State of Washington
Joint Legislative Audit & Review Committee (JLARC)

# State Risk Management Practices in Washington

## Report 11-8

September 21, 2011

*Upon request, this document is available in alternative formats for persons with disabilities.*

***Joint Legislative Audit and Review Committee***
*1300 Quince St SE*
*PO Box 40910*
*Olympia, WA 98504*
*(360) 786-5171*
*(360) 786-5180 Fax*
*www.jlarc.leg.wa.gov*



## Audit Authority

The Joint Legislative Audit and Review Committee (JLARC) works to make state government operations more efficient and effective. The Committee is comprised of an equal number of House members and Senators, Democrats and Republicans.
JLARC's non-partisan staff auditors, under the direction of the Legislative Auditor, conduct performance audits, program evaluations, sunset reviews, and other analyses assigned by the Legislature and the Committee.

The statutory authority for JLARC, established in Chapter 44.28 RCW, requires the Legislative Auditor to ensure that JLARC studies are conducted in accordance with Generally Accepted Government Auditing Standards, as applicable to the scope of the audit. This study was conducted in accordance with those applicable standards. Those standards require auditors to plan and perform audits to obtain sufficient, appropriate evidence to provide a reasonable basis for findings and conclusions based on the audit objectives. The evidence obtained for this JLARC report provides a reasonable basis for the enclosed findings and conclusions, and any exceptions to the application of audit standards have been explicitly disclosed in the body of this report.

# TABLE OF CONTENTS

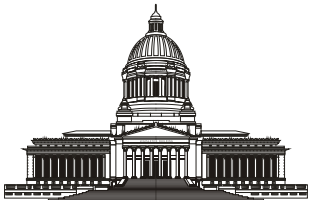
## Committee Approval

On September 21, 2011, this report was approved for distribution by the Joint Legislative Audit and Review Committee.

# State Risk Management Practices in Washington

**Report 11-8**

**September 21, 2011**




STATE OF WASHINGTON

JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE

**STUDY TEAM**
Stacia Hollar

**PROJECT SUPERVISOR**
John Woolley

**LEGISLATIVE AUDITOR**
Keenan Konopaski



Copies of Final Reports and Digests are available on the JLARC website at:

**www.jlarc.leg.wa.gov**

or contact

Joint Legislative Audit & Review Committee
1300 Quince St SE
Olympia, WA 98504-0910
(360) 786-5171
(360) 786-5180 FAX


# REPORT SUMMARY

## Washington Law Provides Much Broader State Government Tort Liability Than Laws in Other States

A tort is a legal action brought to recover damages for bodily injury, death, or property loss. Originally, **the state** could not be sued in a tort action. The Legislature did away with this prohibition in 1961 providing that the state could be sued to the same extent as any person or corporation. Because of this change and other state laws, this state has a higher potential for tort payouts than other states.

According to the Office of Financial Management, the state paid $399 million in tort payouts and defense costs in Fiscal Years 2004-2010. In the 2009-2011 Operating Budget (ESHB 1244), the Legislature directed JLARC to review the effect of risk management practices on tort payouts.

## Current State Risk Management Structure

This report's discussion of risk management structure has two parts: the conducting of post-incident reviews, and the provision of general risk management assistance. The current structure is in response to the recommendations of a 2001 task force convened to improve the state's risk management practices.

In terms of post-incident reviews,

- **The Office of Financial Management (OFM) is conducting fewer post-incident reviews than anticipated.** A fiscal note for the bill assigning OFM the role of conducting these reviews estimated that OFM would lead 12 reviews per year. In contrast, OFM completed a total of ten reviews over seven years (2003 through 2009).
- **State agencies with the highest tort payouts are conducting their own post-incident reviews.** These agencies are the departments of Transportation, Corrections, and Social and Health Services (DSHS). Over the past seven years, actions against these three agencies accounted for 75 percent of the state's total tort payouts.

In terms of general risk management assistance, OFM provides this assistance to all state agencies. OFM provides training and support to all state agencies on issues of common concern such as employee safe driving practices, employment concerns, and safe work place issues.

In 2006, OFM was also chiefly responsible for promoting a new approach to agency risk management practices: **Enterprise Risk Management** (ERM). ERM looks beyond seeking to control fiscal losses and defines risk as anything that interferes with achieving a goal. This approach provides that risk management activities are not done just from a centralized location but rather involve all aspects and employees of an entity. ERM has been recognized as a best practice approach to risk management.

