

Statement of Gary D. Jones

I worked for the Washington State Department of Corrections as an administrator, retiring in October 2001.

On November 1, 1997, I was reassigned to the Washington Corrections Center at Shelton, Washington. Preceding my assignment, this institution had experienced months of violence (assaults, property damage, injuries to staff and offenders) in their satellite maximum security unit.

I personally had been assigned twice by the Department to prepare Critical Incident Reviews in response to major disturbances, less than a month apart.

Washington Super Maximum Units are attached to major facilities throughout the state at four locations. Each Unit is managed by the facility superintendent and his/her administrative team.

November 1, 1997, I began my assignment at the Washington Corrections Center. The day before my assignment, an additional major disturbance occurred that included thousands of dollars of property damage, assault threats on staff and offenders, failure of physical plant, and uses of force incidents. I personally responded to the event, at the request of the superintendent, prior to my official start date.

Though the late October disturbance was violent and tragic, it also allowed me to observe first hand interactions of staff and offenders, and it set in motion yet another critical review investigation. I was given the opportunity to do this investigative review with staff assigned to the institution, as opposed to an outside or independent review.

My previous investigative reviews found several physical plant security failures, unprofessional staff conduct, supervisory failures, management failures, administrative failures, offender dislike towards staff, and staff dislike of offenders.

The assaults toward staff ranged from continuous bombardment of feces and urine to stabbings and much more in between. The physical plant failures included escapes from cells, escapes from showers, malfunctioning control panels opening doors of unrestrained offenders, and fire damage to security lexan, as well as gang graffiti and disrespect scribbled on all areas offenders used.

All of the units in the state were at capacity with a waiting list to get in to the Super Max Units. Each unit in the state was responding to major disturbances and over crowding issues; close custody segregation units, also at capacity, would have a disturbance and the ring leaders would be moved to Maximum Units, giving rise to unearned releases of the least of the worst offenders, and perpetuating the super max need and continuous institution problems. Trouble makers involved in major incidents at Super Max Units were routinely exchanged throughout the state to quiet a major event at a particular unit. That, in most cases, gave way to new problems at the receiving units.

Actions Needed:

Based on the critical reviews, corrective action plans were developed to address all of the operational and non-generational deficiencies.

Additional findings:

Staff and offenders feared for their safety due to physical plant failures, and stress was extremely high in both staff and offenders from months of what each described as war. Disrespect and profane language were common by both.

Administratively, I found the desk of my predecessor with a three foot high stack of unheard major rule violation reports; a like size pile of un-reviewed classification referrals; and a larger stack of offender grievances. I was shocked, and no wonder staff and offenders were at war with each other. I found policies and procedures outdated and un-reviewed; in fact, staff had begun scratching out policies and procedure statements and were hand writing in their own rules into the operations.

I knew without relief from administrative failures, I would be unable to manage any better than the person I replaced. Each stack of unprocessed paperwork was a compilation of failures of staff and continuous frustration of offenders. Offender trust had been lost. They were in a situation of isolation without response.

I developed a plan to bring order to the unit.

1. An emergency request for funding was submitted to address all the staff-identified physical plant failures. Repair and replacement schedules were established and communicated.
2. Policy and procedures were assigned for reviews with established dates of completion and plans for implementation.
3. All classifications were reviewed and signed. An assigned team from the Department addressed grievances. A Hearing Officer was assigned to address rule violations, just for this unit.
4. Staff training needs were identified and initiated.
5. I, from day one, began a daily walk-through of the unit, talking to offenders (line staff and supervisors initially hated this). I learned quickly the offenders' side of our failures and was able to communicate my expectations of better responses from them. I was able to reinforce, personally, that they were being heard, and they were able to observe changes and actions occurring from established corrective actions ongoing. After my first couple of weeks on the unit, I changed daily walk-throughs to twice a week. Supervisors were content to let this occur, but I knew it was important for them to hear and respond to what I was hearing and passing on to them to follow up on. I knew that the longer I was able to continue this practice, the sooner they would follow. I met with them after each walk-through and discussed the importance of their

follow-up on items assigned to them. Within a few weeks, I found them on the tiers addressing assigned items with offenders, but still not attending walk-throughs with me. The second month, supervisors asked if they could come along on my walk-throughs. I informed them that I expected them to conduct walk-throughs and would appreciate their coming along. I informed them that profanity was not to be tolerated from offenders and reinforced not to be used by staff either; and that respect was to be given, and it would be expected that offenders show respect. Of course, I already knew they had been hearing this from the booth staff monitoring tiers in the control booths and, as well, they had heard me communicating it at all meetings. I informed all managers and supervisors that we did our work in this unit within the frame work of the 3 R's. Respect of staff, Respect to others, and Responsibility of all of our actions. Nothing less would be accepted.

