STATE HOSPITAL SECURITY ASSESSMENT

Western State Hospital

Security/Escape Response Assessment

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Washington Department of Corrections Assessment Team:
Keri L. Waterland, Assistant Secretary
David Flynn, Associate Superintendent
Charlotte Headley, Chief of Security

Executive Summary

On April 7 2 overnor Jay Inslee directed the Washington Department of Corrections DOC) to assemble a team of security and organizational experts to evaluate the security practices at Western State Hospital WSH). The evaluation was directed in response to the escape of two patients from the hospital on April 2 .

Richard Morgan Secretary of the DOC responded to this request and assigned Keri Waterland PhD Assistant Secretary – Offender Change Division; David Flynn Associate Superintendent – Washington Corrections Center for Women; and Charlotte Headley Chief of Security – Prisons as the DOC Team responsible for this review.

The DOC team found the WSH ward-based staff to be professional and cooperative yet had issues with the Executive Leadership Team being responsive to requests for documents and displaying openness to DOC feedback and recommendations. While this report focuses primarily on security recommendations the DOC team has several recommendations specific to organizational structure and culture as well. The DOC team witnessed staff committed to treating patience with dignity respect and caring but noted clear lack of presence communication authority and accountability from the Executive Leadership Team leading many staff to report that the Executive Leadership Team was not supportive or caring of staff or of public safety and security.

Scope of Review
This report reviews WSH's response to critical incidents such as security breaches and escape and offers recommendations and opportunities for improvement. The team examined the forensic and civil units' policies practices and physical plant issues as they relate to security of the facility. The team also examined the organizational culture of WSH including its Executive Leadership Team and its impact on security. The team also made site visits which included spending time in various civil and forensic wards and interviewed staff from a variety of job classifications.

Findings
Similar to DOC's findings in its 2 report which focused on the forensic units of both WSH and Eastern State Hospital ESH) one of the greatest challenges facing WSH is defining a clear mission for the treatment of patients who are civilly committed to WSH and how that mission should be balanced with public safety and security. Staff continue to struggle with how security and treatment may coexist.

The Findings section of the 2 DOC report states that "[h]istorically the culture in the organization has been that treatment and recovery is paramount to all things. Staff members are clear on this. However staff members are not clear about the role of safety and security in an environment focused on good treatment and recovery."

In that same report DOC outlined that treatment and security are not mutually exclusive and that a dedication to both disciplines is possible yet the cultural ideology that treatment with staff patient and ultimately safety and security is somehow impossible at WSH still exists and is currently supported and promoted by several members of the existing Executive Leadership Team.

Security availability and the perceived utility of the security team is inconsistent between the civil and forensic centers which leads to safety and security concerns as well as management and personnel issues.

Just as in the 2 DOC report the 2 team also found that there is a lack of awareness of the foundational role that security plays in the operation of a psychiatric hospital that treats patients committed under both RCW .77 and RCW 7 . 5. Security staff members are seemingly not seen as valuable members of the WSH leadership.

This assessment offers recommendations that are essential to improving security practices at WSH and encourages DSHS to review and develop Corrective Action Plans CAP) for several recommendations still pending from the 2 DOC report as well as recommendations from the 2 assessment.

The theme of patient rights being incompatible with safety and security remains deeply embedded in the culture. This is evidenced by the persistence of the entrenched culture and practices reviewed in 2 and those encountered in the 2 assessment. **The foremost challenge is changing the culture to recognize that patients are dangerously imperiled by failing to put safety first.** Throughout this report the reader will encounter the words "safety" and "security." They are synonymous as are "*public* safety" and "*patient* safety."

Section 1 – General Information

Patient History

The escape of [redacted] and [redacted] from WSH posed a significant risk to public safety and generated an intense multi-agency law enforcement response. The event generated multiple news media inquiries and was included in national headline stories of both CBS and NBC.

[redacted] was charged with st degree murder in 2 3 the 2 -year old female victim was found tied to a bed and stabbed to death. Mr. [redacted] arrived at WSH in August 2 4 hospital records detail a long documented history of mental illness with multiple instances of violent acts and documented threats to commit violence to include threats of shooting into schools. He has experienced multiple commitments to mental health care centers and state hospital facilities throughout his lifetime. Mr. [redacted] most recent violent outburst occurred on April 2 2 four days prior to his escape) when he spit on staff and threatened violence toward a female staff on this ward. Mr. [redacted] historically focuses attention to committing violence toward women and is documented as a threat to the safety of WSH female staff. It should also be noted that ward staff indicated that Mr. [redacted] was clearly identified to hospital leadership as an escape risk.

[redacted] was charged with Assault 2 domestic violence in 2 4. WSH records reflect Mr. [redacted] presents with a combination of diagnoses which cause him to act out violently when he experiences frustration or disappointment. He has experienced several commitments to mental health facilities throughout his lifetime and expresses discontent toward treatment efforts of WSH staff.

[redacted] and [redacted] are both patients who were civilly committed under RCW 7 . 5) to WSH after being found incompetent and non-restorable to stand trial for accused crimes under RCW .77). Both patients are committed as HB 4 patients and were housed on ward C-4 which primarily houses patients who are criminal justice involved yet are unable to stand trial for their crimes.

Initial Impressions and Observations

The DOC team began the assessment at WSH on April 7 2 and was accompanied by Deputy Director of Prisons Rob Herzog who participated in the 2 security review) for initial briefing and introduction from WSH Director of Security Steve Mauer. The DOC team began the assessment by evaluating the outside areas of the building where the patients were presumed to have escaped. Footprints were present in the bark under the window that had been accessed by the patients and ultimately used as the egress for escape.

The WSH security director explained the windows were secured from the inside and not accessible without the use of a specialized tool. Hospital policy prevented windows from being opened by patients and although the windows were not inspected on a regular basis hospital staff presumed the windows were secure enough to prevent patients from escaping.

The team was escorted to ward C-4 the living area where the two patients were housed at the time of escape. [redacted] and [redacted] shared room [redacted] with two other patients of similar circumstances. The physical layout of the room was assessed and found to have four windows with access facing Steilacoom Boulevard. The four windows in the room measured approximately 3x foot and provided a clear view of community activity and potential for escape. The street front is a heavily traveled route in the city of Lakewood and is regularly accessed by members of the community. The view from the room provides immediate access to public transportation bus routes and a local city park.

The security officer who responded to ward C-4 on the night of the escape described his attempt to assess the window after the escapes. He stated maintenance staff arrived prior to security staff and the window was already in the process of being repaired when he arrived on the ward. He attempted to capture photos

o the indo prior to the repair ut the maintenance sta re used to halt ork to allo photos. In short the window rom which the escapees departed was compromised prior to local law en orcement or WS security determining how it had een opened. There ore the DOC team was presented with the ollowing theories of how [redacted] and [redacted] were able to open the window leading to escape:

- The security director provided an explanation that the window had been kicked open and the locking mechanism was knocked free from the use of blunt force.
- Ward staff present at the time of the escape stated they observed screws were removed and the locking mechanism dismantled into pieces lying next to the window frame.
- Maintenance staff stated screws were intact when they arrived but provided no explanation of how the window was opened.
- Patients assigned to the room reported the window had been "loose" for quite some time. They indicated the information had been reported to staff and stated they made numerous requests for repair. Patients reported the window allowed wind to blow through the room and created a whistling noise which caused disruption to their sleep.

The DOC team requested to review individual reports from staff who were present on the evening of the escape and to view photos taken of the window prior to its repair. The team was informed that WSH does not have a policy or expectation of staff to individually document significant events. Minimal documentation was given to the DOC team regarding the escapes and no photos were taken of the window prior to it being repaired. Since documentation and evidence collection practices are not in place it is difficult to determine the order of events or make a solid determination of how the patients defeated and exited the window.

Upon inspection the DOC team observed no signs that force had been used to open the window. The glass and window frame were both fully intact and did not exhibit physical evidence of tampering or damage. Some of the screws which secured the window shut were fully exposed it should be noted that not all screws in the windows required a security tool to gain access as some were simply Phillips head screws).

The DOC team observed that ward C-4 lacked security features commonly found in secure confinement environments. Of immediate concern was the inconsistent use of security hardware throughout the ward. For example the DOC team observed many screws in the ward including those used to secure windows could easily be turned by using a thumbnail. The DOC team observed a smoke detector partially unscrewed and hanging from the ceiling in [redacted] and [redacted] assigned room. This provided the DOC team indication that tampering of hardware was occurring within the room.