## JLARC Examined Three Agencies' Risk Management Practices Using Enterprise Risk Management Principles

ERM includes five basic principles that have been recognized as elements of an effective risk management system. Rather than a linear process, the ERM principles function as a continuous improvement loop. Within the three agencies, JLARC used these five principles to evaluate whether the programs with the highest tort payouts were consistently using the principles in some way to assist in their risk management.


## Results: All Three Agencies Reviewed Have Taken Steps to Implement Enterprise Risk Management Principles

The agencies are applying Enterprise Risk Management principles, but at two agencies we found examples where some ERM principles were not consistently addressed.

| Agency/ Program | Does the Agency *Consistently* Apply the ERM Principles? | | | | |
|---|---|---|---|---|---|
| | Identify Risk | Analyze Risk | Prioritize Risk | Address Risk | Review & Report |
| Transportation/Highway Safety Program | ✓ | ✓ | ✓ | ✓ | ✓ |
| Corrections/Div. of Community Corrections | ✓ | ✓ | ✓ | ✓ | ? |
| DSHS/Children's Administration | ✓ | ✓ | ✓ | × | × |

JLARC has the following recommendations to address the three instances noted in the table above.

1. **The Department of Corrections should develop and implement a policy for the consistent review of, and reporting on, the effects of actions taken in the Community Corrections Division to address risks.**
2. **The Department of Social and Health Services should address the risks identified in the RSVP report regarding Children's Protective Services investigations and report its results to the Legislature by December 2011.**
3. **The Department of Social and Health Services should develop a method for reviewing and reporting on the effect of actions taken in the Children's Administration to address risks.**

# PART ONE – WASHINGTON LAW PROVIDES MUCH BROADER TORT LIABILITY FOR THE STATE THAN LAWS IN OTHER STATES

This part of the report explains what a tort is and what elements are required in order for an injured party to collect payment. It also reviews tort liability in Washington and how Washington's law regarding liability differs from the laws in other states, leaving Washington with more potential tort liability than other states.

## What Is a Tort?

**A tort is a civil wrong that causes damages to property, bodily injury, or death.**

A tort action is the type of legal proceeding brought by an injured party, such as a car accident or slipping on an icy sidewalk, to recover from the person or entity causing the loss or injury. Tort actions do not just involve the state, but may be brought against an individual or a corporation.

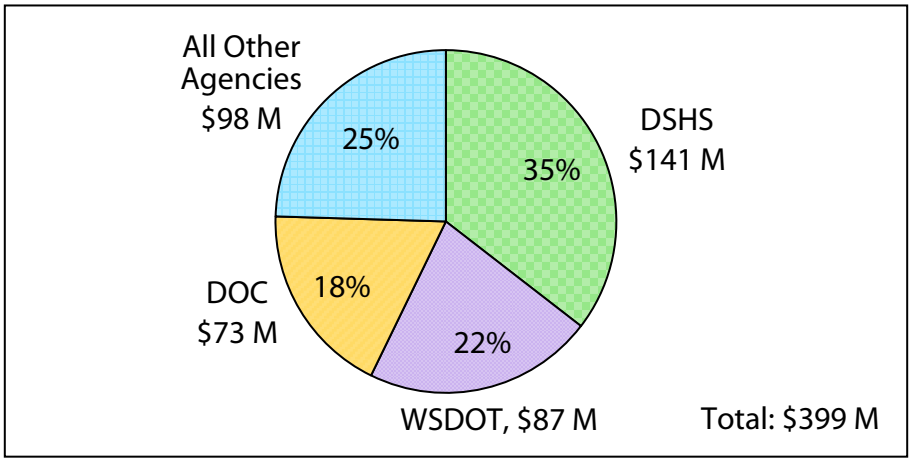
In order to collect payment from a defendant (the party alleged to have caused the injury) in a tort action, the plaintiff (the injured party) must prove the following elements:

1. The defendant had a duty to protect the plaintiff from harm;
2. The defendant acted in a negligent manner that breached that duty;
    - To be negligent, the defendant must have failed to act in a manner consistent with the actions of a reasonable person.
3. The defendant's actions are the legal cause of the injuries; and
4. The plaintiff incurred damages as a result of the defendant's actions or failure to act.

