

FINAL BILL REPORT

ESSB 5119

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Synopsis as Enacted

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.).

Senate Committee on Human Services, Reentry & Rehabilitation
Senate Committee on Ways & Means
House Committee on Public Safety
House Committee on Appropriations

Background: State Correctional Facilities. As of September 30, 2020, the Washington State Department of Corrections (DOC) is responsible for the custody of approximately 16,183 individuals in 12 correctional facilities and 12 work release facilities across the state. According to DOC, in 2018, from a prison population of 19,369 inmates, 34 died of natural causes, one due to accident, zero from homicide, and two died of suicide. In 2019, from a prison population of 19,160 inmates, 30 died of natural causes, one due to accident, zero from homicide, and five died of suicide.

Critical Incident Reviews. DOC currently has an internal policy that requires a critical incident review when there is an unnatural death or serious bodily injury of an incarcerated individual, contract staff, volunteer, or visitor occurring on DOC premises, including death by suicide of an incarcerated individual. Information gathered through incident reviews is analyzed to identify activities that contributed to successful outcomes, improve DOC policies and procedures, and determine whether improvements are needed. Critical incident reviews are completed within 120 days of assignment, and an extension may only be approved by specified individuals.

When an incident occurs, the appropriate assistant secretary or their designee will initiate the critical incident review and designate team members to serve on the review team. Team members should be appointed to provide a complete review and avoid potential conflicts of

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interest. All assigned team members should have appropriate experience, training, and knowledge of DOC policies, procedures, and practices necessary to conduct the review. After completion of a critical incident review, an associated corrective action plan is initiated within ten business days. Critical incident review reports and resulting action plans are subject to public disclosure.

Fatality Reviews. There is no formal review process outlined in statute for a fatality of an incarcerated individual. 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.

Office of Corrections Ombuds. The Office of Corrections Ombuds (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 DOC Statewide Family Council on 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. In both its 2019 and 2020 annual report, the OCO recommended 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 the critical incident review.

Jails and Jail Deaths. There is no statutory requirement for local jails to report a death of an individual confined in the jail. The Washington Association of Sheriffs and Police Chiefs conducts an annual jail population survey among the jails that includes in- custody deaths, however the survey is voluntary. The Bureau of Justice Statistics, a division of the federal Department of Justice, also conducts a voluntary annual survey of in- custody deaths at local jails across the country.

Current law authorizes a city or county primarily responsible for the operation of a jail to create a department of corrections to be in charge of such jail and the persons confined in the jail. If a city or county does not create a department of corrections, the chief law enforcement officer of the city or county is in charge of the jail and the persons confined in the jail.

Summary: Unexpected Fatality Reviews at State Correctional Facilities. DOC must conduct an unexpected fatality review when an incarcerated individual dies unexpectedly or a case is identified by the OCO for review. DOC must convene an unexpected fatality review team consisting of individuals with certain expertise and no prior involvement in the case. The OCO, or the OCO's designee, and a representative from the Department of

Health must serve as members of the review team. The purpose of the review is to develop recommendations for changes in policies and practices to prevent fatalities and strengthen safety and health protections for prisoners. Within 120 days of a fatality, DOC must issue a report on the results of the review, unless an extension has been granted by the Governor. Reports must be distributed to appropriate committees of the Legislature and DOC must create a public website where reports must be posted and maintained. Reports are subject to public disclosure and confidential information may be redacted by DOC consistent with applicable state and federal laws.

Within 10 days of completing an unexpected fatality review, an associated corrective action plan must be developed to implement any recommendations from the unexpected fatality review. Corrective action plans must 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 DOC's website, with any confidential information redacted by DOC consistent with applicable state and federal laws.

DOC must permit the OCO physical access to state institutions and state-licensed facilities or residences and grant access to inspect and copy all relevant records and information necessary in the investigation. The OCO must issue an annual report to the Legislature on the implementation of unexpected fatality review recommendations.

Unexpected fatality review is defined as 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 DOC's jurisdiction, regardless of where the death actually occurred. Jurisdiction of DOC does not include persons under DOC supervision. A review must include an analysis of the root cause or causes of the unexpected fatality and an associated corrective action plan for DOC to address identified root causes and recommendations made by the unexpected fatality team.

Unexpected Fatality Reviews at Jails. A city or county department of corrections or chief law enforcement officer responsible for the operation of a jail must conduct an unexpected fatality review when a person confined in the jail dies unexpectedly. The membership and purpose of the team is specified. The city or county department of corrections or chief law enforcement officer must issue a report on the results of the review within 120 days of the fatality, 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. The Department of Health must create a public website where reports must be posted and maintained. Reports are subject to public disclosure and confidential information may be redacted by the city or county department of corrections or chief law enforcement officer consistent with applicable state and federal laws. No provision of this act 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.

Unexpected fatality review is defined as 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 expected fatality, and an associated corrective action plan for the jail to address identified root causes and recommendations made by the unexpected fatality review team.

Procedural restrictions and permissions related to the use and admissibility of certain items as evidence and the availability of certain witnesses in a civil or administrative proceeding are created for unexpected fatality reviews at DOC and jails. The restrictions do not apply in a licensing or disciplinary proceeding based on allegations of wrongdoing in connection with an unexpected fatality that is reviewed by the team.

Votes on Final Passage:

Senate	48	0
House	89	8

Effective: July 25, 2021