of this change, and recommends the agency be proactive in addressing these three primary areas. They are:

- First, revisit the policy decisions associated with the OAA sanction and hearing process, and the workload of the judicial system to determine whether the hearing process is being administered in the optimal way to deter re-offending;
- Second, manage the supervision, work assignments and resources available to CCOs so that a lack of backup, a focus on paperwork and an inability to have greater contact with high risk offenders are eliminated; and
- Third, re-open the issue with the judiciary about the benefits of using comprehensive risk assessment prior to sentencing so that the most effective sentences for purposes of supervision can be imposed. Act as an advocate for the policy that DOC's experience in this area indicates is the most effective in eliminating recidivism.

APPENDICES

APPENDIX A - INCIDENT REPORTS

Office of
Financial Management
State of Washington

This report is submitted to OFM for the sole purpose of fulfilling the notification requirement in RCW 43.41.370(4) as further described in the Guidelines for Reporting Incidents to OFM. This report is not an admission of fault nor has any determination of fault been made. The information reported is a brief summary of known facts at this time and is subject to change.

AGENCY NAME:

Department of Corrections

NAME OF PERSON MAKING REPORT:

Kathy Gastreich, Risk Manager, Department of Corrections

DATE OF INCIDENT OR LOSS:

January 19, 2003

NAME OF PERSON, DESCRIPTION OF INCIDENT OR LOSS:

Anthony Shirihama DOC 958172 and Daniel Haggerty DOC 769729 were arrested for allegedly murdering John Roberson DOC 781854.

AGENCY CONTACT PERSON (NAME, TITLE, TELEPHONE NUMBER AND EMAIL ADDRESS)

Kathy Gastreich, DOC Risk Manager
360-664-0380

HAS THE AGENCY CONVENED AN INTERNAL REVIEW PROCESS? IF YES, PROVIDE INFORMATION ON THE STATUS OF THE REVIEW:

This report is submitted to OFM for the sole purpose of fulfilling the notification requirement in RCW 43.41.370(4) as further described in the Guidelines for Reporting Incidents to OFM. This report is not an admission of fault nor has any determination of fault been made. The information reported is a brief summary of known facts at this time and is subject to change.

AGENCY NAME:

Department of Corrections

NAME OF PERSON MAKING REPORT:

Kathy Gastreich, DOC, Risk Manager

DATE OF INCIDENT OR LOSS:

March 29, 2003

NAME OF PERSON, DESCRIPTION OF INCIDENT OR LOSS:

Daniel Rodriguez DOC 805027, an offender on supervision, was arrested and charged with 1st degree murder for allegedly shooting Armando Perea, Isasis Rodriguez was also shot, but was treated and released.

AGENCY CONTACT PERSON (Name, title, telephone number and email address):

Kathy Gastreich, DOC Risk Manager
360-664-0380

HAS THE AGENCY CONVENED AN INTERNAL REVIEW PROCESS? IF YES, PROVIDE INFORMATION ON THE STATUS OF THE REVIEW:

APPENDIX B - LOSS PREVENTION REVIEW TEAM MEMBERS

Agency: Department of Corrections Review

DAYLE CRANE
Director, Kitsap County District Court Probation Department
LV Bollard Bldg.
614 Division Street MS# 39
Port Orchard, WA 98366

GREGG J. GAGLIARDI
Clinical Associate Professor
The Washington Institute, Western Branch, University of Washington
Department of Psychiatry and Behavioral Sciences
9601 Steilacoom Boulevard SW
Tacoma, WA 98498-7213

MICHAEL OLIVERO
Department of Law and Justice
Central Washington University
Ellensburg, WA 98926

PHIL STANLEY
Corrections Consultant
3026 12th Avenue W.
Seattle, WA 98119

APPENDIX C – TEAM MEMBER BIOGRAPHIES

DAYLE CRANE

Director, Kitsap County District Court Probation Department. 28 years in law and justice programs.