During day one of the assessment the DOC team made the following recommendations to minimize the immediate possibility of additional escapes from ward C-4:

- Inspect all windows to ensure security hardware was present and intact to limit patient access.
- Search patient rooms for escape related contraband eliminate the possibility of escape related items concealed on ward C-4 tools weapons maps etc.).
- Assign security staff to the ward to ensure % accountability of ward C-4 patients.
- Arrange for an alternative housing option such as the Center for Forensic Services CFS) for [redacted] and [redacted] to provide a more secure environment once they were apprehended and returned to WSH.

As the DOC team continued the inspection concern egan to increase a out ard C-4's a ility to securely house patients without risk o escape. O servations included exit doors eing le t open sta ocused on personal cell phones keyrings lying around without sta present and statements made y the staff that security is not prioritized in the decisions impacting patient housing assignments or hospital grounds access. Additionally the DOC team was informed patient [redacted] was apprehended and would be returning to the same room from which he escaped.

The DOC team insisted searches be conducted and [redacted] not be returned to ward C-4. It was evident the return of [redacted] to the same room from which he escaped would likely result in an additional escape situation. The security director left to complete phone calls regarding the team's recommendations. As the inspection continued [redacted] was escorted onto the ward for housing placement. When the security director returned he informed the DOC team that [redacted] would be assigned to a different room within ward C-4. To prevent Mr. [redacted] from escaping again a security guard would be exclusively assigned to ward C-4 and Mr. [redacted] would be housed in a room that overlooked the quadrangle. Note: the quadrangle is a fenced area linking the hospital buildings together and creating a secure perimeter fence line.) If Mr. [redacted] defeated a window in his newly assigned room he would drop down into a secure area that is staffed with a security officer at all times.

The security director expressed reluctance to coordinate searches of patient rooms and explained written orders from a doctor were required before searches could be conducted. Though seemingly reluctant security staff did arrive to conduct searches of patient rooms. Patients remained in the room as searches were conducted. Patient presence inhibited the staff's ability to systematically search the rooms. The DOC team recommended patients not be present as searches were completed yet it was explained that patients have the right to be present as searches are conducted.

Prior to leaving ward C-4 the DOC team met with [redacted]. Mr. [redacted] described returning to his room from the dinner meal on April 2 and witnessing an open window. He stated [redacted] stood next to the open window preparing for exit. He could not provide details how the window was opened he assumed Mr. [redacted] had kicked the window open. At that time he told the DOC team that he made a spontaneous decision to escape. Mr. [redacted] explained he planned to constructively use his time away from WSH to meet with his attorney and seek assistance with release planning. He expressed surprise that his escape through the window generated public interest and had no concept of why law enforcement was interested in his return to WSH.

At the conclusion of the evening the DOC team out-briefed with WSH Executive Leadership Team members and shared initial concerns and recommendations regarding ward C-4 patients. Chief Executive Officer CEO) Ron Adler agreed that priority would be given to completing inspections of the windows and additional security staff would be placed in ward C-4 to ensure patient accountability. The DOC team strongly recommended ward C-4 patients be moved immediately to a vacant ward within the CFS building as security during the weekend was of paramount concern and importance. The CFS patient area provided a controlled secure environment and was regularly staffed with security employees. Comparatively ward C-4 lacked access and egress security was not regularly staffed with security employees and lacked basic security practices and a secure perimeter to prevent patient escape. The DOC team shared their immediate priority to mitigate the risk of additional escapes from ward C-4 and ensure patient accountability going forward throughout the assessment.

Hospital leadership acknowledged additional security was needed for ward C-4 patients but expressed reluctance to move patients from the civil side of the hospital for the purpose of providing additional security. Note: it is currently common practice to move individual patients who are "unmanageable" on the civil units.) Hospital leadership explained that patients residing on ward C-4 were considered civil

commitment patients and could not e housed in the CFS due to the unmanagea le status. ospital leadership shared concerns that moving ward C-4 patients to CFS would preclude asic patient rights and inhi it person centered therapy e orts o sta . To that end hospital leadership shared alternative options for housing patients from ward C-4. One suggestion discussed at length by hospital leadership was to seek $ .5 million funding to secure a vacant civil ward. The DOC team questioned why this option should be considered as this seemed to be an expensive project and it was determined that there was a vacant ward in CFS that could be used to provide an immediate more secure housing option for the patients on ward C-4.

On day two of the assessment the DOC team toured the vacant CFS ward which was suggested as a more secure housing option for ward C-4 patients. The DOC team was pleasantly surprised by the open and bright environment the CFS building could provide ward C-4 patients. The treatment area provided in the CFS increased space for patients and appeared to provide a secure location to house patients without further risk of escape.

The DOC team experienced several setbacks to making progress of evaluating WSH throughout the remainder of the assessment. The DOC team requested security related policies and documents on the first day of the assessment yet many were never received. Each day the DOC team requested to review documents but were given various reasons why the documents were unavailable. At one point it was suggested that the DOC team search the computer system for needed documents and that the team "can have the documents but will have to spend a couple hours making copies." It should be noted the majority of the documents received on day five were in relation to the operation of CFS and did not provide an accurate or clear picture of the policies and procedures in place at the time of the [redacted] and [redacted] escape.

Security related policies that were eventually provided to the DOC team were in relation to the operation of the CFS patient area. The DOC team noted an absence of security related policies procedures and staff expectations in operation of the hospital civil patient wards. Upon interviewing ward C-4 staff many expressed frustration as they described their many attempts to bring forward to the Executive Leadership Team their concerns surrounding a lack of security focused training policies and culture within their work area.

Throughout the course of the assessment the DOC team shared recommendations observations and staff concerns resulting in multiple occurrences of difficult conversations with the WSH Executive Leadership Team. The DOC team observed a noted presence of resistance to security related ideas and suggestions and received comments like "we're not a prison we are a hospital" "we're not in the confinement business" and "we can't do that because patient treatment is our priority."

Section 2 - Organizational Culture

Organizational Culture

Similar to what the DOC team experienced in the review of WSH in 2 the team observed a general void and lack of regard for security practices at WSH. Hospital leadership expressed confusion on how to merge their deep commitment to patient-centered therapy with principles of safety and security. While the DOC team believes CFS provides a more secure environment for criminal justice-involved patients and presents more of a challenge to patients with intent to escape it is evident the hospital-wide culture supports the notion that security practices are a hindrance to effective patient treatment efforts which condones staff rebuffing and disregarding security interventions.

As an example the DOC team o served patient yard time in the CFS area here a psychiatric security attendant PSA) was supervising the patient yard and was o served sitting at a ta le and appeared to e staring down at a personal cell phone. Patients walked ehind the PSA as he o liviously ignored their presence. The security director called on the radio and asked the PSA to place himself in the appropriate observation point to which the PSA replied that he was in the appropriate observation area. From our vantage point we observed the staff member continuing to sit at the table with his attention on his phone. The staff member made no effort to move toward the appropriate observation point. The security director explained that PSAs had been corrected multiple times regarding appropriate supervision of patient recreation periods and described a general disregard for his efforts to enforce established security practices. He expressed frustration in holding staff accountable to security processes and reported little support in his role as security director. This claim was later evidenced in the security director's absence at critical security related discussions and hospital leadership's own admission that he has not historically been included in the Executive Leadership Team meetings or in security related decisions.

Another example of the confusion surrounding security practices at WSH involved the medical transport staff's own admission that they refuse to use the process in place to transport patients through the quadrangle vehicle sally port to transport patients to off-site medical appointments. The staff member stated to the DOC team that "it takes too long to get through the gate so I walk the patients through the front door for transport; my supervisor knows." Using the sally port would provide a record that the staff member had left the hospital with the patient for an off-site trip.

Security staff posted at the vehicle gate in the quadrangle expressed confusion in their role and responsibility for management of this important security gate. A review of their standard operating procedures do not indicate what they should be doing and instead indicate many duties they will <u>not</u> do such as:

- Search incoming and outgoing vehicles.
- Verify staff identification for entry into the secure perimeter.
- Verify grounds privileges of patients accessing the gate under escort of staff.