## Three State Agencies Account for 75 Percent of State Tort Payouts

According to the Office of Financial Management, between Fiscal Years 2004 and 2010, the state paid $399 million in tort payouts and defense costs. Three state agencies account for 75 percent of that total: the departments of Transportation (WSDOT), Corrections (DOC), and Social and Health Services (DSHS). Exhibit 1 shows the percentages of tort payouts for these agencies for the last seven fiscal years.

**Exhibit 1 – Total Seven-Year Tort Expenditures for FY 2004-10 ($ in Millions)**




Source: Office of Financial Management.

## *WSDOT*

The Department of Transportation's liability arises from accidents on state roadways alleged to have been caused by negligent design or signage in the highways or failure by the state to properly maintain the highway.

## *DOC*

In situations involving the Department of Corrections, those claims resulting in the highest tort payout result from allegations that the state, in carrying out its responsibility to supervise an offender released to the community, failed to exercise sufficient control to keep the offender from causing harm to a member of the public. For example, an offender failed to contact the community corrections officer as scheduled, but the community corrections officer did not take action to place the offender back into custody. The offender subsequently assaulted an individual. The individual harmed by the offender claims the state is liable for the injuries based on the community corrections officer's failure to act.

## *DSHS*

Claims against the Department of Social and Health Services often relate to allegations that the agency failed to act, or acted negligently, in investigating allegations that a child has been abused or neglected by a parent or caregiver or for failure to protect children while in the state's care.

In the majority of the cases against the state, the injury was alleged to have been directly caused by a non-state employee such as an offender under supervision, a caretaker for a child receiving state services, or a driver on the state's highways. In these cases, the state may be sued for some action or inaction that allegedly allowed the injury to occur. Liability for these types of incidents is one factor that distinguishes the level of Washington's tort liability from that of many other states.

# Washington Law Provides Much Broader State Government Tort Liability for the State than Laws in Other States

American tort law is based on English common law. Historically, English citizens did not have the legal ability to sue their government on the basis that "the king could do no wrong." This protection from lawsuits was known as "sovereign immunity." This legal doctrine was applied in the United States, including Washington, thereby prohibiting individuals from suing the state government for alleged wrongdoing. In 1961, however, the Washington Legislature waived the state's immunity by providing in statute that the state could be sued the same as any private person or corporation.

Each state chooses to enact its own set of liability laws. An analysis of all states' laws was beyond the scope of this study. We focused on the western states and a selection of other states. Among these states, Washington's waiver is very broad. Washington is distinguished from other states by the following factors:

- **Broad Waiver of Sovereign Immunity**. Rather than a broad waiver like Washington, some states allow suits against the state only in limited situations. As particularly relevant to Washington's liability, other states often do not allow suits relating to the probation, parole, release, or escape of a prisoner.
- **Fewer Available Defenses**. Discretionary immunity, which protects state employees from being sued for making choices between alternative courses of action, is provided in some other states. In Washington, discretionary immunity is restricted to only top agency officials making policy decisions and is not available for line staff acting to implement those policies.
- **Fewer Duties in Other States.** As previously noted, the first element in a tort lawsuit is the existence of a duty to protect. Washington differs from other states regarding the situations in which the state has been found to have a duty to protect members of the public.

  Courts recognize a tort law principle known as the "Public Duty Doctrine." The Public Duty Doctrine provides that "a duty to all is a duty to none" and is often applied in the public safety arena to bar finding a duty to a particular individual. For example, police officers have a general duty to protect the public from harm. For purposes of a tort lawsuit, however, a police officer cannot be held liable for failure to protect a particular member of the public from harm caused by a criminal because that officer did not have a duty to that individual.

  If, however, a "special relationship" exists, then the officer can be held liable. A special relationship can arise from a specific assurance or from a "take-charge relationship." The Washington courts have determined that such a "take-charge relationship" exists between the Department of Corrections and the offenders it supervises, and thus the Department does have a duty to protect the public from the "dangerous propensities" of the offender. Some other states have declined to find such a relationship and have found under the Public Duty Doctrine that no duty, and thus no liability, exists in offender supervision situations.

