

Fiscal Estimate Narratives
DOC 8/11/2005

LRB Number	05-0585/1	Introduction Number	AB-480	Estimate Type	Original
Subject					
Inmate and resident mortality board					

Assumptions Used in Arriving at Fiscal Estimate

Under current law when an inmate death occurs in a state correctional facility, the coroner or medical examiner for the county where the death occurred must conduct an autopsy. The Department of Corrections (DOC) must notify a relative of the inmate's death and that DOC, upon request, will provide the relative with a copy of the autopsy report or any other report or information regarding the inmate's death.

Current law requires a coroner or medical examiner to notify the district attorney of any deaths that occur as the result of homicide, suicide or unexplained/suspicious circumstances. Current law also establishes procedures for district attorneys to follow in ordering inquests under these circumstances.

This bill expands the scope of the provision requiring autopsies and notification of district attorneys and the ordering of an inquest for persons who die while confined in a state correctional facility so that it also applies to a person in DOC's custody who dies while temporarily confined in, and under a DOC contract with, a county jail, out-of-state contract facility or house of correction. The bill also gives the authority to order and conduct an inquest into an inmate's death to the attorney general.

This bill creates an Inmate and Resident Mortality Board which must be composed of 12 members and is attached to DOC. The bill further requires DOC to notify and provide a summary of information regarding each death to each of the board members within three business days after the person's death. If the Mortality Board requests, the bill also requires DOC to provide a board member with all records regarding the person who died and with any information obtained as the result of DOC's internal review of the death.

DOC is also required to provide any assistance the Inmate and Resident Mortality Board needs to review the circumstances of the death. The bill requires the board to issue a report regarding its review of an inmate's death within 30 days after the meeting at which the board completes its review. This report is required to be sent to a relative of the deceased person, to members of the appropriate standing committees of the senate and assembly, to the Secretary of DOC, and to the district attorney or attorney general, if appropriate. The board is also required to prepare and forward a complaint to the appropriate credentialing board if a determination is made that a medical provider failed to provide appropriate, proper and necessary medical care.

The Department of Corrections has conducted mortality reviews since 1994. In May of 2001 a mortality review committee was formed by DOC to conduct these reviews. This committee currently has nine members. In addition to the mortality review committee, last year the Department added the requirement for an internal investigation for all unexpected inmate deaths to be completed within 10 to 14 days after the inmate death. These internal investigations are completed by a team of DOC staff that include: the Bureau of Health Services (BHS) Director, the BHS Medical Director, the BHS Nursing Coordinator, the institution's health services unit manager, a Division of Adult Institutions Assistant Administrator and the BHS Psychiatrist Supervisor (if mental health issues are involved).

The current mortality review committee is composed of a DOC Warden, a DOC Health Services Unit Manager, a University of Wisconsin Hospital physician, a nurse from a private medical clinic, an emergency medical technician, two private physicians, a pathologist and the Deputy Director of the Wisconsin Resource Center. Although the committee completes mortality reviews for inmates in DOC institutions and out-of-state contract beds, it does not review inmate deaths that occur in county jail contract beds. The Department currently notifies the mortality review committee members of a death within 3 business days, provides records to the committee, provides assistance to the committee and produces minutes of mortality review meetings that include committee

recommendations only. This bill requires a much more inclusive report to be completed by the mortality review board within 30 days of meeting. Current meeting minute summaries are completed by two DOC FTE that staff the mortality review board. Depending on the volume and size of these new report formats, additional staff may be needed to complete and route these reports in a timely manner.

This bill requires additional routing (copies to the deceased relative and standing committees of the senate and assembly). Although increased costs would result from additional copies and mailings, it is not possible to project the number or size of the reports that will be generated by the review board. In FY04 there were 36 inmate deaths (34 in DOC institutions, 2 in out-of-state contracts and 0 in county contracts). In FY03 there were 46 inmate deaths (45 in DOC institutions, 1 in out-of-state contracts and 0 in county contracts).

The current mortality review committee meets quarterly and reviews all inmate deaths in DOC institutions and out-of-state contract beds. It is anticipated that if the size of the mortality review committee is increased that additional meeting times may be needed. The current configuration of nine members and the discussion they bring to the reviews has at times caused some difficulty with completing all of the reviews within a quarterly meeting schedule. It is anticipated that with an increase in the size of the review committee that more frequent meetings may be needed.

The Department currently covers lunch costs for committee members at the quarterly meetings. Non-DOC/State committee members are also eligible for reimbursement for travel costs, a \$500 per day per diem and a \$200 payment for each medical record that is reviewed. Although none of the current committee members request any of the reimbursements noted above, in the past some committee members have accessed reimbursements.

If the compilation of the proposed 12 member mortality review board remained with three state employees and nine non-state employees and all of the non-state employee members chose to access a \$500/day per diem rate for quarterly meetings only, DOC would have increased costs of \$18,000 related to per diem reimbursements. If DOC averaged 46 deaths per year (same as FY03) and each non-state employee board member accessed the \$200/record review reimbursement, DOC would have increased costs of \$82,800 per year related to record reviews. It is not possible to predict the number of files that would be reviewed or what travel cost reimbursements would be requested.

Although the Department anticipates increased cost for mortality reviews due to the increased size and requirements of the mortality review board established in this legislation it is not possible to provide an estimated fiscal impact. There does not appear to be any local impact from this legislation.

Long-Range Fiscal Implications