SENATE BILL REPORT
SB 5119

As of January 20, 2021

Title: An act relating to individuals in custody.

Brief Description: Concerning individuals in custody.

Sponsors: Senators Darneille, Das, Hasegawa, Mullet, Nguyen, Robinson, Salomon and Wilson, C..

Brief History:
Committee Activity: Human Services, Reentry & Rehabilitation: 1/21/21.

Brief Summary of Bill

- Requires the Department of Corrections to convene an unexpected fatality review team to conduct a review when an incarcerated individual dies unexpectedly or a case is identified by the Office of Corrections Ombuds (OCO) for review.
- Specifies that the OCO must serve as a member of the unexpected fatality review team and issue an annual legislative report on the implementation of unexpected fatality review recommendations.
- Requires a city or county department of corrections or chief law enforcement officer responsible for the operation of a jail to convene an unexpected fatality review team to conduct a review when an individual confined in the jail dies unexpectedly.

SENATE COMMITTEE ON HUMAN SERVICES, REENTRY & REHABILITATION

Staff: Kelsey-anne Fung (786-7479)

Background: State Correctional Facilities. As of September 30, 2020, the Washington State Department of Corrections (DOC) is responsible for the custody of approximately

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16,183 individuals in 12 correctional facilities and 12 work release facilities across the state. According to DOC, in 2018, from a prison population of 19,369 inmates, 34 died of natural causes, one due to accident, zero from homicide, and two died of suicide. In 2019, from a prison population of 19,160 inmates, 30 died of natural causes, one due to accident, zero from homicide, and five died of suicide.

Critical Incident Reviews. DOC currently has an internal policy that requires a critical incident review when there is an unnatural death or serious bodily injury of an incarcerated individual, contract staff, volunteer, or visitor occurring on DOC premises, including death by suicide of an incarcerated individual. Information gathered through incident reviews is analyzed to identify activities that contributed to successful outcomes, improve DOC policies and procedures, and determine whether improvements are needed. Critical incident reviews are completed within 120 days of assignment, and an extension may only be approved by specified individuals.

When an incident occurs, the appropriate assistant secretary or their designee will initiate the critical incident review and designate team members to serve on the review team. Teams members should be appointed to provide a complete review and avoid potential conflicts of interest. All assigned team members should have appropriate experience, training, and knowledge of DOC policies, procedures, and practices necessary to conduct the review. After completion of a critical incident review, an associated corrective action plan is initiated within ten business days. Critical incident review reports and resulting action plans are subject to public disclosure.

Fatality Reviews. There is no formal review process outlined in statute for a fatality of an incarcerated individual. Current law outlines a review process for child fatalities suspected to be caused by child abuse or neglect; child fatalities occurring in early learning programs; and vulnerable adult fatalities believed to be related to abuse, abandonment, exploitation, neglect of the vulnerable adult, or related to the adult's self-neglect.

Office of Corrections Ombuds. The Office of Corrections Ombuds (OCO) was created in 2018 as an independent and impartial office to provide information to inmates and their families; promote public awareness and understanding of inmates rights and responsibilities; identify system issues and responses for the Governor and the Legislature; and ensure compliance with relevant statutes, rules, and policies pertaining to corrections facilities, services, and treatment of inmates under the jurisdiction of DOC. The OCO must annually report to the Governor, Legislature, and DOC Statewide Family Council on the number of complaints received and resolved by the OCO, significant systemic or individual investigations or outcomes achieved by the OCO, and any outstanding or unresolved concerns or recommendations of the OCO. In both its 2019 annual report and 2020 annual report, the OCO recommended that DOC should be required to produce an annual report on deaths in custody that provides an explanation of cause of death and any findings or recommendations developed by the Department of Health or critical incident review.

Jails and Jail Deaths. There is no statutory requirement for local jails to report a death of an individual confined in the jail. The Washington Association of Sheriffs and Police Chiefs conducts an annual jail population survey among the jails that includes in custody deaths, however the survey is voluntary. The Bureau of Justice Statistics, a division of the federal Department of Justice, also conducts a voluntary annual survey of in custody deaths at local jails across the country.

Current law authorizes a city or county primarily responsible for the operation of a jail to create a department of corrections to be in charge of such jail and the persons confined in the jail. If a city or county does not create a department of corrections, the chief law enforcement officer of the city or county is in charge of the jail and the persons confined in the jail.

Summary of Bill: Unexpected Fatality Reviews at State Correctional Facilities. DOC must conduct an unexpected fatality review when an incarcerated individual dies unexpectedly or a case is identified by the OCO for review. DOC must convene an unexpected fatality review team consisting of individuals with certain expertise and no prior involvement in the case. The OCO, or the OCO's designee, must serve as a member of the review team. The purpose of the review is to develop recommendations for changes in policies and practices to prevent fatalities and strengthen safety and health protections for prisoners. Within 180 days of a fatality, DOC must issue a report on the results of the review, unless an extension has been granted by the Governor. Reports must be distributed to appropriate committees of the Legislature and DOC must create a public website where reports must be posted and maintained. Reports are subject to public disclosure and confidential information may be redacted by DOC consistent with applicable state and federal laws.

DOC must permit the OCO physical access to state institutions and state-licensed facilities or residences and grant access to inspect and copy all relevant records and information necessary in the investigation. The OCO must issue an annual report to the Legislature on the implementation of unexpected fatality review recommendations.

Unexpected Fatality Reviews atJails. A city or county department of corrections or chief law enforcement officer responsible for the operation of a jail must conduct an unexpected fatality review when a person confined in the jail dies unexpectedly. The membership and purpose of the team is specified and the city or county department of corrections or chief law enforcement officer must issue a report on the results of the review within 180 days of the fatality, unless an extension has been granted by the Governor. Reports must be distributed to the governing unit with primary responsibility for the operation of the jail and appropriate committees of the Legislature. The Department of Health must create a public website where reports must be posted and maintained. Reports are subject to public disclosure and confidential information may be redacted by the city or county department of corrections or chief law enforcement officer consistent with applicable state and federal laws.

Procedural restrictions and permissions related to the use and admissibility of certain items as evidence and the availability of certain witnesses in a civil or administrative proceeding are created for unexpected fatality reviews at DOC and jails. The restrictions do not apply in a licensing or disciplinary proceeding based on allegations of wrongdoing in connection with an unexpected fatality that is reviewed by the team.

Appropriation: None.

Fiscal Note: Requested on January 11, 2021.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.