
ENGROSSED SUBSTITUTE SENATE BILL 5119

State of Washington

67th Legislature

2021 Regular Session

By Senate Human Services, Reentry & Rehabilitation (originally sponsored by Senators Darneille, Das, Hasegawa, Mullet, Nguyen, Robinson, Salomon, and Wilson, C.)

READ FIRST TIME 02/03/21.

1 AN ACT Relating to individuals in custody; adding a new section
2 to chapter 72.09 RCW; adding a new section to chapter 43.06C RCW;
3 adding a new section to chapter 70.48 RCW; and creating a new
4 section.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

6 NEW SECTION. **Sec. 1.** A new section is added to chapter 72.09
7 RCW to read as follows:

8 (1)(a) The department shall conduct an unexpected fatality review
9 in any case in which the death of an incarcerated individual is
10 unexpected, or any case identified by the office of the corrections
11 ombuds for review.

12 (b) The department shall convene an unexpected fatality review
13 team and determine the membership of the review team. The team shall
14 comprise of individuals with appropriate expertise including, but not
15 limited to, individuals whose professional expertise is pertinent to
16 the dynamics of the case. The unexpected fatality review team shall
17 include the office of the corrections ombuds or the ombuds' designee,
18 and a representative from the department of health. The department
19 shall ensure that the unexpected fatality review team is made up of
20 individuals who had no previous involvement in the case.

1 (c) The primary purpose of the unexpected fatality review shall
2 be the development of recommendations to the department and
3 legislature regarding changes in practices or policies to prevent
4 fatalities and strengthen safety and health protections for prisoners
5 in the custody of the department.

6 (d) Upon conclusion of an unexpected fatality review required
7 pursuant to this section, the department shall, within 120 days
8 following the fatality, issue a report on the results of the review,
9 unless an extension has been granted by the governor. Reports must be
10 distributed to the appropriate committees of the legislature, and the
11 department shall create a public website where all unexpected
12 fatality review reports required under this section must be posted
13 and maintained. An unexpected fatality review report completed
14 pursuant to this section is subject to public disclosure and must be
15 posted on the public website, except that confidential information
16 may be redacted by the department consistent with the requirements of
17 applicable state and federal laws.

18 (e) Within 10 days of completion of an unexpected fatality review
19 under this section, the department shall develop an associated
20 corrective action plan to implement any recommendations made by the
21 review team in the unexpected fatality review report. Corrective
22 action plans shall be implemented within 120 days, unless an
23 extension has been granted by the governor. Corrective action plans
24 are subject to public disclosure, and must be posted on the
25 department's website in accordance with (d) of this subsection,
26 except that confidential information may be redacted by the
27 department consistent with the requirements of applicable state and
28 federal laws.

29 (f) The department shall develop and implement procedures to
30 carry out the requirements of this section.

31 (2) In any review of an unexpected fatality, the department and
32 the unexpected fatality review team shall have access to all records
33 and files regarding the person or otherwise relevant to the review
34 that have been produced or retained by the agency.

35 (3) (a) An unexpected fatality review completed pursuant to this
36 section is subject to discovery in a civil or administrative
37 proceeding, but may not be admitted into evidence or otherwise used
38 in a civil or administrative proceeding except pursuant to this
39 section.

1 (b) A department employee responsible for conducting an
2 unexpected fatality review, or member of an unexpected fatality
3 review team, may not be examined in a civil or administrative
4 proceeding regarding: (i) The work of the unexpected fatality review
5 team; (ii) the incident under review; (iii) his or her statements,
6 deliberations, thoughts, analyses, or impressions relating to the
7 work of the unexpected fatality review team or the incident under
8 review; or (iv) the statements, deliberations, thoughts, analyses, or
9 impressions of any other member of the unexpected fatality review
10 team, or any person who provided information to the unexpected
11 fatality review team relating to the work of the unexpected fatality
12 review team or the incident under review.

