WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2007-08
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Corrections and Courts (AC-CC)

(Form Updated: 07/24/2009)

COMMITTEE NOTICES ...

➢ Committee Reports ... CR
**

➢ Executive Sessions ... ES
**

➢ Public Hearings ... PH
**

➢ Record of Comm. Proceedings ... RCP
**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL ...

➢ Appointments ... Appt
**

Name:

➢ Clearinghouse Rules ... CRule
**

➢ Hearing Records ... HR (bills and resolutions)
** **07hr_ab0139_AC-CC_pt01**

➢ Miscellaneous ... Misc
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Assembly Committee on Corrections and the Courts

DATE
Moved by Wag Seconded by Pas
AB 139 SB _____ Clearinghouse Rule _____
AJR _____ SJR _____
A _____ SR _____ Other _____
A/S Amdt _____
A/S Amdt _____ to A/S Amdt _____
A/S Sub Amdt _____
A/S Amdt _____ to A/S Sub Amdt _____
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AB 139

Be recommended for:

- ☒ Passage
- ☐ Introduction
- ☐ Adoption
- ☐ Rejection
- ☐ Indefinite Postponement
- ☐ Tabling
- ☐ Concurrence
- ☐ Nonconcurrence

	Committee Member	Aye	No	Absent	Not voting
1.	Rep. Garey Bies, chair	1			
2.	Rep. Phil Montgomery, vice-chair	2			
3.	Rep. Dean Kaufert	3			
4.	Rep. Carol Owens				
5.	Rep. Steve Kestell	4			
6.	Rep. Daniel LeMahieu	5			
7.	Rep. Joe Parisi	6			
8.	Rep. Mark Pocan	7			
9.	Rep. Sheldon Wasserman	8			
10.	Rep. Sondy Pope-Roberts				
11.	Rep. Donna Seidel	9			
	Totals				

MOTION CARRIED ☒ MOTION FAILED ☐

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Assembly Committee on Corrections and the Courts

DATE
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AB 139 SB _____ Clearinghouse Rule _____
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	Totals				

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Assembly Committee on Corrections and the Courts

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AB 139 SB _____ Clearinghouse Rule _____
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	Totals	6	0		

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FORWARD

WISCONSIN
STATE
ASSEMBLY

SHELDON
WASSERMAN
STATE REPRESENTATIVE

March 28, 2007

Representative Garey Bies, Chair
Assembly Corrections and the Courts Committee
Room 125 West
State Capitol
Madison, WI 53708

Dear Representative Bies,

Thank you for the memo indicating that the Assembly Corrections and the Courts Committee is tentatively scheduled to meet on April 19th. I appreciate your efforts to give us advance notice of when the committee will meet.

I am writing to ask you to please consider adding Assembly Bill 139 to the agenda for the April 19th public hearing. AB 139 would establish a statutory board for the review of inmate deaths. It is modeled on 2003 AB 152 and 2005 AB 480, both of which passed the Assembly but did not get through the Senate. This legislation is needed in order to provide more structure, continuity and accountability to the current process of reviewing deaths within our correctional system, and to bring the process up to national corrections standards.

Thank you for taking the time to consider my request. Please let me know if you have any questions or need additional information from me.

Sincerely,

Sheldon A. Wasserman
State Representative
22nd Assembly District

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WASSERMAN
STATE REPRESENTATIVE

Assembly Corrections and the Courts Committee
AB 139 Testimony - July 26, 2007

Good morning, Chairman Bies and my fellow committee members. Thank you for the opportunity to testify in favor of Assembly Bill 139 today.

I am sure that you all remember the story of Taycheedah inmate Michelle Greer. Ms. Greer was born in Taycheedah, and she died there in February 2000 of an asthma attack on a cafeteria floor. The circumstances surrounding her death spurred numerous newspaper reports and an audit of health care and emergency procedures in Wisconsin's prisons.

Shortly after Ms. Greer's death, former Representative Scott Walker and I co-authored a bill requiring that all prison deaths be investigated by an independent outside panel. We wanted to assure the public that state employees act appropriately and to help identify procedures that can be improved.