- **Fewer Procedural Limitations on Lawsuits**. States have used other methods to decrease their liability such as placing short time lines on the commencement of the lawsuit or providing that cases against the state only can be heard by special courts or judges. Washington law does not include such limitations.
- **No Damage Caps**. Some other states have limitations on the amount of damages that may be awarded in a tort lawsuit. The limit may apply only against the state or against any defendant in tort lawsuits. Washington law does not include such limitations.
- **Applies Joint and Several Liability**. Another factor is the amount of damages that the state must pay when a case involves multiple defendants. In Washington, in a case with more than one defendant, the plaintiff is able to collect the entire amount of the damages from just one defendant as long as the plaintiff bore no responsibility for the injuries. For example, a jury may find that a state agency was 10 percent responsible for the injuries and the non-state defendant was 90 percent responsible. If the jury awards $1,000,000 in damages, state law allows the plaintiff to recover the entire $1,000,000 from the state, rather than the $100,000 attributable to the state's share of the liability. This concept is called joint and several liability. In some states, each party is required to pay only its share. Other states provide that joint and several liability applies only to defendants whose responsibility is above a certain percentage.

While Washington may share some similarities with other states, the fact that distinguishes this state is that it does not have any of the above listed limitations on its liability. For example, like Washington, both Alaska and Idaho provide that the state has a duty to protect members of the public from the dangerous actions of supervised offenders. Alaska, however, provides for discretionary immunity which protects community corrections officers from reasonable choices made in the course of supervision. On the other hand, Idaho, like Washington, does not provide for such immunity. Idaho does, however, limit the amount of damages that can be awarded. Accordingly, it is the combination of the various factors that provide Washington with such broad liability, which exposes this state to higher potential payouts.

A table comparing Washington and other selected states on these six factors is contained in Appendix 3.

# PART TWO – WASHINGTON'S CURRENT RISK MANAGEMENT STRUCTURE

This part of the report describes Washington's current state risk management structure. The discussion is divided into two components: 1) the conducting of post-incident reviews, and 2) the provision of general risk assistance to all state agencies. Washington's current structure is in response to recommendations made by a 2001 task force convened by Governor Locke and Attorney General Gregoire to recommend ways to improve the state's risk management practices.

## Post-Incident Reviews

The task force recommended that the Office of Financial Management (OFM) require agencies to conduct ***post-incident reviews*** to help avoid or reduce losses or incidents in the future. An incident is a situation involving a death, serious injury, or other substantial loss in which the state may have some responsibility.

The Legislature affirmed the concept of conducting reviews but adopted a different approach, requiring OFM, an independent agency, to conduct the reviews with a team of individuals, known as a Loss Prevention Review Team (LPRT), from outside the involved agency. The task force also recommended follow-up by OFM, and specified that the use of such reviews in subsequent lawsuits should be restricted.

The Legislature did adopt the portion of the recommendation providing that the actual reports resulting from the OFM loss prevention reviews could not be admitted as evidence in court or administrative proceedings. Under this statute, the LPRT report itself is not admissible as evidence, but it is available to the public including lawyers bringing actions against the state. Moreover, members of the LPRT may not be questioned in a civil or administrative proceeding regarding the work of the team, the incident under review, and the statements of the member or of anyone who provided information to the team.

JLARC examined the post-incident review practices of both OFM and the three state agencies with the highest tort payouts. We also asked for information on what it costs each agency to conduct the post-incidents reviews.

### *The Office of Financial Management is Conducting Fewer Post-Incident Reviews Than Anticipated*

The Loss Prevention Review statutes provide that state agencies are to report incidents involving the death or serious injury of a person or other substantial loss that is "alleged or suspected to be caused at least in part by the actions of a state agency" to OFM (RCW 43.41.370). If the Director of OFM determines a Loss Prevention Review Team (LPRT) review should occur, he or she appoints a team. The team is comprised of independent volunteers, at least one of whom is to have specific expertise in the area under review.

The team provides a report to OFM and the affected agency at the completion of the review. The agency must respond within 120 days, and the response is included in the final report. The agency is responsible for identifying which report recommendations it intends to implement, and OFM is charged with monitoring such implementation. OFM publishes the reports and agency responses on its website.

On an annual average, state agencies report 1,700 incidents to OFM. The Director of OFM has the discretion to determine whether to investigate any incidents. The fiscal note connected to the 2002 legislation creating this program estimated that OFM would lead 12 reviews per year. In contrast, over seven years (2003 through 2009), OFM completed 10 LPRT studies. These reviews covered a variety of topics including injuries to children receiving state services and state employees' driver safety. The involved agencies ranged in size from DSHS, to the Secretary of State's Office.