13 (c) Documents prepared by or for an unexpected fatality review
14 team are inadmissible and may not be used in a civil or
15 administrative proceeding, except that any document that exists
16 before its use or consideration in an unexpected fatality review, or
17 that is created independently of such review, does not become
18 inadmissible merely because it is reviewed or used by an unexpected
19 fatality review team. A person is not unavailable as a witness merely
20 because the person has been interviewed by, or has provided a
21 statement for, an unexpected fatality review, but if the person is
22 called as a witness, the person may not be examined regarding the
23 person's interactions with the unexpected fatality review including,
24 without limitation, whether the person was interviewed during such
25 review, the questions that were asked during such review, and the
26 answers that the person provided during such review. This section may
27 not be construed as restricting the person from testifying fully in
28 any proceeding regarding his or her knowledge of the incident under
29 review.

30 (d) The restrictions set forth in this section do not apply in a
31 licensing or disciplinary proceeding arising from an agency's effort
32 to revoke or suspend the license of any licensed professional based
33 in whole or in part upon allegations of wrongdoing in connection with
34 an unexpected fatality reviewed by an unexpected fatality review
35 team.

36 (4) For the purposes of this section:

37 (a) "Unexpected fatality review" means a review of any death that
38 was not the result of a diagnosed or documented terminal illness or
39 other debilitating or deteriorating illness or condition where the
40 death was anticipated, and includes the death of any person under the

1 jurisdiction of the department, regardless of where the death
2 actually occurred. A review must include an analysis of the root
3 cause or causes of the unexpected fatality, and an associated
4 corrective action plan for the department to address identified root
5 causes and recommendations made by the unexpected fatality review
6 team under this section.

7 (b) "Jurisdiction of the department" does not include persons on
8 community custody under the supervision of the department.

9 NEW SECTION. **Sec. 2.** A new section is added to chapter 43.06C
10 RCW to read as follows:

11 (1) The ombuds or the ombuds' designee shall serve as a member of
12 the unexpected fatality review team convened under chapter 72.09 RCW.

13 (2) The department shall:

14 (a) Permit the ombuds or the ombuds' designee physical access to
15 state institutions serving incarcerated individuals and state-
16 licensed facilities or residences for the purposes of carrying out
17 its duties under this chapter; and

18 (b) Upon the ombuds' request, grant the ombuds or the ombuds'
19 designee the right to access, inspect, and copy all relevant
20 information, records, or documents in the possession or control of
21 the department that the ombuds considers necessary in an
22 investigation.

23 (3) The office shall issue an annual report to the legislature on
24 the status of the implementation of unexpected fatality review
25 recommendations.

26 NEW SECTION. **Sec. 3.** A new section is added to chapter 70.48
27 RCW to read as follows:

28 (1)(a) A city or county department of corrections or chief law
29 enforcement officer responsible for the operation of a jail shall
30 conduct an unexpected fatality review in any case in which the death
31 of an individual confined in the jail is unexpected.

32 (b) The city or county department of corrections or chief law
33 enforcement officer shall convene an unexpected fatality review team
34 and determine the membership of the review team. The team shall
35 comprise of individuals with appropriate expertise including, but not
36 limited to, individuals whose professional expertise is pertinent to
37 the dynamics of the case. The city or county department of
38 corrections or chief law enforcement officer shall ensure that the

1 unexpected fatality review team is made up of individuals who had no
2 previous involvement in the case.

3 (c) The primary purpose of the unexpected fatality review shall
4 be the development of recommendations to the governing unit with
5 primary responsibility for the operation of the jail and legislature
6 regarding changes in practices or policies to prevent fatalities and
7 strengthen safety and health protections for individuals in custody.

8 (d) Upon conclusion of an unexpected fatality review required
9 pursuant to this section, the city or county department of
10 corrections or chief law enforcement officer shall, within 120 days
11 following the fatality, issue a report on the results of the review,
12 unless an extension has been granted by the chief executive or, if
13 appropriate, the county legislative authority of the governing unit
14 with primary responsibility for the operation of the jail. Reports
15 must be distributed to the governing unit with primary responsibility
16 for the operation of the jail and appropriate committees of the
17 legislature, and the department of health shall create a public
18 website where all unexpected fatality review reports required under
19 this section must be posted and maintained. An unexpected fatality
20 review report completed pursuant to this section is subject to public
21 disclosure and must be posted on the department of health public
22 website, except that confidential information may be redacted by the
23 city or county department of corrections or chief law enforcement
24 officer consistent with the requirements of applicable state and
25 federal laws.