Similar bills I introduced in the 2003 and 2005 sessions passed the full Assembly, but stalled in the Senate. Over the years since Ms. Greer's death, the Department of Corrections (DOC) has made improvements in health care delivery. I have toured four prisons and have been impressed with many of the things I have seen and the people I have met. However, I believe we can improve the current inmate death review process.

I appreciate the work that DOC's current internal inmate mortality review panel is doing. However, I believe we need to create an independent board and make it statutory.
An external panel will provide truly independent reviews, and inspire public trust. Both the inmate population and the department would be well served – politically and legally – if the review board was external and independent - as proposed in my legislation.

I have worked with DOC Secretary Matt Frank, his staff, the Legislative Reference Bureau and other interested parties on changes to the original proposal. As currently written, AB 139 will make several key improvements:

AB 139 creates a new Inmate and Resident Mortality Board within DOC. The board will be made up of 12 members appointed to staggered 4-year terms:

- 8 members appointed by the governor, including 2 physicians from the UW Medical School, 2 from the Medical College of Wisconsin, one physician from a health care provider other than the UW or MCW, an RN employed by a private HMO, an RN employed by a private hospital, and one at-large member of the public.

- 4 members appointed by the DOC secretary, including a warden, a manager of a Health Services Unit, a health care provider who is employed by DOC, and a correctional officer.

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- At least one of member of the board must be a board-certified forensic pathologist.

The board's duties and abilities would include:

- Preparing reports on every inmate death to be submitted to a relative of the deceased, the DOC secretary, and if appropriate, the district attorney and the attorney general. The chair and ranking member of the standing assembly and senate committees will also receive these reports.

- Making recommendations to the department regarding medical and other prison procedures based on its medical review, and the work performance of department staff.

- Forwarding a complaint to the appropriate credentialing board if a medical provider is found negligent.

DOC is required to cooperate with the board and provide any assistance the board requests to review the circumstances of a death. Specific timelines are set for the notification of inmate deaths, and when reports must be submitted.

All records prepared by and for the board will be exempt from Wisconsin's open records law. This ensures the confidentiality of medical and personnel records.

If there is a criminal investigation pending on an inmate death, the board must wait until that investigation is concluded before issuing its final report on the death.

Having all of this spelled out in the statutes will provide continuity through changes in the administration. It will bring more accountability and structure to the process of reviewing inmate deaths, with a focus on the expertise of independent medical professionals. It will serve the government and the public well, and has the potential to prevent lawsuits and save the state millions.

As I mentioned Assembly Bill 139 is the product of years of work with interested parties, work that continues. After speaking with the Attorney General's office this week, I have decided to offer an amendment that removes language in the bill giving the Attorney General the same power to order an inquest that district attorneys have under current law. The intention was to give coroners and medical examiners an additional avenue for requesting an inquest if the local district attorney refuses to order one. I now realize that having the Attorney General conduct an inquest of a death in a state correctional institution would create a conflict of interest if any state employee is ever named in a legal proceeding stemming from that death.

I am also considering other minor modifications to the bill, including allowing the outside medical professionals who serve on the panel to receive nominal compensation for their work at a rate similar to what other state board members are allowed. I would like to listen to today's testimony and talk with committee members about these ideas before I offer an amendment.

Thank you for your time and consideration. I look forward to your questions and comments.


FORWARD

Testimony of James Greer, Director of the Bureau of Health Services
Wisconsin Department of Corrections
AB 139, Relating to Review of Deaths at Correctional Institutions
Assembly Committee on Corrections and Courts
July 26, 2007

Good morning, Chairman Bies and Committee members. I am James Greer, Director of the Bureau of Health Services, in the Wisconsin Department of Corrections. Thank you for the opportunity to testify on Assembly Bill 139, relating to the formation of an inmate and resident death mortality board to review deaths at state correctional institutions.
The Department believes that an external peer review of inmate deaths is an essential component of quality assurance for health care service delivery within our correctional system. We support this proposal as good public policy and sound medical practice.

