HOUSE BILL REPORT
ESSB 5119

As Reported by House Committee On:
Public Safety

Title: An act relating to individuals in custody.

Brief Description: Concerning individuals in custody.

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

Brief History:
Committee Activity:
Public Safety: 3/12/21, 3/18/21 [DP].

Brief Summary of Engrossed Substitute Bill

- Requires the Department of Corrections to convene an unexpected fatality review team to conduct an unexpected fatality review when an incarcerated individual dies unexpectedly or a case is identified by the Office of Corrections Ombuds 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.

HOUSE COMMITTEE ON PUBLIC SAFETY

Majority Report: Do pass. Signed by 12 members: Representatives Goodman, Chair; Johnson, J., Vice Chair; Mosbrucker, Ranking Minority Member; Davis, Graham, Griffey, Hackney, Lovick, Orwall, Ramos, Simmons and Young.

Minority Report: Without recommendation. Signed by 1 member: Representative

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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.

Klippert, Assistant Ranking Minority Member.

Staff: Corey Patton (786-7388).

Background:

Critical Incident Reviews at State Correctional Facilities.
The Department of Corrections (DOC) conducts a critical incident review for certain incidents, including the unnatural death or serious bodily injury of an incarcerated individual, contract staff, volunteer, or visitor occurring on DOC premises. Critical incident reviews identify successful outcomes, improve DOC procedures, and determine if improvements are needed.

A critical incident review may be initiated by the appropriate assistant secretary or designee, an assistant secretary from another division, the DOC's deputy secretary, or the DOC's risk management director, and must be conducted by a critical incident review team as follows:

- the initiator must appoint team members with appropriate experience, training, and knowledge of DOC policies, with the goal of providing a complete review and avoiding conflicts of interest;
- the review must be completed within 120 days of assignment, unless the initiator or the DOC's risk management director grants an extension;
- a corrective action plan must be initiated within 10 business days of completing the review;
- the corrective action plan must be completed within 120 days of initiation, unless the initiator or the DOC's risk management director grants an extension; and
- the completed corrective action plan must be documented and forwarded to the DOC's risk management director.

Critical incident review reports and resulting action plans are subject to public disclosure.

Summary of Engrossed Substitute Bill:

Unexpected Fatality Reviews.
The Department of Corrections (DOC) must convene an unexpected fatality review team to conduct an unexpected fatality review in any case where an incarcerated individual unexpectedly dies, or in any case the Office of the Corrections Ombuds (OCO) identifies for review. A city or county department of corrections or chief law enforcement officer responsible for the operation of a jail must convene an unexpected fatality review team to conduct an unexpected fatality review in any case where an individual confined in the jail unexpectedly dies.

An unexpected fatality review is 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 individual under the jurisdiction of the DOC, a city or county department of corrections, or a chief local enforcement officer, regardless of where the death actually occurred. Jurisdiction of the DOC does not include persons under DOC supervision. The primary purpose of the review is to develop recommendations for policy and practice changes to prevent fatalities and strengthen safety and health protections for individuals in custody. The review must include an analysis of the root causes of the fatality and a corrective action plan to implement any recommendations made by the unexpected fatality review team.

Unexpected Fatality Reviews at State Correctional Facilities.
An unexpected fatality review team convened by the DOC must be comprised of individuals with appropriate expertise for the case and must include the OCO or the OCO's designee and a representative from the Department of Health (DOH). The DOC must:

- ensure that unexpected fatality review team members do not have prior involvement in the case;
- grant the OCO physical access to state institutions and licensed facilities or residences;
- grant the OCO access to inspect and copy all relevant records and information necessary in the investigation; and
- create a public website where all unexpected fatality review reports must be posted and maintained.

Upon conclusion of an unexpected fatality review, the DOC must:

- issue a report on the results of the unexpected fatality review to the appropriate legislative committees and post the report on its public website within 120 days of the fatality, unless the Governor grants an extension;
- develop an associated corrective action and post the plan on the public website within 10 days of completing the unexpected fatality review; and
- implement the associated corrective action plan within 120 days, unless the Governor grants an extension.

The OCO must issue an annual report to the Legislature on the implementation of recommendations from unexpected fatality reviews by the DOC.

Unexpected Fatality Reviews at Jails.
An unexpected fatality review team convened by a city or county department of corrections or chief law enforcement officer responsible for the operation of a jail must be comprised of individuals with appropriate expertise for the case. The city or county department of corrections or chief law enforcement officer must ensure that team members do not have prior involvement in the case. The DOH must create a public website where all unexpected fatality review reports must be posted and maintained.

Upon conclusion of an expected fatality review, the city or county department of corrections or chief law enforcement officer must issue a report on the results of the unexpected fatality

review to the governing unit with primary responsibility for the operation of the jail and post the report on its public website within 120 days of the fatality, unless the chief executive or the governing unit with primary responsibility for the operation of the jail grants an extension.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed. However, the bill is null and void unless funded in the budget.

Staff Summary of Public Testimony:

(In support) Fatality reviews facilitate transparency and hold facilities accountable for undertaking corrective action. The goal is to be forward-thinking and ensure conditions that contribute to unexpected deaths can be ameliorated to prevent future deaths. When providing medical care to incarcerated persons, timely diagnosis and treatment is needed to save lives. It is one thing to succumb to an illness despite receiving proper care, but it is another thing to have an illness and never receive care. If physician assistants or doctors cannot do their jobs effectively, they need to be held accountable. If people are held to higher standards, there will be fewer deaths. Families should not have to experience loss due to neglect or incompetence.

(Opposed) None.

(Other) The state has a duty to fully and transparently investigate all deaths that occur in state custody. Fatality reviews may identify liability or bad actors, but they may also teach lessons that lead to improved procedures, policies, and practices. Fatality reviews should not be limited to unexpected deaths because even deaths labeled as expected could reveal opportunities for improvement upon review. Deaths from terminal illnesses such as cancer could be considered expected, but that fails to account for possible delays in diagnosis or treatment that hasten death.

This bill requires financial resources in the form of staff time, but those costs are not provided for in the Governor's budget. Facilities that do not already conduct fatality reviews are limited by resources, so additional funding is needed to ensure facilities can conduct expert reviews.

Persons Testifying: (In support) Senator Darneille, prime sponsor; Meagan Kineman; Rhonda Clemens; and Melody Simle, Washington Coalition for Prison Reform.

(Other) James McMahan, Washington Association of Sheriffs and Police Chiefs; and Dr.

Patricia David and Joanna Carns, Office of the Corrections Ombuds.

Persons Signed In To Testify But Not Testifying: None.