Recommendations:

- Foster an organization that is focused on a "security first" mindset beginning with a determination of each current member of the Executive Leadership Teams ability and willingness to adopt this necessary commitment to public safety and security.
- Begin discussions with The Joint Commission TJC) to determine how not whether safety and security can be a focus in concert with patient care.
- Establish expectations of accountability into the security processes the hospital currently has in place and review policies for areas in which further improvements can be made.
- Educate staff on the value of these security processes as they are designed to enhance safety security and accountability for staff patients and the public.
- Engage staff at all levels to create a security management system interwoven into the mission vision and values of WSH.
- Include the security director in management meetings and operational decision making.
- Clarify the role of security staff in the operation of the civil side of the hospital by increasing their presence and providing standard operating procedures that ensure accountability of patients.

<u>Management Model</u>

The DOC team reviewed the staffing model the hospital currently has in place to staff civil patient wards. Common themes shared included:

- Patient housing areas are understaffed.
- Patient housing areas lack appropriate supervision.
- Ward staff are overworked and exhausted from working substantial amounts of overtime.

While the DOC team does not presume to determine if current staffing levels are adequate at WSH the team did observe a full complement of nursing staff psychiatrists psychologists and mental health attendants present and in full force on the civil patient wards. However the DOC team determined that there is a lack of security personnel in these patient areas. Without security staff in these areas there is a void of focus and dedication on ensuring safety and security of both staff and patients and ultimately the public.

Staff who were present on the civil patient wards work hard and are committed to providing quality care but there was also a general and observable lack of awareness of who was responsible to direct both staff and patients in significant events or in emergency situations. The team observed ward staff in close proximity to patients seemingly unaware of their surroundings usually focused on personal cell phones. It is the opinion of the DOC team that staff could be better utilized and more carefully supervised to ensure WSH's focus is on public staff and patient safety. The team believes that there is an existing culture which has made it difficult for first line supervisors to compel compliance with work related expectations and a general lack of education around security related policies and procedures.

In regard to staff overtime the team found any supervisor could approve staff requests for leave. These decisions are not being made in accordance with the ability to staff the leave within the approved relief factor. The team found staff requests for time off are rarely denied leaving a large amount of vacancies on each shift. The management of mandatory overtime assignments is a familiar issue to the Washington Department of Corrections. The team believes significant changes to the leave approval process could assist WSH in relieving some of the burden placed on staff to work vacant positions and allow for a more rested and refreshed employee.

Lastly though not a formal security issue the DOC team was informed of numerous "ghost positions" at WSH. One example provided is an employee who for the last six months is alleged to be living in another state. Reportedly the staff member telecommutes from another state and provides daily mandatory overtime rosters. The team also learned this position is double filled with the double fill being located on the WSH grounds) leading to two people collecting a manager's wage to deliver the same work product.

Recommendations:

- Complete a staffing analysis to provide an accounting of double fill and telecommute positions to determine if existing resources are being effectively utilized.
- Determine a leave approval process that allows for leave to be taken within the established relief factor.
- Consider a staffing pattern that incorporates security staff into each ward to ensure security routines are completed on each shift.
- Consider a unit management model such as current Special Commitment Center staffing an updated ward program manager model or a tailored DOC chain of command model) on each ward which clearly defines who is in charge of the multi-disciplinary ward staff. This will clarify who is in charge during times of emergency or when response to significant events is required.

- Consider replacing the current matrix leadership model with another model that more clearly anchors authority/responsibility with one position for the forensic unit overall and one position responsible for each ward.
- Create a position that reports directly to the CEO and is responsible for the day-to-day administration and management of facility security-related operations. This position would be responsible for the development and review of facility security policy with final approval of the CEO. This position would also manage implementation compliance monitoring and enforcement of operational security procedures and protocols.

Escape Response

The DOC team reviewed the response to the escapes and associated staff actions. We found the response would have been enhanced and timelier by using universally recognized procedures to initiate a quick coordinated response. It was evident ward C-4 staff worked independently without the support of an Incident Command System ICS) command structure or assistance from coordinated escape procedures. The DOC team also discovered disruption to the response process occurred when the supervisor generated electronic documents for the switchboard to request further response resources from hospital staff and law enforcement.

Of note the DOC team discovered the forms required to initiate response assistance for escapes include a section that identifies the patient as either "not dangerous" or "dangerous." It was reported management staff had established an expectation that patients who escape from the hospital would not be marked as "dangerous" without the express permission or signature of the CEO or designee. It should be noted establishing a patient as "dangerous" also requires community notifications to be completed including media and law enforcement.

In the instance of the [redacted] and [redacted] escape the ward C-4 supervisor initially submitted the form and marked both patients as "dangerous." A delay in response occurred when switchboard the initial contact) sent the form back requiring the supervisor revise the form and uncheck the box indicating the patients as "dangerous."

When the DOC team talked with hospital leadership about the process they denied knowledge that the reporting criteria existed. However numerous staff including switchboard staff reported and validated the expectation as an operational expectation and indicated that it was common place to refuse forms and not initiate escape notification for patients that were identified as "dangerous" by ward staff. Recently the Associated Press reported on the same issue; the story highlighted the hospital had experienced over 8 escapes from WSH since 2 3. Many of the patients were not identified as dangerous despite being charged with crimes such as murder rape kidnapping assault and robbery. In these instances the hospital failed to notify community and law enforcement stakeholders despite the dangerousness of the escapees.

The DOC team met with the Lakewood Police Department with regard to the contract services they provide WSH. Lakewood police serves as a first responder to all WSH events. In the [redacted] and [redacted] escape Lakewood police provided detailed information on how they assisted WSH the night of the escape. They explained the form which provided them patient information of [redacted] and [redacted] was marked "not dangerous". Lakewood police representatives estimated this caused about an hour and a half delay of full department resources to search for [redacted] and [redacted] This was due to the form not providing full disclosure of the patients' criminal history. They further explained they receive numerous notifications of patient escapes from the hospital but they rarely see a patient marked as "dangerous". Lakewood police are in the process of requesting that revisions to the notification form be completed and

clarity e provided in regard to the term “dangerous”. Currently a con lict o the term exists et een the two agencies and must e resolved to preserve pu lic sa ety.

Recommendations:

- Provide clear expectations to staff regarding the identification and notification process in the event of escape of dangerous patients.
- Meet with Lakewood police in regard to properly defining “dangerous” patients and required response. Consider restructuring the notification form to include information the police department needs to properly respond.
- Implement ICS structure and procedures clearly identifying an Incident Commander and other ICS roles for the purpose of developing a more coordinated response in the event of an escape.
- Create escape related checklists training and expectations of staff in the event of an escape of a dangerous patient.
- Incorporate the use of escape related training exercises as means to familiarize staff with required actions and expectations. Incorporate Lakewood Police Department into the development of training and escape related exercises.
- Develop policy related directives for staff to properly document staff actions in significant events and evidence collection.
- Develop a Memorandum of Understanding MOU) between DSHS and DOC including but not limited to topics such as determining housing location and processes for notification for escapes of patients who are or would be if they were not civilly committed) involved with DOC.

Section 3 - Security

Tool Control

WSH has a policy for tool control but it lacks the guidance and accountability required to maintain control of tools. One example is the lack of accountability for the tool that opens patient windows. Maintenance staff estimated thousands of these tools within the hospital are unaccounted for described as stored in ward drawers and staff offices. The lack of accountability of these important tools could ultimately provide patient access and opportunity for escape. It must be recognized that tools at WSH require proper inventories and accountability to eliminate the possibility of a patient acquiring a tool.

Recommendations:

- Revise policy to establish a process that is uniform and creates tool accountability. Identify a single process owner tool control manager) to oversee the accountability and inventory process.
- Create a standard inventory form attached to the policy for all employees to document tool inventory and use.
- Establish a process to account for the daily inventory of tools.
- Establish a reporting procedure to notify staff at all levels the percentage of inventory compliance which exists at the hospital.
- Establish a process for appropriate response to a missing tool.
- Create a process to ensure staff who carry tools through the hospital carry a list/inventory of tools that can be accessed and reviewed for accuracy at any time.
- Missing tools are to be reported to the supervisor. There is no process in place to conduct a unified search of missing tools. There is no procedure to communicate missing tools through the hospital.