Past involvements:
President of the Washington State Misdemeanant Corrections Association,
Chair of the Kitsap County Domestic Violence Task Force,
Member of the Washington State Law & Justice Advisory Council.

Honors:
2000 Kitsap County Women of Achievement Award,
1997 Washington State Corrections Association "Professional of the Year" Award.
Speaker & trainer in the areas of: probation department development, risk management in probation, case management systems, restorative justice programs in probation, sentencing alternatives for courts, community partnerships, domestic violence.

Educational Credentials:
Undergraduate degree in Sociology from Pacific Lutheran University
Post Graduate work in Chemical Addictions

GREGG J. GAGLIARDI, Ph.D.

Clinical Associate Professor, The Washington Institute, Western Branch, University of Washington, Department of Psychiatry and Behavioral Sciences, Division of Public Behavioral Health & Justice Policy. Dr. Gagliardi received his Ph.D. in psychology from SUNY-Albany in 1977 from 1982-1985; he served as a captain and clinical psychologist with the USAF. From 1985 to 1996, he practiced as a staff psychologist at Western State Hospital, most of his tenure spent working in the Center For Forensic Services conducting forensic psychological evaluations. Dr. Gagliardi has been employed by The Washington Institute since 1996 where he directs a post-doctoral training program in forensic clinical psychology jointly sponsored by the University of Washington Department of Psychiatry and Behavioral Sciences, The Washington Institute and Western State Hospital. He is also a consultant to DOC and the Department of Social and Health Services, and he conducts clinical research on mentally ill offenders, particularly on the assessment of future dangerousness. He has published numerous articles, monographs and book chapters.

MICHAEL OLIVERO

Michael Olivero has a Ph.D. in sociology from Southern Illinois University, a master's degree in Social Work from Eastern Washington University, a master's degree in Criminal Justice Science from Illinois State University and two bachelor's degrees from San Francisco State University. He is the former chair and a full professor of Law and Justice at Central Washington University in the Department of Law and Justice. He has worked in various capacities in criminal justice, including as a police officer and a correctional officer. He has also published books and scholarly articles in the field.

PHIL STANLEY

A graduate of the University of Washington (Sociology) and Seattle University (Masters of Public Administration). A native of Washington, he has worked in corrections in Washington State and New Hampshire for thirty-four years. Phil Stanley was employed with the Washington Department of Corrections for thirty years before retiring in 2000. Upon retirement in Washington, he became Commissioner of DOC for New Hampshire until November 2003. He is currently a corrections consultant and part-time college instructor in Criminal justice at Central Washington University. While with the Washington Department of Corrections, he worked as a probation and parole officer, a work release supervisor, Associate Superintendent at Twin Rivers Correction Center in Monroe, Superintendent of Coyote Ridge Correction Center in Connell, Superintendent of the Special Offender Center in Monroe and Superintendent of the Washington Correction Center in Shelton. Prior to retirement, he was the Regional Administrator of the Northwest region for DOC.