After a couple of months, all supervisors and unit managers were attending walk-throughs, and I had reduced the walk-through to once per week. All along, offenders and staff were seeing corrective action plans and physical plant work move forward. Supervisors and managers began seeing less paperwork to respond to. Grievances were nearly non-existent because we could handle the problem much more quickly than it took for the months of a grievance response and due to a weekly visit. Infraction behavior was reduced by 50 percent in the first six months. Hundreds of grievances that lay on my desk when I started at the unit were gone within six months, and none replaced them. The thousands of dollars in damages to the unit had been reduced to zero during the first six months. Supervisors were finding they had more time to manage and supervise and actively pursued those endeavors.

Officers were made an integral part of the unit team, and interactions by offenders with officers became a active part of their program for release consideration.

The weekly walk-throughs visits allowed me to identify offenders that were struggling with their assignment to the unit, as well as those that were suffering from mental health problems or mental health deterioration. I assigned a full time mental health professional to assist us with mental health assessments and to work with difficult-to-manage offenders within the first few weeks of my assignment. The mental health professional did walk-throughs with us and assisted us in developing behavior programs for difficult-to-manage offenders. The mental health professional provided mental health treatment and referrals for those in need.

The design of the Super Max had very limited program space, so to provide needed change opportunities for offenders was very limited. Many complaints by offenders were that they could not get involved in programs required of the release consideration while in the unit. Areas were remodeled and secure/safe program space was designed and installed within the first 18 months. This space enhanced educational offerings, provided space for mental health groups, anger management groups, and victim awareness groups.

Uses of Force:

All uses of force were reviewed over the previous year and training needs identified. Each incident was reviewed and flaws identified: poor escort procedures; using cell entry when cell

extractions was the preferred method of contact (placing staff at risk when offenders were known to be armed and ready for entry).

Negotiations were established, in the first month of my assignment, for all uses of force. Direction that controlled uses of force was not to be used until all negotiation options had been explored, up to and including my involvement. Officer, supervisors, counselors, managers, mental health, and myself would negotiate, and the understanding became that controlled use of force would be the last resort, not the first action.

Offenders became confused by this change in practice and commonly said, "Why didn't you come and get me?"

Use of force incidents were reduced by 50 percent in the first six months and over 90 percent in the first 18 months.

I found that all controlled uses of force had a cause and effect in these units. My review of all the incidents prior to my assignment, in overwhelming numbers found the cause to be staff actions or inaction that precipitated the event. Example: the officer brought cold food and refused to do anything about it; the counselor said I was being released last week two months in a row; the officer had refused to turn on my radio for four days; etc., etc.

A use of force incident always puts staff at risk of injury; always puts the offender at risk of injury; always caused a shut down of the unit and all activities (costing other offenders yards, showers, phone, visits, medical, food on time, etc.), sometimes for the day. It caused staff additional work and time (over time); exposure to chemicals in most cases; and lots of additional paperwork. I always considered controlled use of force preventable. What a savings!!

Programs:

Offenders in Super Max need direct access to change programs: mental health programming, behavior programming, self-help, and education. A secure setting is needed, and small groups are helpful. These programs and all releases [should] be to transitional units with additional programs designed for re-entry to a general population.

Legislation:

Too often, offenders we are saying are too dangerous to live in our prisons are released straight back to our communities right out of a Super Max. Everything possible should be tried to prevent this from occurring. I assisted in getting a law passed, that we called a "Prison Misbehavior" law, that was for the non-compliant Super Max offenders who had lost all good time credits and were completing their full sentence. We could refer them for prosecution under our Prison Misbehavior statute. This statute assisted us in getting all offenders into needed programs while housed in Super Max and assisted in keeping very dangerous long-term Super Max offenders that were non-compliant with release strategies from going straight to the community from the Super Max.

All of the preceding strategy was messaged, mentored, modeled, and managed by me throughout the four year period.

The combination of establishing a safe/secure operational physical plant; administrator and administrative team weekly cell front visits with maximum custody offenders; safe/secure program delivery; administrative policy/procedure change that was current and kept current; training for staff supervisors, managers, and officers that was designed on performance-based criteria specific to maximum security; assignment of a mental health professional; and establishment of a misbehavior statute led to the following results:

1997-2001

0 physical plant damage
75% reduced infraction behavior
90% reduced uses of force
95% reduced offender grievances
0 disturbances
100% reduced staff injuries
100% reduced offender injuries

The book "Total Confinement," authored by Lorna A. Rhodes, chapter 6, discusses much of the struggle we went through from perspectives of staff and offenders.

The Washington Corrections Center continues with these actions today, and similar results are continuing.

Thank you for the opportunity to provide input to the commission.

Sincerely
Gary D. Jones
Associate Supt. (Retired)