S-0799.1

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.

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

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

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

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

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

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

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

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

(e) Within 10 days of completion of an unexpected fatality review under this section, the department shall develop an associated corrective action plan to implement any recommendations made by the review team in the unexpected fatality review report. Corrective action plans shall 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 the department's website in accordance with (d) of this subsection, except that confidential information may be redacted by the department consistent with the requirements of applicable state and federal laws.

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

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

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

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

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

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

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

(4) For the purposes of this section:

(a) "Unexpected fatality review" means 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 jurisdiction of the department, regardless of where the death actually occurred. A review must include an analysis of the root cause or causes of the unexpected fatality, and an associated

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

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

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

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

(2) The department shall:

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

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

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

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

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

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

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

(d) Upon conclusion of an unexpected fatality review required pursuant to this section, the city or county department of corrections or chief law enforcement officer shall, within 120 days following the fatality, issue a report on the results of the review, 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, and the department of health shall create a public website where all unexpected fatality review reports required under this section must be posted and maintained. An unexpected fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the department of health public website, except that confidential information may be redacted by the city or county department of corrections or chief law enforcement officer consistent with the requirements of applicable state and federal laws.

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

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

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

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

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

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

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

(4) No provision of this section 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.

(5) For the purposes of this section:

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

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

(c) "Unexpected fatality review" means 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 unexpected fatality, and an associated corrective action plan for the jail to address identified root causes and recommendations made by the unexpected fatality review team under this section.

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