APPENDIX D – DOCUMENT LOG

Incident No.: **03-52 and 03-58**
Agency: **DOC Review**

DOCUMENT	SOURCE	CONFIDENTIAL
Matter Report (1/19/03)-03-52	OFM	
Matter Report (3/29/03)-03-58	OFM	
Incident Report (1/19/03)-03-52 (staff: C. Schilling)	DOCHQ	
Incident Report (3/29/03)-03-58-(cco:Kurt Elder)	DOCHQ	
Offender Accountability Act of 1981	RCW Index	
WA State DOC Community Supervision Policies (Policy Directives)	DOC	
Current Criminal Charges for Shirihama/ Haggerty- including Affidavit (filed 1/30/03))	DOC	
Court Documents for Prior Convictions - Haggerty	DOC	
Offender Chrono Report-Haggerty (officer-Beck Marnee)	DOC	
Criminal History-Haggerty-(intake dates-8/14/97-12/8/00)	DOC	
Court Documents for Prior Convictions – Shirihama (2002)-	DOC	
Offender Chrono Report-Shirihama (Officer: Chris Schilling)	DOC	
Criminal History-Shirihama (intake dates-9/18/89-5/17/02)	DOC	
Current Criminal Charges for Rodriguez (filed 4/3/03)	DOC	
Email from Charles Malone, DOC Risk Mitigation Manager to Michelle Whetsel, LPRT Leader-Guilty Plea for Rodriguez	DOC-OFM	
Court Documents for Prior Convictions-Rodriguez (crime dates-9/96-8/2-02)	DOC	
Offender Chrono Report-Rodriguez (Officer: Kurt Elder)	DOC	
Criminal History- Rodriguez (Intake dates-1/03/00-8/2/02)	DOC	
LSI-R Offender Management Overview-2003 edition	DOC	
WSIPP Current Study Assignments (studies directed by the 2003 Legislature)		
"Washington State to Release Prisoners Early"-Drug Policy News (5/1/03)	Website- drugpolicy.org/news/05_01_03washington.cfm	
"Veterans' Incarcerated Project Lowers Recidivism"-Join Together Online	Website- jointogether.org/sa/action/dt/news/reader/0,2812,566363,00.html	
"Understanding and Implementing Effective Offender Supervision Practices and Programming"-Rural Teleconferences	Website- appa-net.org/grant%20and%20special%20projects/understa.htm	
Course: Basic Safety Workshop for Probation and Parole Officers-BJA	Website appa-net.org/interactives/workshop01/intro.htm	
Log of OAA-DOC staff development activities	DOC	
Policy Directive-DOC 280.530 (3/6/03) and File Maintenance Checklist (1/29/03) DOC	DOC	
Adult Services Academy-CCOs Student Manual-OAA Violation & Hearing Process-Version 1.0- Year 2000	DOC	
Offender Risk Management Offender Accountability: From Policy to Practice Notebook, Version 2.1-2000	DOC	

DOCUMENT	SOURCE	CONFIDENTIAL
Insert In Offender Accountability Notebook: From Policy to Practice Notebook-LSI-R Electronic File Review Checklist-Version 1.1-2000	DOC	
Insert In Offender Accountability Notebook: From Policy to Practice Notebook-Tools for LSI-R Prep and Documentation-OBTS Screens-Version 2.0-2000	DOC	
Adult Services Academy Seattle Notebook-Risk Management Information-Version 3.1-2002 (including OAA Plan Key Question Small Insert)	DOC	
Field File-John P. Roberson (Victim/Offender) (3/8/04)	DOC	
Field File-Daniel M. Rodriguez (Offender) (1/22/04)	DOC	
Field File-Anthony M. Shirihama (Offender)(1/12/04)	DOC	
Field File-Daniel J. Haggerty (Offender)	DOC	
Offender Risk Management Implementation	DOC	
“Implementing Offender Accountability From Policy to Practice” Conference Participant Manual June 13-15, 2000	DOC	
Email between Michelle Whetsel, Team Leader and Gary Andrews, DOC Risk Management-RAR and Warrant Teams	LPRT program	
Email between Michelle Whetsel, Team Leader and Charles Malone, DOC Risk Management-SSI and field file information	LPRT program	
Shirihama, Rodriguez, Haggarty judgment and sentence information	DOC	
OAA Implementation Memo #27 via email from Lynn Scott to Anne Fiala	DOC	
Community Based Chemical Dependency Treatment Site List and provider list	DOC	
Offender Behavior Response Guide	DOC	
Workload Management for Supervisors, March 1999	DOC	
Supervisors Guide to Offender Risk Management Version 2.1, March 2004	DOC	

APPENDIX E – DOC RESPONSE

This section is reserved for the Department of Correction's response to this report. The Loss Prevention Review program should receive this response within 120 days of DOC receiving this report. The report and response will be posted on the LPRT website at http://www.ofm.wa.gov/rmd/lprt/reports.htm.

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