Key Control

Although WSH has a policy for key control it lacks the necessary components for a sound key control system. The WW key is a master key that exists on every key ring for the civil side of the hospital. The WW key can be used for movement from each civil patient ward accessing all the way out through each perimeter gate. It was reported there are approximately 25 lost or unaccounted for WW keys.

Current key control policy requires all supervisors to complete an annual inventory/inspection of all employee key rings within their chain of command. With the exception of one manager there is no documentation to support a key inventory has ever been completed.

Segments of WSH maintain their keys using a key watcher system. In an interview with the key control manager the team became aware of staff actively attempting to defeat the key watcher by braking off the fob causing the system to erroneously report that keys are accounted for.

- The entire carpentry shop has complete access to the lock shop to include all key blanks.
- No existing perpetual inventory of key blanks. With few exceptions any key can be added to a key ring with the approval of a supervisor and does not require a higher level of approval.
- Lack of a requirement to update key inventories which serve to identify the addition of keys to key rings.
- Staff were observed leaving keys unsecure.
- Lack of ability to recover issued keys from employees separating from employment at WSH.

Recommendations:

- Create a comprehensive key control policy.
- Re-core all perimeter access/egress gates to prevent the ability of the WW key to be used freely throughout the hospital from the ward to outside the perimeter.
- Conduct an inventory of all hospital key rings.
- Update all existing key inventories.
- Establish a secure lock shop with limited access to keys equipment and key blanks.
- Reduce approval processes of individual supervisors to add keys to key rings. Supervisors should make recommendations to the *key control manager*.
- Eliminate the WW key. There are far too many missing "master" keys to have any form of key control while the WW remains in use.
- Reduce the number of access/egress gates available for staff movement.

Physical Plant Inspections

Presently WSH does not have procedures or expectations that the physical plant of the hospital is routinely inspected. The lack of routine inspections creates the opportunity for patients to work to defeat the security features which exist. To ensure accountability of patients inspections of security related features must be inspected on a routine basis.

Recommendations:

- Create procedures to inspect all security features of the physical plant on a regular basis.
- Create forms and associated processes to ensure security inspections are reviewed by the hospital Executive Leadership Team on a weekly basis and accountability to the process exists.

Section 4 – Patient Classification System

Classification Security/Risk Level System

As with the 2 DOC report the 2 DOC team noted that the lack of a formal classification system created significant concern. There are currently several "types" of civilly committed patients at WSH yet the types of commitment e.g. general civil under RCW 7 . 5 patients committed under RCW 7 . 5 and HB 4 intent those under RCW .77) do not necessarily equate to security and risk level. WSH has many patients who have necessary notifications in the event of an escape and these are denoted as "red folders" due to the color of their clinical file.

Recommendations:

- Adopt a security/risk level system and instrument for assigning housing location based on security and risk predictive factors not civil commitment type. This tool should be a validated assessment instrument if possible.
- Establish a state-level Risk Review Board that will work in conjunction with the already established Public Safety Review Panel PSRP) with the primary focus being public safety. All leave requests for patients determined to be a risk to public safety should be reviewed by the state-level Risk Review Board after hospital level review by the clinical team.
    - The DOC team does not believe that the culture at WSH is in a position to subjectively review cases with a focus on public safety and believes that a state-level Risk Review Board is necessary.

APPENDIX A

Department of Corrections 2010 State Hospital Security Assessment

February 8, 2010

Department of Corrections
WASHINGTON STATE

STATE HOSPITAL SECURITY ASSESSMENT

Eastern State Hospital
Western State Hospital

Assessment Team Leader: Doug Waddington,
Superintendent, Washington Corrections Center,
Washington Department of Corrections

Executive Summary

On October 2 2 9 Richard Kellogg Director of Mental Health Division - Department of Social and Health Services DSHS) requested assistance from the Department of Corrections DOC) to conduct a security assessment of Western State Hospital WSH) and Eastern State Hospital ESH) Forensic Units. Richard Morgan Director of Prisons – DOC responded to this request and assigned Doug Waddington Superintendent – Washington Corrections Center as Team Lead. The team was divided into two parts East and West.

The Westside Team members are Kerry Arlow Associate Superintendent of Custody and Operations and Timothy Hunter Health Care Manager 2 both from Washington Corrections Center in Shelton. The Eastside Team members are Robert Herzog Associate Superintendent of Programs from Airway Heights Corrections Center in Spokane and Thomas Roe Psychological Associate from Washington State Penitentiary in Walla Walla.

The Team found all the DSHS staff professional and cooperative. Jess Jamieson CEO at WSH and Connie Wilmot Acting CEO at ESH provided access to everything we requested. While this report focuses on security the Team was impressed with staff/patient interactions. The Team witnessed patience compassion kindness and professionalism as staff interacted with patients.

Scope of Review
This report looks at the security programs in the two forensic units and where the units can find opportunities for improvement. The project examined the forensic units' policies practices and physical plant issues as they relate to security of the facilities. The project also examined the organizational culture of the forensic programs and its impact on security. The Teams reviewed policy and procedures made site visits which included spending time in each unit and interviewed staff from many job classifications.

Findings
One of the greatest challenges facing the WSH/Center for Forensic Services CFS) and ESH/Forensics Services Unit FSU) is defining a clear mission for the forensic programs. Staff struggle with how security and treatment coexist. Historically the culture in the organization has been that treatment and recovery is paramount to all things. Staff members are clear on this. However staff members aren't clear about the role of safety and security in an environment focused on good treatment and recovery. The unique role as a forensic hospital does not appear to be clearly defined. There is a need for a clearly articulated mission vision and values to direct policy and procedure at the forensic units.

Our belief is treatment and security are not mutually exclusive. A dedication to both disciplines is possible. An uncompromising commitment to the core values of each discipline must be integrated in order to operate a highly effective forensic hospital that ensures public staff and patient safety.

Consistency between the forensic units is lacking in many areas and leads to safety and security concerns as well as management and personnel issues. For example the forensics unit at ESH is called the Forensics Services Unit while at WSH it is called the Center for Forensic Services. These programs have the same mission – to provide forensic services – yet their names differ.

Inconsistencies between the two facilities carry through programs policies and operations. Many policies address the same subject but are referred to differently by title and provide vastly different procedures and direction. One example is the escape response policy. At ESH policy is titled "Unauthorized Leave" while at WSH the title is "Reporting and Recovery of Patients on Unauthorized Leave". The Purpose

Scope and Definition statements in each policy are different. Centrally developed policy could begin to create consistency and pull the two programs in alignment with each other.

There is a lack of awareness of the foundational role that security plays in the operation of a forensic hospital. Security staff members are viewed differently in the forensic units. Both facilities struggle with security staff receiving proper authority and security staff at each facility are used in very different ways.

Outings for patients were reviewed and the Teams found that increased training and improved consistent patient risk assessments are needed to provide the outings in a safe and secure manner. We recommend that carefully structured transitional opportunities be resumed and that patient eligibility for these opportunities be based on the kind of multi-disciplinary analysis of risk that is conducted by the WSH/CFS Risk Review Board. All of this must occur in the greater context of a security mindset for all staff members who work in the forensic units.

We have offered recommendations in this report for substantive improvements in security practices at the forensic units. It is clear a commitment to a security-first mindset is foundational to the ability to perform clinical work within the forensic units.

Section 1 - Organizational Culture

Organizational Culture

Organizational culture is an important aspect of a safety and security program. The Teams noted a common theme about organizational culture that impacts safety at both facilities:

- Staff expressed confusion about how to merge their deep commitment to the principles of person-centered treatment with a commitment to safety and security. Staff stated that they tend to see these two disciplines as opposing forces.
- Several staff members asked "Are we running a hospital or a prison?"

At both hospitals security considerations as well as security staff are viewed as irrelevant. It appears this is driven by an underlying lack of awareness of the important role that security plays in the operation of a forensic hospital.

The West Team noticed a lack of respect given to the security staff. Some findings include:

- WSH security staff members feel they have no authority.
- Some staff members report they do not feel safe at work.
- Security staff reported that when asking other staff to show their identification badges upon entering the facility they were "flipped off."

The East Team noted that staff felt upper management at ESH outside the FSU had no concern about improving security.

- Staff perception is that management believes security interferes with the role of the hospital related to patient treatment.
- Many staff stated that when security issues were brought up the chain of command they were ignored.