When the Director of OFM chooses not to have an LPRT investigate an incident, by statute, the Director must publish on the OFM website the reasons for not doing so. Currently, the website has such determinations for Fiscal Years 2005-2009. The following list of reasons for not investigating incidents accompanies the Director's determinations:

1. Agency actions addressed risk.
2. Incident already subject of investigation, audit or similar review by external agency or entity, and LPRT review would interfere or duplicate that effort.
3. LPRT Program priorities preclude review at this time.
4. Agency program not causally linked to event.
5. Although reported, upon assessment determined not to be a substantial loss.
6. A review team is unlikely to identify strategies for reducing risk of future similar loss.
7. Other accompanied by explanation on website.
8. Incident of a type substantially similar to ongoing LPRT review.

OFM reported that in 2008, 63 percent of the incident reports were closed because they had been reviewed by the source agency or an outside group (Reason 2) or the agency had addressed the risk to prevent further losses (Reason 1). OFM stated that 81 percent of the incident reports were closed for the same reasons in 2009.

## *Costs for Loss Prevention Review Team Program*

OFM estimated that its general risk management costs for the 2009-11 Biennium were $4.4 million. This estimate includes costs for the LPRT program and other risk management activities. OFM did not provide a separate cost estimate for administering the LPRT program.

As part of the LPRT process, agencies are required to report incidents to OFM and provide follow-up information as requested by OFM. The agencies with the three largest tort payout amounts, (the departments of Transportation, Corrections, and Social and Health Services) each estimated that their costs for complying with the LPRT requirements were less than $40,000 for the 2009-11 Biennium.

## *State Agencies With Highest Tort Payouts Are Conducting Their Own Post-Incident Reviews*

In addition to reviewing the practices of OFM, JLARC looked at the post-incident review practices of the departments of Transportation, Corrections, and Social and Health Services. For each agency, we further refined our focus by looking at the area within each agency that had the largest portion of the agency's payouts during that time. All three agencies have procedures in place to conduct internal post-incident reviews. Additionally, as part of the LPRT process, OFM has the authority to review the agencies' actions and determine if further investigation is necessary. OFM has exercised this authority.

### Department of Transportation: Highway Safety

In the Department of Transportation (WSDOT), we focused on the area of highway safety. Between Fiscal Years 2004-2010, tort payouts and defense costs for the Highway Safety Program accounted for 68 percent of total WSDOT tort payouts according to the Office of Financial Management.

In 2009, there were 43,096 collisions reported on state routes. Of these reported collisions, 1,062 involved serious injury and fatalities. These accidents are investigated by the Washington State Patrol or other local law enforcement officials at the time of the accident. As needed, WSDOT staff may assist law enforcement at the time of the accident or conduct their own additional investigations.

The Department maintains databases to collect the crash information. Rather than focusing on the individual incidents, WSDOT uses this aggregate data to ***identify patterns and contributing factors***. The Department analyzes this data to determine specific highway locations or highway traffic corridors that have a higher than expected accident rate. WSDOT looks at the causes and contributing factors of accidents at a given location to determine if an engineering solution is available.

Thus, rather than only seeking to address just a particular incident, WSDOT uses this information in its planning process for future road safety projects. Examples of where these types of reviews have resulted in improved safety measures include replacement of highway median concrete barriers with cable barriers, placement of rumble strips, and actions to mitigate rock slides onto highways.

WSDOT estimated that its costs for the 2009-2011 Biennium were $4.5 million. WSDOT considers its entire safety program as a tort reduction activity. Thus in addition to investigation costs, WSDOT included costs it feels are directly related to its enterprise risk and safety management activities.

### Department of Corrections: Community Corrections Division

According to the Office of Financial Management, over the past seven fiscal years, 57 percent of the Department of Corrections' total tort expenditures resulted from tort payouts and defense costs related to the Community Corrections Division's supervision of offenders. The agency conducts post-incident reviews through its critical incident process.

In 2006, the Department of Corrections adopted policies addressing the reporting and reviewing of critical incidents. Critical incidents may be addressed either through a fact finding process or a critical incident review. Upon completion of a fact finding review, a critical incident review may be conducted.