We believe it would be helpful for the Committee to have background on the Department's current practices in reviewing inmate deaths.

As you know, providing inmate health care is a very challenging part of our business. Offenders come to DOC after several years of inadequate health care and many have chronic conditions such as HIV, Hepatitis, Diabetes and Asthma. In addition, as a result of longer sentences, the inmate population is getting older, a demographic change that naturally results in additional health care problems. The percentage of inmates over the age of 40 has gone from 21% in 1999 to 32% in 2006. The percentage of inmates over the age of 60 has gone from 1.4% in 1999 to 2.3% in 2006.
The Department of Corrections has a 62 bed secure infirmary at Dodge Correctional Institution that has an average daily census of 56 offenders, all of whom meet state nursing home admission criteria. Recently, the institution started a two bed hospice program for offenders that have less than six months to live. This program provides increased training for health care staff, pain management, and training for other offenders to assist the dying patient. In 2006, the infirmary had 18 anticipated deaths due to cancer, end state liver, cardiac, and lung disease.

Over the past 6 years, the Wisconsin Department of Corrections has seen an increase in offenders with mental health diagnoses from 20% in 2000 to 30% in 2006. Due to this significant increase in offenders with mental health needs, the department has implemented several new initiatives. These include a mandatory two hour training program on suicide prevention for all staff that have direct contact with inmates, implementing physical changes in our facilities to reduce the risk of suicide, revising our policies and procedures to improve response time for suicides in progress, and providing 7 day per week psychology visits for inmates in clinical observation.
The Department takes all inmate deaths, both anticipated and unanticipated, very seriously. An anticipated death is defined as any death where the inmate was in the terminal stage of illness and had an anticipated life expectancy of 12 months or less. An unanticipated death is any death which occurs where there was no diagnosis by a physician of a terminal medical condition or where the physician had indicated the anticipated life expectancy should be 12 months or longer with a terminal medical condition. In 2004, we had 40 deaths (19 anticipated, 21 unanticipated), in 2005 we

had 29 deaths (12 anticipated, 17 unanticipated), in 2006 we had 45 deaths (23 anticipated, 22 unanticipated) and in 2007 so far we have had 19 deaths (12 anticipated, 7 unanticipated).

In the event of the death of an inmate or youth in the Department's custody, the Department has procedures in place for both an internal review of the circumstances surrounding the death, and an external peer review performed by an established Committee on Inmate/Youth Deaths. Under Secretary Frank's leadership, the Department has strengthened these processes over the past several years. These revisions have included an expedited timeframe for completion of an internal investigation, a higher level staff review at all stages of the process, and greater personal communication with the families of the deceased.

When a death occurs, an internal mortality review team is designated to conduct a review of the circumstances surrounding the individual's death. The warden participates in the onsite review. Recommendation are developed at the meeting and reviewed with the administrator of the Division of Adult Institutions. A report is submitted to the secretary office within 30 days of the death.

The mortality review team then submits its findings, and, where appropriate, an action plan to the Department's Committee on Inmate/Youth Deaths. The Committee on Inmate/Youth Deaths is responsible for conducting an independent peer review of the death, and provides recommendations to the Department for the purpose of improving the quality of health care.

The nine member committee on Inmate/Youth Deaths includes:

- A member of the general public
- A forensic pathologist
- A physician from the UW Hospital or UW Foundation
- A physician from the Medical College of Wisconsin
- A physician from a private health care organization
- A nurse clinician from a private health care organization
- A nurse clinician from another state agency
- A Warden or Superintendent
- A DOC Health Services Manager

The Committee on Inmate/Youth Deaths meets quarterly and conducts reviews of all deaths in the previous quarter. It makes additional recommendations for changes in policies or procedures to improve the quality of health care provided. Each of the Committee's members have the talent, expertise and insight needed to take an outside look at the reasons for deaths that occur within our system, and make recommendations to the Department for changes in policies and procedures, if needed.

