SENATE BILL REPORT
SB 5119

As of February 11, 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, 2/02/21 [DPS-WM].
Ways & Means: 2/15/21.

Brief Summary of First Substitute 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.
- 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

Majority Report: That Substitute Senate Bill No. 5119 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Darneille, Chair; Nguyen, Vice Chair; Gildon, Ranking Member; Dozier, Saldaña and Wilson, C.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

Staff: Kelsey-anne Fung (786-7479)

SENATE COMMITTEE ON WAYS & MEANS

Staff: Sarian Scott (786-7729)

Background: State Correctional Facilities. As of September 30, 2020, the Washington State Department of Corrections (DOC) is responsible for the custody of approximately 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 (First Substitute): 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, and a representative from the Department of Health must serve as members 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 120 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.

Within 10 days of completing an unexpected fatality review, an associated corrective action plan must be developed to implement any recommendations from the unexpected fatality review. Corrective action plans must be implemented within 120 days, unless an extension has been granted by the Governor. Corrective action plans are subject to public disclosure and must be posted on DOC's website, with any confidential information 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 review is defined as a review of any death that was not the result of a diagnosed or documented terminal illness or other debilitating or deteriorating illness or condition where the death was anticipated, and includes the death of any person under DOC's jurisdiction, regardless of where the death actually occurred. Jurisdiction of DOC does not include persons under DOC supervision. A review must include an analysis of the root cause or causes of the unexpected fatality and an associated corrective action plan for DOC to address identified root causes and recommendations made by the unexpected fatality team.

Unexpected Fatality Reviews at Jails. 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. The city or county department of corrections or chief law enforcement officer must issue a report on the results of the review within 120 days of the fatality, unless an extension has been granted by the chief executive, or if appropriate, the county legislative authority of the governing unit with primary responsibility for the operation of the jail. 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. No provision of this act may be interpreted to require a jail to disclose any information in a report that would, as determined by the jail, reveal security information about the jail.

Unexpected fatality review is defined as a review of any death that was not the result of a diagnosed or documented terminal illness or other debilitating or deteriorating illness or condition where the death was anticipated, and includes the death of any person under the care and custody of the city or county department of corrections or chief local enforcement officer, regardless of where the death actually occurred. A review must include an analysis of the root cause or causes of the expected fatality, and an associated corrective action plan for the jail to address identified root causes and recommendations made by the unexpected fatality review team.

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.

EFFECT OF CHANGES MADE BY HUMAN SERVICES, REENTRY &

REHABILITATION COMMITTEE (First Substitute):

- Defines "unexpected fatality review" for DOC and local jails.
- Alters the time period to complete an unexpected fatality review from 180 days to 120 days for both DOC and local jails.
- Requires a representative from the Department of Health to serve as a member of the DOC unexpected fatality review team.
- Requires DOC to develop and implement a corrective action plan within a specified period of time, and post the plan on its website.
- Alters the authority to grant extensions for unexpected fatality reviews for local jails to the chief executive, or if appropriate, the county legislative authority of the governing unit with primary responsibility for the operation of the jail.
- Prohibits any provision from being interpreted to require a jail to disclose any information that would reveal security information about the jail.

Appropriation: None.

Fiscal Note: Available.

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

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

Staff Summary of Public Testimony on Original Bill (Human Services, Reentry & Rehabilitation): *The committee recommended a different version of the bill than what was heard.* PRO: A normative process already exists for the collection of information, investigation, and reporting of children's deaths that occur while they are in the state's care, and this bill would extend those best practices and apply them to other facilities where people are in the care of the state, or local government or municipality. There were a couple of incidents this past year in prisons and local jails where an incarcerated individual unexpectedly died, and state and local policymakers currently do not have a normative way to learn about and understand the gravity of situations happening in facilities. This bill would provide the structure for not only reviewing these kinds of cases internally but provide openness and accountability for these cases with policymakers and the public. This also ensures state correctional institutions and local jails have a consistent approach to collecting, reviewing, and making information available to the public.

OTHER: The majority of provisions in the bill are currently covered by DOC's critical incident review policy, and DOC is supportive of including the Corrections Ombuds to the critical incident review team and creating a mechanism for reports to be posted on DOC's website. It is important to clarify which agency is responsible for reviewing the death of a person under DOC supervision who unexpectedly dies while confined in a local jail. There will be staff costs for the Corrections Ombuds to do this work regularly, and the membership of the review team could be expanded to include a representative from the

Department of Health and a person selected by the DOC Statewide Family Council with sufficient health expertise.

The narrow focus on unexpected deaths is concerning because it would not include deaths caused by cancer, which would be considered an expected death but miss whether delays in an agency's diagnosis or treatment hastened or caused the death. It would also miss persons who are removed from custody and transferred to the local medical facility for care, and die shortly thereafter. The timeframe for a report should be shortened to 30 days after a fatality, and the term review should be changed to root cause analysis to prevent superficial reviews. Deaths should also be reviewed collectively for any themes that would inform policies in the future. The repair part of the bill could be made stronger by setting a timeframe on the development of a corrective action plan and requiring the corrective action plan to be reviewed to determine if it was implemented.

There will be costs associated with this bill for local jails. Jails range in size from large jails in urban areas to small jails in rural areas, and many jails do not have staff with expertise to perform these kinds of reviews. Jails should not be required to share any security or tactical information in a report and the chief elected official from that jurisdiction should have the authority to grant requests for time extensions. There is also a concern regarding the admissibility of a fatality review in federal court.

Persons Testifying (Human Services, Reentry & Rehabilitation): PRO: Senator Jeannie Darneille, Prime Sponsor.

OTHER: James McMahan, Washington Association of Sheriffs and Police Chiefs; Joanna Carns, Office of the Corrections Ombuds; Tomas Fithian, Department of Corrections; Marc Stern, citizen; Rhonda Clemens, citizen; Meagan Kineman, citizen.

Persons Signed In To Testify But Not Testifying (Human Services, Reentry & Rehabilitation): No one.