The mission and vision of both forensic hospitals are not clearly defined. The absence of an articulated mission vision and values prevents the facilities from establishing a culture that focuses on safety security and treatment which are all required within the forensic hospital setting.

Recommendations:

- Foster an organizational culture that is focused on a "Security First" mindset.
- Engage staff at all levels in the development of clear Mission Vision and Values statements which reflect the strategic integration of treatment and security.
- Implement a sustained commitment to the idea that "Security is Everyone's Job".
- The role of security professionals should be given appropriate respect. This approach needs to be supported and modeled by senior leadership.
- Ensure staff are clear about their responsibilities in developing a respectful work place and are held accountable for inappropriate disrespectful and unprofessional behavior.

Management Model

At both forensic units there was a lack of clarity about who is in charge and how lines of authority flow. While the leadership role of the Director of the forensic unit is clear at WSH it is not well defined at ESH. There is confusion at both WSH and ESH about lines of authority and responsibility within wards and across disciplines.

Staff are concerned that the individual disciplines - Nursing Administration Psychology Psychiatry Rehab Services Social Work etc. – operate independently. Staff commonly referred to the organization as a collection of "silos" in which there is no cross communication or collaboration. Coordination between silos was said to be formally and informally a function of the heads of the individual silos.

Each facility had different challenges with the management model. ESH appeared to be operating as a joint site for each discipline and not a single hospital entity. Each discipline was almost entirely accountable only to itself. The Team was told several times that the only way to successfully address concerns between silos was to develop your own professional but mostly personal relationships with members of the other silos. If a good relationship does not exist then no resolution would occur.

WSH's challenges appeared be a lack of respect for supervisory authority. During a leadership team discussion the Team witnessed a subordinate derail an improvement effort by contradicting the formal authority. WSH staff stated there is a lack of respect for supervisory staff in all the disciplines and what leadership exists is informal.

Recommendations:

- Consider replacing the current Matrix Leadership model with another model that more clearly anchors authority/responsibility with one position for the forensic unit overall and one position responsible for each ward.
- Create a position that reports directly to the CEO of each hospital and is responsible for the day-to-day administration and management of facility security-related operations. This position would be responsible for the development and review of facility security policy with final approval of the CEO. This position would also manage implementation compliance monitoring and enforcement of operational security procedures and protocols.

Policy

Policy is vitally critical in establishing effective and consistent operations. In addition policy communicates concrete procedural guidelines for staff to follow to operate effective forensic units on an ongoing basis. However the review revealed that both facilities are inconsistent with their policies as seen in these examples:

- At ESH the second and third shift RN3's report to their respective RN4 who does not report to FSU administration. On third shift the control panel room is left open which creates a significant security breach[1]. Even though FSU administration and the other supervisors from the other two shifts have voiced their concern and asked for this practice to cease the third shift RN4 still allows the practice to occur.
- One shift within the ESH/FSU may place a patient on any form of restricted status. However if the on-coming shift disagrees with the restriction status they remove the restriction for their shift and it will be re-imposed when the originating shift comes back on duty.
- Another issue within ESH/FSU is related to the formal reporting relationships. The RN3s are the charge nurses for their wards managing the operations for their shift. They are supervised by their own respective RN4s. The three first shift RN3 charge nurses report to and are evaluated by the one RN4 assigned to the ESH/FSU. The other two shift RN3s report to and are evaluated by their RN4. So there are a total of nine RN3s managing the 24/7 operations of the ESH/FSU. Six of them report to supervisors who are not directly a part of the ESH/FSU team.

  WSH/CFS staff reported that the Ward Program Manager role at WSH/CFS was abolished in August 2 8. This has led to some confusion regarding the role of the psychologist on the ward and to some degree about who is in charge of making specific decisions.

[1] The control panel issue is addressed further in the Key Control section of this review.

Recommendations:

- Develop policy at the DSHS Headquarters level for both hospitals. Each hospital should then propose as needed local operating procedures to implement the policies. Approval for any local procedures would come from DSHS Headquarters.
- In order to ensure consistency DSHS Headquarters should provide specific instruction to the hospitals on how to develop and propose local procedures.
- Use subject matter experts to develop and write safety and security policies.
- Implement a policy training program that ensures staff are held accountable to review understand and follow policy.
- Create a position at DSHS headquarters for a Security Administrator or other security-focused leadership position.

Section 2 - Security

Key Control

Key control is an area of significant concern at both hospitals. Although both have key control policies crucial components for an overall system of accountability and control are lacking.

While observing key control practices the following concerns were noted:

- Patients at ESH/FSU could potentially gain access to the control panel/nurses station.
- At ESH/FSU hospital keys were observed on one staff member's personal key ring.
- Key rings at both hospitals are not secured and sealed. Keys can be added removed or duplicated. Nothing on the key ring itself indicates how many keys should be on the ring.
- It was reported at the ESH that recently a master key was found in an ESH parking lot which was made from a different kind of key blank than is used at ESH.
- Required key/swipe card inventories at each change of shift within the ESH/FSU are not routinely completed.
- Keys and electronic access cards are currently unaccounted for from the key box on ESH/FSU S .
- There are approximately 4 different keys in use currently at WSH campus. The most recent audit of keys provided was in 2 3. This audit showed that approximately 25 keys hospital wide were unaccounted for.

Policy deficiencies include:

- Lack of a requirement to ensure keys physically cannot be and are not removed from or added to hospital-issued key rings.
- No requirement for up-to-date inventories of key rings/swipe cards maintained in each work area that issues key rings daily or for those staff who have permanent-issue keys.
- Staff training requirements for key control and security.
- Direction for reporting of lost keys/electronic access cards.
- Process for the return of keys by employees upon separation of employment.
- The process to maintain a master inventory and index of all key rings and individual keys issued.
- There is a lack of storage accountability safeguarding and access approval for emergency keys.

Recommendations:

- New key control policy should be drafted by a person with expert knowledge of key control systems applicable to a confinement facility where control of entry/exit has serious public safety staff and patient safety and security implications.
- Develop a locksmith shop at each hospital with a dedicated staff. This is recommended in order to maintain direct control and accountability for keys which is essential to a good key control system. The locksmith would be responsible for inventory audits creating key rings cutting keys and repair of locks.
- Hire an architectural firm with expertise in the basic principles of security design to evaluate and make recommendations to improve the existing internal and external control of building entry/exit as it relates to locks and keys.
- Total rekeying of the entire ESH/FSU and WSH/CFS. Due to the number of missing keys and swipe cards and the lack of accountability this would be the only way to ensure the security of both hospitals.
- Create a committee from a cross section of staff to work collaboratively on security improvements related to key control.
- Establish a visible out-of-bounds area where patients are restricted from being within so many feet of the control panel room.

Tool Control

There are issues at both facilities with tool control. While observing tool control practices the following concerns were noted:

- There is no procedure for checking tools in or out of an area.
- There is no tool control or inventory process to account for what staff bring in or take out of an area.
- There is no accountability for missing tools. Missing tools are usually turned in by one of the ward staff or a patient.

Recommendations:

- Establish a daily inventory and accountability process for tool control.
- Establish a process to report and document lost or missing tools.
- The tool control system should ensure monitoring of tools brought into the forensic units by maintenance/repair staff that come in and ensure they are taken out of the forensic units.
- Shadow boards should be used for tools stored inside the forensic units. The tools should be accounted for at the beginning and end of each shift with the results documented.

Security Inspections

The Teams noted that staff at WSH/CFS conducts nightly security checks and ESH/FSU takes corrective actions after fire safety audits however the Teams also found areas for improvement in security inspections.

- The Teams noted there are no specific security inspection checklists in place that specifically confirm that sound security practices are in place i.e. locks are operational windows are secured there is good visibility into staff offices electrical outlets are in place etc.
- The ESH/FSU doesn't have a policy or routine practice for the inspection of the physical plant to ensure security-related features such as locking devices and glazing on windows are functioning.

Recommendations:

- Develop a security inspection policy that established a process for conducting physical inspections of the hospitals to maintain security. Policy should establish the frequency of inspections specific

areas for inspection and documentation requirements to ensure inspections are occurring as required.
- Develop security inspection checklists for use on a routine basis.
- Require staff to keep their office windows uncovered so staff passing by can confirm their safety.