The Committee on Inmate/Youth Deaths is a tremendous enhancement to the current system. It is not a substitute for a thorough internal review of an inmate death. Good medical management includes peer review, and another level of accountability that will build confidence in DOC's health care system in the legislature, public and the families of offenders. The work of the Committee greatly enhances our efforts to ensure continuous quality improvement in health services for inmates and youths entrusted to our custody and care.

For this committee's information and review, I am providing a copy of Secretary Frank's executive directive regarding the Department's internal review procedures.

AB139 provides an opportunity for the Legislature to endorse and enhance the external peer review process that the Department of Corrections has worked hard to put in place. Thank you for the opportunity to testify today. I welcome any questions you may have.


FORWARD

WISCONSIN
STATE
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SHELDON
WASSERMAN
STATE REPRESENTATIVE

December 18, 2007

Representative Garey Bies, Chair
Assembly Corrections and the Courts Committee
Room 125 West
State Capitol

Dear Representative Bies,

Thank you for holding a public hearing earlier this year on Assembly Bill 139, relating to: review of deaths at correctional institutions. After the public hearing, I drafted a substitute amendment to deal with concerns raised by the Department of Corrections, the Attorney General and the Wisconsin District Attorneys Association. The sub makes the following changes to the bill:

-Reduces the size of the Inmate and Resident Mortality Board from 12 members to 9. Instead of two physician members from both the University of Wisconsin School of Medicine and Public Health and the Medical College of Wisconsin, the sub calls for one. Instead of one registered nurse employed by a private health maintenance organization and one registered nurse employed by a private hospital, the sub calls for one registered nurse employed either by a private health maintenance organization or by a private hospital.

-Removes the requirement that the district attorney or attorney general approve release of records in the custody of law enforcement agencies. Both the attorney general and the Wisconsin District Attorneys Association were uncomfortable with putting the attorney general and/or district attorneys in the position of having to approve the release of records in the custody of independent law enforcement agencies.

-Adds a provision specifying that Section 146.38 of the Wisconsin statutes - Health care services review; confidentiality of information - applies to the information provided to, and the deliberations and reports of, the Board.

-Removes the provisions in the original bill that required coroners and medical examiners to notify the attorney general when a person confined in a state correctional died under circumstances that would permit a district attorney to order an inquest and gave the attorney general the powers as district attorneys to order inquests. Involving the attorney general in these inquests creates a conflict of interest as the attorney general would be called upon to defend any state employee charged at the conclusion of an inquest.

I appreciate your willingness to work with me on this issue and respectfully ask that you add AB 139 to the schedule the next time the committee meets for an executive session. Thank you for taking the time to consider my request. Please let me know if you have any questions or need additional information from me.

Sincerely,

Sheldon A. Wasserman
State Representative
22nd Assembly District

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FORWARD

AB 139

Med College of WI

Compensation

Flexibility


FORWARD

Jim Doyle
Governor

Matthew J. Frank
Secretary

State of Wisconsin
Department of Corrections

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Found In AB 139 Folder

02-22-2006

Executive Directive #58

SUBJECT: Department of Corrections Review of Inmate/Youth Deaths

I. Policy

Upon the death of an inmate/youth in the custody of the Department of Corrections, (DOC) the appropriate DOC Division shall designate a mortality review team which shall conduct a review of the circumstances surrounding the individual's death and submit its findings and, when appropriate, an action plan to the Committee on Inmate/Youth Deaths (COIYD). The COIYD shall conduct an independent peer review of the individual's death and provide recommendations to the DOC for the purpose of improving the quality of health care provided inmates/youth in its custody. This peer review process shall be conducted in conformity with Sec. 146.37 and 146.38, Wis. Stats.

II. Definitions

"Anticipated death" means any death where the inmate/youth was in the terminal stage of illness and had an anticipated life expectancy of 12 months or less.

"Unanticipated death" means any death which occurs where there was no diagnosis by a physician of a terminal medical condition or where the physician had indicated the anticipated life expectancy should be 12 months or longer with a terminal medical condition.

