Wisconsin Department of Administration
Division of Executive Budget and Finance

Fiscal Estimate - 2007 Session

☒ Original ☐ Updated ☐ Corrected ☐ Supplemental

LRB Number **07-0150/1**	Introduction Number **AB-0139**

Description
Review of deaths at correctional institutions

Fiscal Effect

State:
- ☐ No State Fiscal Effect
- ☒ Indeterminate
  - ☐ Increase Existing Appropriations
  - ☐ Decrease Existing Appropriations
  - ☐ Create New Appropriations
  - ☐ Increase Existing Revenues
  - ☐ Decrease Existing Revenues
  - ☐ Increase Costs - May be possible to absorb within agency's budget ☐ Yes ☐ No
  - ☐ Decrease Costs

Local:
- ☒ No Local Government Costs
- ☐ Indeterminate
  - 1. ☐ Increase Costs ☐ Permissive ☐ Mandatory
  - 2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory
  - 3. ☐ Increase Revenue ☐ Permissive ☐ Mandatory
  - 4. ☐ Decrease Revenue ☐ Permissive ☐ Mandatory
  - 5. Types of Local Government Units Affected: ☐ Towns ☐ Village ☐ Cities ☐ Counties ☐ Others ☐ School Districts ☐ WTCS Districts

Fund Sources Affected **Affected Ch. 20 Appropriations**

☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEGS

Agency/Prepared By	Authorized Signature	Date
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Fiscal Estimate Narratives

DOC 5/9/2007

LRB Number **07-0150/1**	Introduction Number **AB-0139**	Estimate Type **Original**
Description Review of deaths at correctional institutions		

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 must notify a relative of the inmate's death and DOC, upon request, must 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. Each facility conducts an internal mortality review, within 1 month for expected deaths and 2 weeks for unexpected deaths. In the event of expected deaths, the Bureau of Health Services (BHS) Medical Director, the BHS Nursing Coordinator, and the BHS Mental Health Director (if mental illness is involved) also conduct a review of the medical record relative to the care provided to the inmate before and at the time of the inmate's death. For the internal review of unexpected deaths, the BHS Director, BHS Medical Director, BHS Nursing Coordinator, a Division of Adult Institutions Assistant Administrator and the BHS Mental Health Director (if mental illness is involved) attend the facility internal review, and conduct the internal review with facility personnel.

All information obtained by DOC internal mortality reviews are provided to the Committee on Inmate/Youth Deaths (COIYD). The current COIYD is composed of a DOC Warden, a DOC Health Services Unit Manager, a University of Wisconsin Hospital physician, a nurse from a private health care organization, an emergency medical technician, two private physicians, a forensic pathologist and a Nursing Supervisor of the Wisconsin Resource Center. The committee completes mortality reviews for inmates in DOC institutions. While there currently are no inmates housed in out-of-state contracted facilities, the committee would conduct mortality reviews for inmate deaths which would occur in those facilities. It does not review inmate deaths that occur in county jail contract beds, or inmate deaths which occur at the Wisconsin Resource Center.

The Department currently notifies the 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 relatives of the deceased and to 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 FY 06 there were 35 inmate deaths (35 in DOC institutions and 0 in county contracts). In FY05 there were 35 inmate deaths (34 in DOC institutions, 1 in out-of-state contracts and 0 in county contracts).

The COIYD meets quarterly at this time and reviews all inmate deaths in DOC institutions. It is anticipated that if the size of the COIYD 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 would 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 35 deaths per year (same as FY05 and FY06) and each non-state employee board member accessed the $200/record review reimbursement, DOC would have increased costs of $63,000 per year related to record reviews. It is not possible to predict the number of files that would be reviewed or what travel cost reimbursement 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