Contraband Management

Proper contraband management allows for ongoing safety of patients and staff. The Teams found multiple ways in which contraband could be introduced into both facilities.

- At both hospitals contraband control is mostly controlled at the "ward level" which at that point any contraband has already been introduced into the secure perimeter. Staff bags luggage and personal belongings are not searched at the main entrance. Staff members report there is no control over what they bring in.
- Visitor searches are basic. Visitors are only required to remove their jackets and submit to an electronic wand search.
- There are inconsistencies in the definitions of contraband and the application of the contraband policies at the two facilities.

Recommendations:

- Identify what is classified as contraband inside the forensic units. The definition should apply to all staff patients and visitors.
- Limit what staff can bring inside the facility and how it is brought in – i.e. no luggage large back packs large boxes etc.
- Enhance search procedures at the entrance to the forensic units in order to control introduction before it is inside the facilities. Conduct random searches of all people entering the facility and document this action.
- Utilize local law enforcement to assist in determining if charges are warranted based on the type and amount of contraband.
- Consider changes to policy that require routine searches of patient rooms and property at the ESH/FSU that doesn't require reasonable suspicion or a physician's order.
- Consider changes to policy that would authorize the routine pat search of FSU patients during ward movements and/or at other times without needing reasonable suspicion.
- Develop new policies for contraband management and searches within the forensics units that clearly define how to handle discovered contraband and better define procedures for the searches of facilities and patients.

Entrance/Exit Procedures

Facility entrance/exit procedures are critical to ensuring community staff and patient safety and to maintain a secure facility. The physical plant and process are very different at WSH/CFS and ESH/FSU and as a result will be addressed separately in this report.

The following are observations regarding these procedures at WSH/CFS:

- The main floor sally port is the primary entrance/exit for all staff and visitors into the WSH/CFS. It is a very busy location during shift change. Laundry and food carts come out of the facility through this central sally port as well. The laundry and food carts are not inspected or searched either entering or exiting.
- The process for the basement sally port changed on August 9 2 9 following an escape from that location. Phones have been installed on each side of the sally port. Staff are required to call the security booth identify themselves and show their ID badge. Entry/exit practices have been changed to allow only staff delivering meals laundry or other items in order to utilize this sally

port. Staff was unhappy about this security change and has been challenging to staff that control entrance/exit. Laundry and food carts coming out of this sally port are not opened for security camera review. It is left up to the staff taking out the cart to ensure no patients are inside.

- Many staff reluctantly show their ID badges entering/exiting the first floor sally port. After entering many staff then place their badges inside their pockets and do not make them visible while inside the facility. Security staff has a difficult time distinguishing staff from patients.
- The review team observed security staff opening the vehicle sally port for individuals before making positive identification of who was requesting entry.
- Some stairwell door alarms activate several times during high traffic times. Security does not always send an officer to confirm that it is staff entering/exiting the stairwells and doors to the outside yards. Security staff did not appear to be concerned about the door alarms activating because it is assumed that only staff have keys to open these doors.
- The elevator that leads in to the WSH/Treatment Recovery Center TRC) is an area of concern. If both sides of the elevator are opened at the same time there is a direct path to the main corridor and sally ports. Staff who monitor the bathrooms and elevator spend a great deal of time either on their personal cell phones or reading. One staff who was monitoring the elevator had a security radio but it was sitting on the rail behind her as she talked on her cell phone. It is unclear how staff obtains approval to bring something into the facility or who enforces what can/can't be brought inside WSH/CFS. For instance while policy states that staff are not to bring cell phones with photography capability inside WSH/CFS staff routinely bring cell phones inside and use them for personal purposes while on duty.

Recommendations:

- All laundry and food carts should only be processed through the basement sally port. All carts should be visually inspected prior to exiting the facility.
- A security stop point should be painted on the floors a reasonable distance from the sally ports as a visual reminder for patients not to go past a specific check point or get too close to the slider doors.
- In order to provide enhanced security and positive identification all staff should be required to wear the ID badge on their outer most garment at all times while in the facility.
- The elevator doors between the TRC and the main hallways should not be opened at the same time unless there is an override during an emergency.
- Disable the TRC doors during treatment times.

The following are observations regarding these procedures at ESH/FSU:

- Entry/exit is controlled electronically from control panels located on each ward. The control panels that operate the ward doors are located within each of the ward's nursing stations and are operated by a PSA.
- On S ward the control panel operator electronically controls entry/exit into the ESH/FSU administration area vehicle sally port a lower hallway leading to staff offices elevator sally port entrance onto the ward and the tunnel leading to other areas of the ESH.
- On 2S and 3S wards respectively the control panel operator controls entry/exit onto their wards.
- Access to the control panel room/nurses station is electronically controlled by the panel operator or access can be gained by any number of staff members who carry the J- key. There is no sally port that can isolate the access door; as such patients are often in close proximity when the door is opened. This scenario could lead to an easy patient takeover of the control panel room thus control of entry/exit and keys which are maintained in the control panel room.

- Due to key and swipe card accountability concerns and reports by staff that the stairwell door is often propped open for convenience purposes control of entry/exit is not under strict control.
- ESH staff members do not consistently wear their ID cards or wear them in a visible location.
- Laundry carts are taken out of the unit by one staff member and are not routinely searched prior to leaving.

Recommendations:

- Remodel the control panel room so there is an isolation of entry/exit to the control panel room. A sally-port style of design is recommended. If a redesign isn't possible remove the manual locking mechanism from the door to stop manual key access and establish a visible out-of-bounds area.
- Stop the practice of routinely propping open any door that is associated with entry/exit especially the control panel rooms.
- Deactivate the stairwell swipe card access for 2S and 3S .
- Require all staff to wear ID badges on their outer garments at all times while in the facility.
- Process all laundry and food carts through the basement sally port only. All carts should be visually inspected prior to exiting the facility.
- Require an inspection of all carts exiting through the sally port.

Cameras

Cameras in this environment are an excellent way to enhance safety. At ESH cameras adequately capture primary entry/egress locations and video picture quality is adequate. Many of the cameras the team observed at WSH were inadequate outdated or not maintained. Examples include:

- Newly installed cameras located in the basement sally port of WSH/CFS lack adequate zooming capabilities.
- There are stationary cameras on the patient wards and in the yards. The picture quality is poor and at a glance it is difficult to determine which ward is being viewed.
- There are no cameras in the stairwells.
- There are hardwired duress buttons in the duty stations on each of the patient wards. When the duress button is pushed a camera for that control booth automatically comes up on screen in the security station however there is no audio. The team asked the ward at WSH/CFS to test their duress button—the staff could not locate the button.
- Work orders submitted for security concerns are not being addressed in a timely manner. Staff reported in July that a yard security camera has spider webs all over it and they can't see the picture clearly; this has still not been addressed.

Recommendations:

- Establish a regular maintenance schedule for the cameras on the wards and in the yards. The entire camera and video recording system should be considered for replacement.
- **Consider adding cameras to monitor dayrooms at the ESH FSU**

Emergency Response Plans

A review of the Emergency Response Plans at each facility found that improvements could be made in most areas including incident command and preparedness. At both hospitals staff training on emergency response plans and staff responsibilities during an emergency is very limited. Staff knowledge is limited primarily to a review of the policy or plan with little or no formal classroom or hands-on training.

Both hospitals have begun transitioning to the National Incident Management System NIMS) Incident Command System ICS). ICS is fairly new to both hospitals with few staff receiving NIMS training. The Teams recognize that both hospitals are still transitioning to the ICS and it will be some time before staff

familiarity becomes a part of the culture. After a review of both hospitals the Teams found there are significant differences emerging in the application and implementation of ICS. Examples include:

- At ESH the NIMS nomenclature is adopted to identify sections and assignments. WSH is not adopting the NIMS nomenclature and using current titles they already have identified. WSH is in the process of developing a decoder chart to translate NIMS nomenclature into their existing program which defeats the entire intent and purpose of NIMS.
- At ESH the Emergency Management Plan EMP) is a part of the safety program and the EMP policy is found in the Safety Program Manual. The WSH maintains a Comprehensive Emergency Management Plan CEMP) which is a stand-alone approach in which emergency response is not a section of another policy or program.
- At ESH the Safety Manager is responsible for the development of the emergency response plan while the Director of Emergency Services is responsible at the WSH.