III. Facility Review Process

A. Upon the death of an inmate/youth, the DOC Division responsible for the custody of the inmate/youth shall designate a mortality review team which shall initiate a review of the circumstances surrounding the individual's death, with emphasis on the health care provided and when appropriate, submit an action plan to the COIYD, with recommendations for the improvement of health care. The review shall be completed within 10 working days of the individual's death for unanticipated deaths and 20 working days for an anticipated death. Each Division responsible for the custody of inmates/youths shall promulgate internal management procedures establishing the makeup and responsibilities of the mortality review teams.

B. A copy of the mortality review team report shall be forwarded to the COIYD, the Secretary and the appropriate Division Administrator within 10 working days of completion of the team's review. The report provided to the Secretary and Division Administrator shall have the identity of the decedent withheld in compliance with Sec. 146.38(3) stats.

C. The DOC mortality review team shall include at a minimum the following members:
- Warden/Superintendent from that institution/facility
- A security representative
- A physician
- A nursing representative
- Psychological Services (for suicides and others as requested)
- Others as determined.

The DOC employees serving on the COIYD shall not participate in reviews of deaths which occurred at the facilities where they work.

The DOC mortality review team shall also include the following members for all unanticipated deaths:
- Bureau of Health Services (BHS) Director
- DOC Medical Director
- Mental Health Director (for suicides and others as requested)
- BHS Nursing Coordinator
- Assistant Administrator or DOC Security Chief (as determined by the Division Administrator)

D. In its review, the DOC mortality review team may look at the following issues, among others:

- Adequacy of care practices.
- Clinical judgment.
- Utilization of expertise
- Staff training
- Staffing issues
- Presence and appropriateness of internal policies
- Implementation of internal policies and procedures
- Notification and involvement of appropriate family members
- Notification of external agencies
- Reporting of the death to the DOC facility review team.

E. Families will be notified of the inmate's/youth's death according to DOC 306 IMP 1.

IV. Committee on Inmate/Youth Deaths

A. The purpose of the COIYD is to:

1. Conduct independent reviews of inmate/youth deaths occurring at adult correctional facilities, juvenile correctional facilities, correctional centers, and private out-of-state contracted facilities housing Wisconsin offenders, in conformity with Secs. 146.37 and 146.38 stats.

2. Review the causes and circumstances surrounding deaths with particular attention to those considered to be unusual or unexpected.

3. Make recommendations for changes in policies or procedures designed to improve the quality of health care provided.

4. Ensure that information relating to deaths is properly communicated so that health care can be improved.

5. Conduct its reviews in the interest of public safety and the effective health care of inmates/youths.

6. Review issues relating to the deaths of DOC inmates/youths from a systemic point of view.

B. COIYD composition and organization.

1. The COIYD shall be composed of no more than nine voting members. The Secretary shall appoint:
   - A Warden/Superintendent
   - Health Services Manager
   - A member of the general public
   - A forensic pathologist

   The Secretary shall request the following agencies to select a licensed health care provider, as designated, to serve on the committee:
   - Physician from University of Wisconsin Hospital/UW Foundation
   - Physician from Medical College of Wisconsin
   - Physician from a private health care organization.
   - Nurse Clinician from a private health care organization.
   - Nurse Clinician from another state agency.

2. The Secretary shall designate a Bureau of Health Services Nursing Coordinator to act as a facilitator and advisor to the committee.

3. The Department of Corrections Medical Director shall attend committee meetings as a non-voting participant when requested by the COIYD.

4. Upon the request of the COIYD, the Secretary may designate other individuals to serve as advisors to assist the COIYD in the performance of its functions.

5. Members are appointed for staggered terms of three years. Members chosen to fill vacancies created other than by expiration of term shall be appointed for the unexpired term of the member for whom she/he is to succeed. Members may be reappointed to serve additional terms.