In the Community Corrections Division (CCD), the "death or serious bodily injury resulting from the action of an offender on supervision" requires a fact finding review, but a critical incident review is required if the offender has been arrested and charged with a criminal act related to the incident.

Critical Incident Reviews (CIRs) are conducted by a team of agency staff. [1] Unlike fact finding reviews which do not necessarily require a written report, CIRs are documented in writing. The CIR process also requires the initiation of a written action plan. The CIR report and the action plan are provided to the Agency Risk Manager. Agency policy directs the Assistant Secretaries to review the CIRs "to identify trends and ensure policy level and cross-division issues are addressed."[2]

An example of an issue that was addressed through the CIR process was the existence of gaps in coverage of offender supervision when the assigned community corrections officer is unavailable due to vacation or other extended leave. In response, DOC revised its policy regarding coverage for unavailable community corrections officer to provide uninterrupted supervision.

Since the overall critical incident policy was adopted in 2006, the Community Corrections Division has conducted 575 critical incident reviews through November 2010. According to DOC, the estimated cost for the Community Corrections Division to perform critical incident reviews for the 2009-11 Biennium was $279,000.

## Department of Social and Health Services

The Office of Financial Management reported that between Fiscal Years 2004-2010, 72 percent of the Department of Social and Health Services' (DSHS) total tort expenditures resulted from tort payouts and defense costs arising from the Children's Administration.

DSHS has both internal directives for performing post-incident reviews as well as a statutory requirement to perform reviews of certain types of child fatalities. The Children's Administration Operations Manual contains guidance on both child fatality reviews and reviews of other serious incidents. The Operations Manual discusses the process for reporting and reviewing the incidents. The Children's Administration also adopted protocols regarding the reporting, response, and review of these incidents.

State law requires that DSHS conduct Child Fatality Reviews (CFR) on unexpected deaths of children in Washington who, within the past 12 months, had been in the care of, or receiving services from, Children's Administration. DSHS policy also provides enhanced investigations known as Executive Child Fatality Reviews. Executive CFRs are conducted when the death is suspected to have been the result of abuse or neglect and requires a more in-depth review.

During the 2011 session, this law was changed. The bill narrowed the application of the CFRs to cases where the fatality is suspected to be the result of abuse or neglect as opposed to medical or

[1] DOC Policy 400.110.

[2] DOC Policy 400.110.

other causes. These are the types of reviews previously done by the agency as Executive Child Fatality Reviews. The new law also requires DSHS to notify the Office of Family and Children's Ombudsman (Ombudsman) in the case of a near-fatality.

A near-fatality occurs when injuries to the child result in serious or critical conditions. DSHS may conduct a review in these cases either on its own initiative or at the request of the Ombudsman. Testimony from DSHS and Ombudsman during hearings on the 2011 bill indicated that its passage would decrease the number of reviews required of DSHS and thus allow better focus on abuse and neglect cases as well as allow for near-fatality reviews. Under this new law, DSHS would be required to perform only abuse related fatalities, as illustrated in the first row of Exhibit 2, below.

**Exhibit 2 – Child Fatality Reviews in Washington**

| Category of Child Fatality Requiring Review | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Abuse Related Child Fatalities | 14 | 15 | 12 | 19 | 4 |
| Other Child Fatalities | 48 | 48 | 47 | 69 | 55 |
| **Total Child Fatalities** | **62** | **63** | **59** | **88** | **59** |

Source: Department of Social and Health Services, Children's Administration, Child Fatalities in Washington State.

The 2011 legislation, using language nearly identical to that contained in the Loss Prevention Review Team (LPRT) statutes, provides that the report resulting from a child fatality or near-fatality review is not admissible as evidence in any civil proceeding. Again, similar to the LPRT process, the law now provides that members of the Fatality and Near-Fatality teams may not be questioned in a civil or administrative proceeding regarding the work of the team, the incident under review, and the statements of the team member or of anyone who provided information to the team.

DSHS produces Quarterly Child Fatality Reports which are posted on the Department's website. The reports summarize the results of the CFR reviews and provide recommendations to address issues found during the reviews. The Office of Family and Children's Ombudsman (Ombudsman) also reviews the CFRs and identifies risks to DSHS. As an example, from reviewing Child Fatality reviews, the Ombudsman indentified that DSHS caseworkers were not routinely investigating reports of bruises to pre-mobile infants. Children's Administration responded by changing its policy to require that all such referrals be opened for investigation.