At ESH all the familiar ICS manuals for each ICS position which detail the responsibilities are present and located in the designated and alternate command centers. Staff members have been pre-designated to fill the various ICS positions. At the WSH the CEMP is located at the designated Command Centers and ICS Sections. The functions of each ICS position are defined in the CEMP; however individual manuals for each ICS position are not developed and available for issue to a staff member in the event that position is activated. During interviews with staff it became clear that unless you are involved in the development of policy or have a pre-designated ICS role your knowledge of the emergency plan is limited.

Quarterly fire drills are required. However drills do not involve the evacuation of staff and patients. Staff members are not routinely conducting drills for other types of emergencies.

Recommendations

- Partner with an agency that has emergency planning expertise to develop a comprehensive and checklist-driven approach to emergency response and recovery. This partnership should also include a plan to fully develop and implement NIMS and ICS.
- Require all staff to receive training in ICS levels and 7 and all incident commanders and section chiefs should attend ICS levels 3 and 4 training in addition to and 7 .
- Drill with different emergency types on all shifts. These should be both functional and table top drills. Involve staff at all levels so they have an increased understanding and awareness of emergency response.

Internal Reporting and Communication of Incidents

Each facility has its own methods of reporting emergencies which creates inconsistencies in response and follow up. There is no single policy at either facility that defines the initial reporting requirements when a staff member detects an emergency.

At ESH the Emergency Management Plan does not identify initial reporting requirements. There are three different procedures to report an incident depending on the type of emergency. One involves a radio announcement another involves a phone call and another involves a written report. The three reporting methods are required by three separate policies.

Written reporting requirements for ESH are called Unusual Occurrence Reports UOR). At the WSH similar reports are called Administrative Incident Reporting AROI).

Other concerns noted by the team at WSH are:

- At WSH sometimes staff members dial 9- - instead of the internal emergency line. When this happens the rest of the facility does not know there is an emergency.
- At WSH when an incident requiring security staff is announced security staff is dispatched from the Central Dispatch office to provide back up and arrive on scene not knowing the nature of the emergency.

Recommendations:

- Clearly define staff initial emergency reporting requirements in the Emergency Management Plan to include:
  - Identifying one location to receive the initial emergency notification and define the elements of the notification e.g. type of emergency number of patients etc. involved type of back-up requested security staff medical staff) any weapons involved number of on-lookers etc. This type of information expedites the response by ensuring the right resources are directed to the problem.
  - Require individual statements of involvement in the incident from all involved staff prior to leaving the shift on which the incident occurred.
- Develop an incident reporting form that would be used at both hospitals. The form would have space to describe the incident people involved actions taken resolution and corrective actions necessary. This would eliminate the separate process of AROI and UORs.

Security Staff

The review Teams found significant differences in the roles of security staff at the two facilities. They also noted challenges in security staff training and enforcement of policy expectations. enerally speaking the security staffs are not viewed as increasing safety at the facilities. Examples include:

- At ESH the primary functions are to patrol the facility grounds. They do not have a presence inside the forensics unit. At the WSH they provide facility ground patrol but also provide some of the security functions inside the forensics unit.
- There is no staffing model at WSH/CFS that identifies how security staffs are required to effectively manage operations.
  - There is no process that enables supervisors to require mandatory overtime to vacant posts.
  - Shift times do not allow for adequate coverage on all shifts.
- There is no requirement for law enforcement officers to secure their firearms prior to entering the forensic unit.
- Some security staff are concerned that minimum qualifications are not being adhered to for the hiring of security officers. The Team verified that some security officers didn't meet the minimum qualifications.
- A pass-down communication tool was developed for WSH and has been adopted by all three shifts. It advises staff of significant events or any other information that should be passed on between shifts. This is shared with staff during their 5 minutes of Shift Summary/Muster. This is not used by ESH.

Recommendations:

- Clearly define the roles of Security officers at WSH/CFS and ESH/FSU and provide the appropriate training.

- Develop a staffing model for each facility that encompasses all security functions to include the forensic units. The staffing model should ensure minimum staffing levels and schedules meet program/escorting requirements.
  Require all law enforcement officers to secure their weapons prior to entering the facilities.
- Ensure new staff members meet minimum qualifications.
- Establish a Chief of Security position for each facility that requires a qualified background in safety and security issues management.
- Establish consistency of how security staff members are utilized in both facilities.

Count Procedures

One of the most important processes for ensuring safety and security of the facility staff patients and the community is knowing where patients are at all times. Count procedures are similar at both facilities.

Depending on the ward staff account for each patient either every 3 minutes or every hour. This is accomplished by one staff with a clipboard and a roster going to each patient on the ward and confirming his/her presence on the ward or confirming their location off the ward. However there is no written documentation that directs count procedures.

Recommendations:

- Develop written procedures for consistency with count within the ward and TRC. This includes a procedure for conducting a formalized body count.

Patient Outings

Social work staff members at WSH/CFS were passionate and articulate in pointing out the value of "transitional opportunities" for patients who will ultimately return to the community. They are eager to see transitional opportunities such as supervised grounds walks and supervised outings for eligible patients resume.

The WSH/CFS Risk Review Board system and the Risk Level system serve as a check and balance to determine who is appropriate for grounds walks and outings. Staff members are constantly using these tools to review patient risk levels. This structured risk assessment work helps determine which patients are eligible for transitional opportunities.

At ESH the staff believes the outings were an integral part of the reintegration to society process. However many staff members at ESH believed there was more pressure on approving numbers of patients for outings versus approving patients who qualified through a risk evaluation process. For example if there were 8 slots then it has been more important to have 8 patients go than to ensure only qualified patients go.

As for staff assigned to escort on outings at ESH there is no formal training on escort procedures. If a staff member had not escorted before there is a requirement the staff go with another staff member who has escorting experience.

Recommendations

- Provide formal training to staff members on escort procedures.
- Implement a Risk Review Board system that is used consistently at both hospitals to assess the eligibility for patients to participate in outings.

Unauthorized Leave/Escape/Elopement

Both institutions reviewed their policies for Unauthorized Leave/Escape/Elopement following the September 2 9 escape of a forensics patient at the Spokane County Fair. This review addresses the latest revision of "ESH Unauthorized Leave No: .28 dated 2/2 9" and "WSH Reporting and Recovery of Patients on Unauthorized Leave No: 4.3. dated 2/ 5/ 5." There are inconsistencies in how the facilities respond to and report an escape. Examples include:

- When there is an off-campus elopement/escape ESH immediately notifies 9 . WSH immediately notifies its Communication Center which then notifies security management and the patient's assigned ward. There is no mention of a time frame for notifying local law enforcement.
- Patients are not assessed in advance for their level of risk. The Medical Director or Chief Executive Officer must approve a physician's request to designate a 7 . 5 civil commitment for dangerous mentally ill persons) patient.
- WSH has a reporting requirement to notify DSHS Victim/Witness unit if there are victim notification requirements for that patient. ESH does not have this reporting requirement in its policy.

Recommendations:

- Develop and implement uniform emergency response procedures that include emergency checklist for escapes/unauthorized leave when the patient is not immediately apprehended. In the procedures direction should be given regarding the practice of hospital staff attempting to apprehend escaped patients.
- Develop a specific and inclusive reporting process for escapes/unauthorized leave that includes notification of the victim or witness.
- Assess 7 . 5 patients in advance to determine their levels of risk.

Section 3 - Training

Training is decentralized at both institutions except for new hires and required annual updates. Some of the annual requirements such as annual AROI update safety update Emergency Code Training) are tracked by routing a hard copy of policy throughout the hospital for review and sign-off by staff. Additionally at ESH some of the annual training is accomplished by staff reviewing power point presentations or other curriculum that is accessible via the hospitals intranet. All discipline-specific training is managed by their specific disciplines.

At ESH after the one-week new employee orientation all new nursing staff members attend four additional weeks of security-related training. The training includes key control contraband searches and Therapeutic Options.

Annual training must be completed by the time of the employee's annual evaluation and consists primarily of computer-based delivery with some post testing. Security-related topics are not included in the annual in-service at ESH. Many staff members are not in compliance with training requirements due to scheduling conflicts.

