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**SUBSTITUTE SENATE BILL 5119**

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**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; and  
3 adding a new section to chapter 70.48 RCW.

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

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

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

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

20 (c) The primary purpose of the unexpected fatality review shall  
21 be the development of recommendations to the department and

1 legislature regarding changes in practices or policies to prevent  
2 fatalities and strengthen safety and health protections for prisoners  
3 in the custody of the department.

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

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

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

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

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

38 (b) A department employee responsible for conducting an  
39 unexpected fatality review, or member of an unexpected fatality  
40 review team, may not be examined in a civil or administrative

1 proceeding regarding: (i) The work of the unexpected fatality review  
2 team; (ii) the incident under review; (iii) his or her statements,  
3 deliberations, thoughts, analyses, or impressions relating to the  
4 work of the unexpected fatality review team or the incident under  
5 review; or (iv) the statements, deliberations, thoughts, analyses, or  
6 impressions of any other member of the unexpected fatality review  
7 team, or any person who provided information to the unexpected  
8 fatality review team relating to the work of the unexpected fatality  
9 review team or the incident under review.

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

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

33 (4) For the purposes of this section:

34 (a) "Unexpected fatality review" means a review of any death that  
35 was not the result of a diagnosed or documented terminal illness or  
36 other debilitating or deteriorating illness or condition where the  
37 death was anticipated, and includes the death of any person under the  
38 jurisdiction of the department, regardless of where the death  
39 actually occurred. A review must include an analysis of the root  
40 cause or causes of the unexpected fatality, and an associated

1 corrective action plan for the department to address identified root  
2 causes and recommendations made by the unexpected fatality review  
3 team under this section.

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

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

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

10 (2) The department shall:

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

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

20 (3) The office shall issue an annual report to the legislature on  
21 the status of the implementation of unexpected fatality review  
22 recommendations.

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

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

29 (b) The city or county department of corrections or chief law  
30 enforcement officer shall convene an unexpected fatality review team  
31 and determine the membership of the review team. The team shall  
32 comprise of individuals with appropriate expertise including, but not  
33 limited to, individuals whose professional expertise is pertinent to  
34 the dynamics of the case. The city or county department of  
35 corrections or chief law enforcement officer shall ensure that the  
36 unexpected fatality review team is made up of individuals who had no  
37 previous involvement in the case.

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

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

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

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

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

37 (b) An employee of a city or county department of corrections or  
38 law enforcement employee responsible for conducting an unexpected  
39 fatality review, or member of an unexpected fatality review team, may  
40 not be examined in a civil or administrative proceeding regarding:

1 (i) The work of the unexpected fatality review team; (ii) the  
2 incident under review; (iii) his or her statements, deliberations,  
3 thoughts, analyses, or impressions relating to the work of the  
4 unexpected fatality review team or the incident under review; or (iv)  
5 the statements, deliberations, thoughts, analyses, or impressions of  
6 any other member of the unexpected fatality review team, or any  
7 person who provided information to the unexpected fatality review  
8 team relating to the work of the unexpected fatality review team or  
9 the incident under review.

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

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

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

36 (5) For the purposes of this section:

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

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

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

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