SENATE BILL REPORT
SB 6204

As of February 4, 2020

Title: An act relating to prisoner fatality and near fatality reviews for persons in the custody of the department of corrections.

Brief Description: Concerning prisoner fatality and near fatality reviews for persons in the custody of the department of corrections.

Sponsors: Senators Darneille, Hasegawa, Keiser, Nguyen, Stanford, Das and Wilson, C.

Brief History:
Committee Activity: Human Services, Reentry & Rehabilitation: 1/14/20, 1/22/20 [DPS-WM].
Ways & Means: 1/29/20.

Brief Summary of First Substitute Bill

- Requires the Department of Corrections (DOC) to convene a prisoner fatality review team to conduct a prisoner fatality review when a fatality, or in some cases near fatality, occurs and report the results of the review.
- Requires DOC to promptly notify the Office of the Corrections Ombuds (OCO) in the event of a near fatality of a prisoner in DOC's custody.
- Requires the OCO to issue an annual report to the Legislature on the implementation of prisoner fatality review recommendations.

SENATE COMMITTEE ON HUMAN SERVICES, REENTRY & REHABILITATION

Majority Report: That Substitute Senate Bill No. 6204 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; Walsh, Ranking Member; Cleveland, O'Ban, Wilson, C. and Zeiger.

Staff: Kelsey-anne Fung (786-7479)

SENATE COMMITTEE ON WAYS & MEANS

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

Staff: Kayla Hammer (786-7305)

Background: Fatality Reviews. DOC is responsible for the custody of approximately 19,500 individuals in 12 correctional facilities and 14 work release facilities across the state. According to DOC, in 2017, from a prison population of 19,528 inmates, 38 died of natural causes, 1 due to accident, 1 from homicide, and 2 died of suicide. In 2018, from a prison population of 19,369 inmates, 34 died of natural causes, 1 due to accident, and 2 died of suicide.

Since 2014, DOC has had an internal policy that requires a critical incident review for when there is an unnatural death or serious bodily injury of an offender occurring on DOC premises, including offender suicide. Each assistant secretary must designate at least five employees with appropriate expertise, training, and knowledge of DOC policies, procedures, and practices necessary to conduct the review. The review includes a review of employee and offender actions during the incident, incident impact on employees and offenders, and corrective actions taken and still needed. The review also includes plans for improvement to avoid another incident. Reviews must be completed within 45 days of assignment. After reviewing critical incident trends, an action plan summary report is produced that analyzes actions taken and measures effectiveness. At the end of the year, the summary reports are forwarded to the risk management safety director who compiles information and provides it to the executive leadership team. Critical incident review reports and resulting action plans are subject to public disclosure.

There is no formal review process outlined in statute for a prisoner fatality. The OCO recently recommended in its 2019 report 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.

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.

The Office of the Corrections Ombuds. The 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 statewide Family Council 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.

Summary of Bill (First Substitute): DOC must conduct a prisoner fatality review when a person dies in DOC's custody. DOC must convene a prisoner fatality review team consisting of individuals with certain expertise and no prior involvement in the case. The purpose of the review is to develop recommendations for policies and practices to prevent fatalities and strengthen safety and health protections for prisoners. Within 180 days of a fatality, DOC

must issue the review, unless an extension has been granted by the Governor. Reviews must be distributed to appropriate committees of the Legislature and DOC must create a public website where all prisoner fatality reviews must be posted and maintained.

DOC must promptly notify the OCO if there is a near fatality of a prisoner in DOC's custody. Near fatality is defined as an act as certified by a physician that places the prisoner in serious or critical condition. DOC may conduct a review of the near fatality at its discretion or at the request of the OCO.

While conducting a prisoner fatality or near fatality review, DOC and the fatality team must have access to all records and files about the person, or information relevant to the review, that have been produced or retained by the agency.

Procedural restrictions and permissions on the use and admissibility of certain items as evidence and the availability of certain witnesses in a civil or administrative proceeding are created. The restrictions do not apply in a licensing or disciplinary proceeding based on allegations of wrongdoing in connection with a prisoner's fatality or near fatality that is reviewed by the review team.

For an investigation by the OCO, DOC must allow the OCO to privately communicate with certain prisoners; permit the OCO physical access to state institutions and state-licensed facilities or residences; and grant the OCO the right to access and inspect all relevant records and information necessary in the investigation. The OCO must issue an annual report to the Legislature on the implementation of prisoner fatality review recommendations.

EFFECT OF CHANGES MADE BY HUMAN SERVICES, REENTRY & REHABILITATION COMMITTEE (First Substitute):

- Requires the prisoner fatality review team to include the OCO or the OCO's designee.

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: There has been a long held process in place for addressing deaths and near deaths of children in the state's care. Since DOC has the largest population of people in the state's care, and is an aging population, there should be a standard process that involves the Legislature. This is information the Legislature should regularly have, and the Legislature should be participating in and have knowledge of DOC's critical incident review processes to make sure they are consistent with how other departments address fatalities. To maintain accountability, transparency, and trust of the citizens of the state, every agency including DOC needs close supervision.

OTHER: There should be a bright light shined on all state operations. State agencies should not be allowed to hide behind their expertise and not be subject to public scrutiny. The government works for the citizens because citizens pay their wages through taxes. Supportive of bill but would like prisoner fatality review teams include a member of the OCO. DOC should not have discretion to appoint the membership of the review team because it gives DOC the potential to make a mistake that will end up in litigation and cost the state money. Instead, there should be a strong independent voice in fatality investigations. Holding DOC accountable will help them become a more responsive and more responsible agency. The bill aligns with some of the initiatives DOC has been working on in the past year, including patient safety review committees and mortality review committees. DOC is currently working on a memorandum of understanding with the OCO to establish an annual report of deaths.

Persons Testifying (Human Services, Reentry & Rehabilitation): PRO: Senator Jeannie Darneille, Prime Sponsor; Noreen Light, Washington Community Action Network and Coalition for Parole.

OTHER: Zachary Kinneman, Whats Next Washington; Mary Jo Currey and Sara Kariko, DOC.

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

Staff Summary of Public Testimony on First Substitute (Ways & Means): PRO: Certain deaths of individuals in the state's custody are to be expected annually, but not all are considered expected. As policy makers it would be beneficial to have a better understanding of all of these instances of deaths in order to create appropriate courses of action when needed.

Persons Testifying (Ways & Means): PRO: Senator Jeannie Darneille, Prime Sponsor.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.