The ESH/FSU policy on escorts dated 998 states security training is required before a staff member is allowed to escort patients. However there is no specific security training available. ESH/FSU management staff told the review team they are working on development of a comprehensive security training program.

WSH has three-week orientation from the SAFE Safe Alternatives for Everyone) team. This includes training on working with dangerous and/or disruptive patients. Specifically staff members are trained to use the least restrictive approach that is effective in gaining compliance from a challenging patient. Staff members are taught de-escalation skills. If these are not effective they must obtain RN approval to physically escort the patient to seclusion. If any physical contact with the patient takes place then staff members are required to complete an Administrative Report of Incident AROI) to describe the exact nature of the incident. The ESH equivalent is called Therapeutic Options which also stresses verbal de-escalation techniques. The RN approval requirement is the same as WSH. If this technique is not effective and physical control of a patient is needed then the reporting requirement is for an Unusual Occurrence Report UOR).

Recommendations:

- Develop a comprehensive security training program that encompasses critical security topics such as key control incident command system and emergency preparedness and response searches of facility and patients physical interventions forensic unit management proper use of radios defensive tactics contraband management and control and use of seclusion/restraints.
- Develop an Employee Training and Development policy that defines required training for new employees and annual in-service for all employees.
- Develop one comprehensive training record that documents annual requirements and training for all staff members.
- Develop a policy that defines when staff members are authorized to use physical interventions who may authorize physical interventions in non-emergent and emergent situations and a common formal reporting and review process when physical interventions have occurred.
- Provide necessary relief for training so that staffing issues do not result in staff being pulled from training to cover shift.

Section 4 - Risk Level System

Risk Level System

While there are some aspects of the risk level system that appear to be strengths this is generally an area of significant concern. From a policy perspective there are inconsistencies between the two hospitals. There is not a consistent policy direction from the state level to guide policy and practice at the forensic units. Policy concerns include:

- Each hospital reported that it developed their own policies procedures and tools regarding risk level systems and risk assessment.
- Each hospital reported that it developed their own policies procedures and tools for oversight of risk levels and risk assessment e.g. Risk Review Boards).
- Currently no state-level Risk Review Board exists.

While observing risk assessment and risk level system practices the following concerns were noted:

- WSH/CFS and ESH/FSU use different risk assessment tools and different level systems.
- WSH/CFS uses a Risk Review Board which interlocks with the risk level system to serve as a check-and-balance in reviewing risk levels at fourteen key decision points e.g. whether or not a conditional release should be sought or revoked etc). ESH/FSU has a somewhat similar function via their "Senior Staff Committee." But in comparison to the WSH/CFS system this Senior Staff Committee's function does not seem as integrally tied to the risk level system and privileging decisions.

- Initial Risk Screening is done upon admission to WSH's Center for Forensic Services using the "WSH/CFS Defendant Screening Form". Results guide decisions about where a patient will be placed within WSH/CFS. This tool was developed locally and is not a validated instrument.

  Recommendations:
  - Use the same risk assessment and risk level system and procedures for assigning privilege levels at both forensic units. These tools should be current validated instruments.
  - Adopt a common Initial Risk Screening tool at both forensic units that is more clearly based on risk predictive factors.
  - Use initial screening results to inform decisions about exactly where patients will be placed.
  - Establish a state-level Risk Review Board.

Patient Mixing

The issue of patient mixing is related to the risk assessment/classification process. The Team noted that the staffs at both ESH and WSH are concerned for patient safety due to the patient populations.

Staff at ESH/FSU said the intake ward mixes the 5-day court-ordered patient population that is a higher-risk group with patients admitted for long-term treatment. Combining these two populations could place the long-term patients at risk from the fifteen-day group. WSH/CFS staff also reported concerns about patient mixing at the Treatment Recovery Center TRC).

Recommendations:
- Separate the 5-day intake/court-ordered competency evaluation patients from the longer term forensic patients.
- Revise the recovery model that governs the protocol for 5- and 9 -day patients. This was seen as a forensic issue not a pure treatment and recovery issue.

Section 5 - Best Practices

There were some best practices identified by the Teams during the assessment.

- Much to their credit three WSH/CFS staff members recently traveled – at their own expense – to Broadmoor Hospital in England specifically to study its integration of treatment and security principles. The Director of WSH/CFS described studying models of forensic hospitals in other states to look for ideas that could be applied in Washington. This included looking at Mendota State Hospital in Wisconsin and Patton State Hospital in California. The Patton State Hospital mission vision and values statements reflect a level of maturity in their work to integrate security and Person Centered Treatment.
- SAFE – Team training: **S**afe **A**lternatives **F**or **E**veryone). This includes Therapeutic Relationship Understanding Patient Behavior Understanding Aggression and De-escalation. This is not mandatory training but staff members are encouraged to participate.
- The Treatment and Recovery Center TRC) developed and implemented a process for identification and storage of sharps and materials considered a risk to the safety and security of the TRC.
- A pass-down communication tool was developed by the security supervisors and has been adopted by all three shifts. This communication tool lets staff know what significant events have happened

or any other information on the previous two shifts that should be passed on. The information is shared with staff during their fifteen minutes of Shift Summary/Muster.

- Personal alarms: Most staff members who worked in patient areas carry personal alarms they could activate in the event of an emergency. The alarms terminate through the switchboard which then dispatches assistance. It is recommended that all staff members who work in patient areas carry personal alarms.
- Both hospitals have outstanding housekeeping and maintenance programs. The facilities were immaculate and well maintained.
- Both hospitals are implementing NIMS. There is a very good move to standardize emergency response both internally and externally. Continue developing the program and staff training related to NIMS and ICS.
- Both hospitals have a Safety Management Program and Safety Management policy that defines basic hospital safety and training requirements. An annual review and audit is conducted on both hospitals by the DSHS Risk Management Office. ESH received an extremely favorable audit with very few non-compliance findings. WSH also received an extremely favorable audit with no significant non-compliance findings. The auditors were impressed with the amount of resources dedicated to ensuring employee safety during 2 9. WSH Claims Management is considered to be a best practice a model for DSHS.

APPENDIX B

Team Member Biographies

Keri Waterland is currently the Assistant Secretary of the Offender Change Division. Dr. Waterland has been with the DOC since June 2 4 and was appointed as Acting Assistant Secretary of the Offender Change Division in October 2 4 and permanently appointed on July 2 5.

Prior to her work with DOC Waterland served from July 2 8 to May 2 4 with the Department of Social and Health Services DSHS) including two of which she served as State Hospital Forensic Policy Programming and Legislation Administrator. She was the Executive Director for the statewide Public Safety Review Panel PSRP) from December 2 to January 2 2 and held various program administrator and clinical positions in the Center for Forensic Services at Western State Hospital from July 2 8 to November 2 . Waterland has performed numerous organizational audits focused on improving organization structures and communication.

Waterland holds a Doctorate in Forensic Psychology with an emphasis in public policy and law. She also holds Master's degrees in Counseling Psychology Forensic Psychology and Organizational Behavior.

David Flynn is currently the Associate Superintendent of Operations at the Washington Corrections Center for Women WCCW). He also served as the Interim Superintendent at WCCW in 2 5.

Flynn began his DOC career as a correctional officer at McNeil Island Corrections Center MICC) in 993. While at McNeil Island he also held the positions of sergeant lieutenant and captain. In 2 9 he accepted the captain position at Cedar Creek Corrections Center. He has spent nearly 25 years working in the Washington Department of Corrections.

Flynn has conducted numerous Critical Incident Reviews CIRs) throughout the DOC. He has a great deal of experience in the realm of emergency response. Flynn has a strong background in custody and security and has been instrumental in physical plant improvements of the prisons for which he has had oversight.

Flynn earned his Bachelor's Degree at Saint Martins and graduated Magna Cum Laude.

Charlotte Headley currently serves as the Department of Corrections' Chief of Security. Headley began her career with the Washington Department of Corrections in 998 and brings the experience of working in multiple Washington prisons at all levels of security. She has held the positions of correctional officer sergeant correctional unit supervisor lieutenant and captain. She is an expert in managing security operations conducting operations and emergency response audits and has participated in numerous reviews of critical incidents within the DOC.

Her current position is focused on the development of security related policies processes and routines as well as advancing the agency staff safety initiatives.

Headley earned her Bachelor's Degree in law and justice from Central Washington University in 998.