6. A chairperson shall be selected by the full Committee. A member may serve as chairperson for no more than two years.

7. A quorum shall consist of two-thirds of the members then in office. While most actions are determined by consensus, a majority of those voting shall be required to adopt motions and approve actions. If a quorum is not present, the COIYD members present may proceed with the meeting as specified by the agenda and recommend actions to be ratified by the COIYD, if it has a quorum, at the next meeting. If the chair is absent from a committee meeting, the COIYD may designate one of its members to be the acting chair during that meeting.

8. COIYD members must be present personally to count for a quorum and to participate in decision-making. Members may not send alternates or designees without the prior approval of the Chair.

C. Confidentiality.

1. All information generated by, or on behalf of the Committee, including but not limited to, Committee reports (except its annual report), proceedings of the Committee regarding the cases it reviews, and deliberations, shall be kept confidential by COIYD and mortality review team members, in accordance with Sec. 146.37 and 146.38 Wis. Stats., and the confidentiality agreements signed by each Committee member. Consultants, advisors, committee staff and other individuals with specialized expertise who participate in a review or otherwise provide support to the Committee shall be required to sign a confidentiality agreement.

D. Procedures of the COIYD.

1. The COIYD shall meet at least quarterly unless there were no deaths in the previous quarter. The Secretary or Chair may call additional meetings.

2. Minutes shall be kept at each meeting and shall include:

   - Records of all death reports reviewed by the COIYD.
   - Records of all actions taken by the COIYD.
   - The status of all pending reviews.

3. Minutes shall be ratified by the COIYD.

4. Members of the COIYD may visit and inspect any DOC facility and shall have access to all records and data necessary to conduct a review.

5. The COIYD may request other persons having relevant information to appear before the Committee as part of a review.

6. The COIYD shall establish the format for all mortality review team reports, including the information to be included, and the timelines under which the mortality review team will present its reports regarding the cause and circumstances of death.

7. The COIYD may request persons with specialized expertise to serve as consultants and participate in a review. If the consultant requires compensation, that must be pre-approved by the Secretary.

8. The COIYD shall review all documents and information deemed relevant for purposes of conducting its review, including but not limited to the review and recommendations of the mortality review team and reports, if any, from external agencies.

9. In its review, the COIYD may look at the following issues, among others:

   - Adequacy of care practices.
   - Clinical judgment.
   - Utilization of expertise
   - Staff training
   - Staffing issues
   - Presence and appropriateness of internal policies
   - Implementation of internal policies and procedures
   - Notification and involvement of appropriate family members
   - Notification of external agencies

10. When the COIYD is satisfied that it can make no recommendations, or no further recommendations, it shall consider the review closed and communicate the closure to the DOC administration.

11. The COIYD shall issue an annual report summarizing its work and identifying any significant trends and make the report available to outside agencies as requested.

12. The COIYD may require institution staff to provide additional review or assistance as necessary to ensure full cooperation with the DOC facility review team. If the COIYD believes there is an attempt to influence or interfere with the DOC facility review team the COIYD shall refer the complaint to the Secretary for immediate review and follow up.

V. Recommendations and Actions

A. Within 20 days from the date of the meeting at which they are finalized, the designated Nursing Coordinator shall communicate recommendations from the COIYD to the Secretary, the applicable Division Administrator, and other appropriate persons within the department for follow-up.

B. The Division Administrator shall assign appropriate staff to implement the recommendations to the extent feasible and ensure the implementation process is completed on a timely basis.

C. The Nursing Coordinator shall be notified as the recommendations are implemented and notify the appropriate Division Administrator of lack of response or any inappropriate responses.

D. The Nursing Coordinator shall provide the Secretary an annual summary of the changes resulting from the implementation of the COIYD's recommendations.

E. The Nursing Coordinator shall maintain records reflecting the status of cases pending before the COIYD, recommendations made by the COIYD and whether its recommendations have been implemented. These records shall be accessible to the Secretary, Division Administrator, Medical Director and Bureau of Health Services Director.

Originated by: Bureau of Health Services

Matthew J. Frank, Secretary

February 22, 2005
Date