DSHS estimated the costs in the 2009-11 Biennium for performing CFRs were $538,010.

## General Risk Management: OFM Provides Assistance to All State Agencies

The 2001 task force recommended consolidation of statewide risk management functions in the Office of Financial Management (OFM). The Legislature in 2002 provided for the creation of the Risk Management Division within OFM and transferred to it the risk management responsibilities previously held by the Department of General Administration. The Legislature stated that by its actions, it intended to raise the visibility of risk management, increase executive involvement, and improve statewide accountability. In the 2011 session, the risk management functions were removed from OFM and placed with the new Department of Enterprise Services.

The OFM Risk Management Division currently provides general risk management services through its Safety and Loss Control Program. This program provides training and support to all state agencies on issues of common concern, such as employee safe driving practices, employment concerns and safe work place issues. OFM provides other risk management services, including tort claims processing and procuring insurance.

### *In 2006, the Office of Financial Management and State Agencies Adopted a New Approach for Agency Risk Management Practices: Enterprise Risk Management*

Traditional risk management involves actions undertaken specifically to try to minimize economic loss to an organization. Enterprise Risk Management (ERM) expands on those practices to look at all risks facing an agency, fiscal or other. According to OFM, under ERM, risk is defined broadly as "anything that can interrupt the achievement of [an agency's] goal on time." [3] Enterprise Risk Management provides a framework for managing risk and taking advantage of opportunities.

OFM has defined ERM as a "coordinated method of performing risk management that considers every aspect of risk that affects agency goals." [4] Under this approach, all agency activities are viewed as potential risk management practices, and all levels of employees are involved in helping manage the risk.

Enterprise Risk Management began in the private sector in the 1990s. Since that time, government entities including the United Kingdom, Australia, Canada, and the United States federal government have embraced this approach. Washington's Governor requires that agencies' actions in implementing ERM be tracked through GMAP, the Governor's Management, Accountability and Performance system.

As described in Part Three of this report, JLARC used the principles of Enterprise Risk Management to examine state agency risk management conduct and processes.

[3] OFM Enterprise Risk Management Training Template.

[4] http://performance.wa.gov/GE/GE011510/RiskManagementWorkerSafety/ERMMilestones/ERMMaturity/Pages/ActionPlan.aspx.

# PART THREE – EXAMINING RISK MANAGEMENT PRACTICES IN THE DEPARTMENTS OF TRANSPORTATION, CORRECTIONS, AND SOCIAL AND HEALTH SERVICES

JLARC was asked to review the effect of Washington's risk management practices on tort payouts and state agency conduct. For a number of reasons, JLARC concluded tort payouts are not the best way to measure the effectiveness of risk management practices in Washington. JLARC turned instead to five principles of Enterprise Risk Management to evaluate state agency risk management conduct and processes.

## Tort Payouts Are Only One Way to Look at the Effectiveness of Risk Management Practices

Reviewing the level of tort payouts is one approach to gauging the effectiveness of risk management practices, but not the only way. For a number of reasons, tort payouts may not be the best way to measure effectiveness.

- As discussed in Part One of the report, Washington law provides for broad liability against the state for tort actions. Because some of the factors contributing to this broad liability, such as no damage caps and joint and several liability, have no connection to risk management activities, there may not be a direct relationship between the amount of an award and the actions of the state employee. Accordingly, the amount of the tort payouts alone does not yield a complete picture of the risk management activities.
- In Washington, a consistently small number of events results in the majority of tort payouts. For example, as of December 31, 2010, the Department of Corrections supervised 18,690 offenders. This level was a decrease from nearly 30,000 cases in 2009 due to a change in the law that removed certain types of offenders from supervision and therefore directed DOC to focus on offenders with a high likelihood to reoffend. According to the Office of Financial Management, between Fiscal Year 2004 and Fiscal Year 2010, all of the tort payouts attributable to the Community Corrections Division's negligent supervision claims and lawsuits were caused by five or fewer incidents per year. These limited occurrences may not provide sufficient data to evaluate the effectiveness of specific risk management practices.
- Looking only at incidents which result in payouts does not take advantage of the information that can be derived from reviewing other incidents that did not result in such a payout or even a tort claim. OFM has indicated that between Fiscal Year 2006 and Fiscal Year 2010, state agencies reported 8,801 incidents. OFM reports that at least 138 tort claims have been filed with it based on these reported incidents.
- Finally, a substantial delay (perhaps years) often occurs between the time of the incident that gives rise to liability and the actual tort payout. While the current payouts provide some information regarding risk management practices at the time of the incident, because of the time lag, the information may no longer be accurate.