26 (e) The city or county department of corrections or chief law
27 enforcement officer shall develop and implement procedures to carry
28 out the requirements of this section.

29 (2) In any review of an unexpected fatality, the city or county
30 department of corrections or chief law enforcement officer and the
31 unexpected fatality review team shall have access to all records and
32 files regarding the person or otherwise relevant to the review that
33 have been produced or retained by the agency.

34 (3)(a) An unexpected fatality review completed pursuant to this
35 section is subject to discovery in a civil or administrative
36 proceeding, but may not be admitted into evidence or otherwise used
37 in a civil or administrative proceeding except pursuant to this
38 section.

39 (b) An employee of a city or county department of corrections or
40 law enforcement employee responsible for conducting an unexpected

1 fatality review, or member of an unexpected fatality review team, may
2 not be examined in a civil or administrative proceeding regarding:
3 (i) The work of the unexpected fatality review team; (ii) the
4 incident under review; (iii) his or her statements, deliberations,
5 thoughts, analyses, or impressions relating to the work of the
6 unexpected fatality review team or the incident under review; or (iv)
7 the statements, deliberations, thoughts, analyses, or impressions of
8 any other member of the unexpected fatality review team, or any
9 person who provided information to the unexpected fatality review
10 team relating to the work of the unexpected fatality review team or
11 the incident under review.

12 (c) Documents prepared by or for an unexpected fatality review
13 team are inadmissible and may not be used in a civil or
14 administrative proceeding, except that any document that exists
15 before its use or consideration in an unexpected fatality review, or
16 that is created independently of such review, does not become
17 inadmissible merely because it is reviewed or used by an unexpected
18 fatality review team. A person is not unavailable as a witness merely
19 because the person has been interviewed by, or has provided a
20 statement for, an unexpected fatality review, but if the person is
21 called as a witness, the person may not be examined regarding the
22 person's interactions with the unexpected fatality review including,
23 without limitation, whether the person was interviewed during such
24 review, the questions that were asked during such review, and the
25 answers that the person provided during such review. This section may
26 not be construed as restricting the person from testifying fully in
27 any proceeding regarding his or her knowledge of the incident under
28 review.

29 (d) The restrictions set forth in this section do not apply in a
30 licensing or disciplinary proceeding arising from an agency's effort
31 to revoke or suspend the license of any licensed professional based
32 in whole or in part upon allegations of wrongdoing in connection with
33 an unexpected fatality reviewed by an unexpected fatality review
34 team.

35 (4) No provision of this section may be interpreted to require a
36 jail to disclose any information in a report that would, as
37 determined by the jail, reveal security information about the jail.

38 (5) For the purposes of this section:

1 (a) "City or county department of corrections" means a department
2 of corrections created by a city or county to be in charge of the
3 jail and all persons confined in the jail pursuant to RCW 70.48.090.

4 (b) "Chief law enforcement officer" means the chief law
5 enforcement officer who is in charge of the jail and all persons
6 confined in the jail if no department of corrections was created by a
7 city or county pursuant to RCW 70.48.090.

8 (c) "Unexpected fatality review" means a review of any death that
9 was not the result of a diagnosed or documented terminal illness or
10 other debilitating or deteriorating illness or condition where the
11 death was anticipated, and includes the death of any person under the
12 care and custody of the city or county department of corrections or
13 chief local enforcement officer, regardless of where the death
14 actually occurred. A review must include an analysis of the root
15 cause or causes of the unexpected fatality, and an associated
16 corrective action plan for the jail to address identified root causes
17 and recommendations made by the unexpected fatality review team under
18 this section.

19 NEW SECTION. **Sec. 4.** If specific funding for the purposes of
20 this act, referencing this act by bill or chapter number, is not
21 provided by June 30, 2021, in the omnibus appropriations act, this
22 act is null and void.

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