# WASHINGTON STATE SENATE
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**For immediate release:**
**May 25, 2016**

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**Senate report on deadly prison releases blames Corrections execs, governor's office**

***Comprehensive legislative inquiry finds incompetence, malfeasance at highest levels***

OLYMPIA … A draft Senate report says top officials at the Department of Corrections and the governor's office bear major responsibility for one the worst management failures in state-government history – the improper early release of some 3,000 of Washington's most dangerous and violent prison inmates.

The Senate report is particularly critical of former Corrections Secretary Bernie Warner, who led the department from 2011 to 2015, and of the officials in the office of Gov. Jay Inslee who turned a blind eye to the agency's chaotic management. DOC learned in 2012 that for 10 years it had been incorrectly calculating release dates for prisoners convicted of armed crimes and sexual violence, yet it delayed a fix to its computers for another three years and allowed the early releases to continue. At least two deaths and numerous other crimes have been linked to offenders who should have been behind bars, according to a DOC analysis that remains incomplete.

The draft report, to be considered by the Senate Law and Justice Committee at a meeting May 26, summarizes findings of the first comprehensive investigation of the early-release debacle. The investigation was conducted by the committee over the last four months. Among its findings:

- **Former Corrections Secretary Bernie Warner played a major role in the debacle.** A disengaged management style, a focus on national issues at the expense of detail work, and a misplaced emphasis on ambitious software-development schemes at the expense of computer maintenance and defect correction created a climate where a major public-safety issue could be considered a minor problem.
- **DOC executives failed to take responsibility for the necessary fix.** When alerted to the problem, agency executives failed to recognize the obvious hazards and take immediate action – which would have required hand-calculation of inmate sentences, a major annoyance for the agency.
- **DOC IT programs were mismanaged, a major contributing factor to the delay.** Rational prioritization processes broke down, disastrous reorganizations hampered interdepartmental communication, and management problems led to heavy turnover in the IT department – all of which resulted in delay.
- **The governor's office failed to provide proper oversight to a troubled agency.** The governor's office failed to recognize red flags that should have warned of management problems. It had at least some awareness of the early-release issue yet failed to make

inquiries, and the conflict created by a personal relationship between Warner and a senior member of the governor's staff was not effectively addressed with an appropriate reporting arrangement.

"The problems started at the top," said Sen. Mike Padden, R-Spokane Valley, chair of the Senate Law and Justice Committee. "DOC executives set the stage for this disaster with a series of management blunders, the governor's office just wasn't paying attention, and the people below them were left adrift.

"Top DOC managers knew about the early-release issue – some of them in great detail – and they should have recognized they had a serious problem. Yet they treated it like a hiccup and they displayed an astonishing lack of curiosity. The governor's staff knew enough about the early-release problems to start making inquiries, but it didn't, and it failed to recognize the warning signs of an agency in trouble.

"Now two people are dead, and the governor's office has engaged in an appalling effort to fix the blame somewhere in the middle. The governor reprimanded two mid-level employees who tried to work within the system to fix the problem, and he demoted an IT manager who carried out technical directives from upper management with no knowledge of their effect. Only one executive was directly punished, the agency's risk manager, and rather mildly under the circumstances. The executive branch needs to acknowledge how badly it has let down the state."

In its formal investigation, the Senate Law and Justice Committee invoked powers of inquiry available to the Legislature. It obtained subpoenas for records and reviewed more than 100,000 pages of documents with the assistance of outside counsel. It collected sworn statements from 27 witnesses. It took testimony from 13 witnesses in public session and placed each of them under oath. The committee is releasing hearing transcripts and witness statements along with its report, giving the public a chance to check its work. Documents are available on the web at http://src.wastateleg.org/senate-investigation-doc/ .

The Senate report observes the state still does not know the full impact of the early releases, five months after they were disclosed to the public. The releases started in 2002 when DOC misinterpreted a Supreme Court ruling and provided erroneous instructions to computer programmers. Although DOC in March completed a partial accounting, its analysis covered only the last four years and it did not consider arrest records, a key indicator of criminal impacts. Nor has it looked at the records of inmates released between 2002 and 2011. Until DOC completes its analysis, the exact number of affected inmates cannot be known, nor can the state's liability for negligent supervision be estimated. One wrongful death claim for $5 million already has been filed.

The Senate report is one of three reports issued regarding the early release issue, but the other two were severely limited in scope. The attorney general's office examined the adequacy of legal advice it offered in 2012 – that the agency could wait for a software fix – and concluded the advice was seriously flawed. Meanwhile, the governor's office issued a narrowly focused report regarding decisions made by mid-level managers. It did not consider the breakdown of management systems that contributed to the problem, nor did it consider the duty of DOC executives to monitor what was happening within their agency. The governor's report also failed to consider the oversight responsibilities of the governor's office. Predictably, the governor's

report blamed the mid-level employees closest to the problem and absolved most of the agency's executive team, including Warner.

"The governor's investigation was helpful in establishing the timeline of events, but its narrow focus determined its conclusions," explained Sen. Steve O'Ban, R-Pierce County, the committee's vice chair. "It also made a number of factual errors – for instance, saying the STRONG-R computer project had little impact on agency resources until 2014. It assigned sole responsibility for the decision to delay the computer fix to an IT manager who was not present at the meeting where the decision was made.

"We are particularly puzzled by one statement in the governor's report – the governor's investigators claim no one told them they thought Bernie Warner's management style was a contributing factor to the continued early releases. We heard the opposite from so many people that it is hard to understand how the governor's investigators came to this conclusion. Many witnesses told us the governor's report did not reflect the statements they provided to his investigators. But since the governor did not make available any of the notes taken by his investigators, we can't know if this was a matter of poor note-taking or a deliberate misstatement.

"In the Senate, we recognized the importance of conducting an independent and genuinely transparent investigation, and this has been one of the most serious duties the Legislature has undertaken during my time in office. Washington taxpayers will be paying for these mistakes for years to come, and they deserve the truth. The executive branch failed the state. The Legislature has a duty to hold it accountable, to make recommendations that might prevent similar disasters in the future, and to correct the misimpression some seem eager to create – the buck does not stop in the middle."