## JLARC Used Best Practices to Evaluate Agencies' Risk Management Processes

Enterprise Risk Management's five principles are widely recognized as elements of an effective risk management system, and they provide a framework or criteria for JLARC's analysis of the three agencies' risk management practices.

The five principles are:

1. **Identify Risks** – Risks are potential events that would positively or negatively impact an entity's achievement of its goals.
2. **Analyze Risks** – The agency determines the probability of the adverse event and the severity of its impact.
3. **Prioritize Risks** – Based on the analysis of risk, the agency chooses the order in which to address the risks.
4. **Address Risks** – The agency determines methods for transferring risk (through insurance where possible) or mitigating the risk through changes to policies or procedures. Private sector entities can choose to avoid the risk by discontinuing the activity causing the risk. However, for many activities, this choice is often not available to state agencies.
5. **Review and Report** – This step involves monitoring whether the changed practices are effective and reporting both internally and externally on the impact of these practices. The information gained through this process feeds back into the loop for continued improvement.

As illustrated in Exhibit 3 below, Enterprise Risk Management is a continuous process of managing risk. Professional organizations such as the national Committee of Sponsoring Organizations of the Treadway Commission (COSO) have recognized Enterprise Risk Management as a best practice.

**Exhibit 3 – Enterprise Risk Management Offer a Continuous Process for Managing Risk**


Source: JLARC analysis of ERM process.

# Results From JLARC's Evaluation: WSDOT, DOC, and DSHS Have Taken Steps to Implement Enterprise Risk Management Principles

In each of the three agencies, JLARC focused on risk management activities relating to the area within the agency with the highest tort payouts over the past seven fiscal years. JLARC found evidence that, to varying degrees, the Department of Transportation, the Department of Corrections, and the Department of Social and Health Services were using Enterprise Risk Management principles as they relate to the type of activities involved in tort claims.

Because ERM is a framework, rather than a rigid tool, different entities will employ its principles in different ways. The key component is that the five principles are used in some manner to help recognize, manage, and monitor risk.

Consistent with this view, we found that each of the agencies reviewed had different approaches based on their unique missions, goals, and structures, but all were utilizing the principles in some way to assist in their risk management.

## *In the Highway Safety Program, the Department of Transportation Applies All Five Enterprise Risk Management Principles*

In regard to the Department of Transportation (WSDOT), JLARC focused on the areas of highway maintenance and design as these functions resulted in the highest payouts. JLARC evaluated the risk management practices against the Department's stated goal of providing safe highways. In conjunction with the Washington State Patrol and the Washington Traffic Safety Commission, WSDOT has created the Target Zero Program with the goal of decreasing the fatalities on Washington State roads to zero by 2030. Currently, Washington's fatality rate is the lowest since 1975 when Washington began tracking this information.

WSDOT's risk management practices are overseen by the agency's Office of Enterprise Risk Management formed in 2005. As shown in Exhibit 4, on the following page, WSDOT applies all five ERM principles to manage risks in the Highway Safety Program.

**Exhibit 4 – The Department of Transportation Applies All Five Enterprise Risk Management Principles In Its Highway Safety Program**

| ERM Principle | Applied Consistently? | Examples |
|---|---|---|
| Identify Risk | ✓ | The agency uses information gained from accident data to determine the nature of the collisions and their contributing factors. |
| Analyze Risk | ✓ | The agency maintains and uses a database that can identify the frequency and severity of accidents at particular locations. |
| Prioritize Risk | ✓ | WSDOT stated it used statistical analysis of the collision data to identify areas with higher than average potential for accidents. WSDOT uses this data in conjunction with information regarding costs and feasibility of solutions to determine the order in which to address projects. |
| Address Risk | ✓ | WSDOT addressed the risk of accidents from drivers falling asleep and running off the road by installing rumble strips in areas with increased frequency and severity of these types of accidents. |
| Review & Report | ✓ | The agency reviewed collision information and other department data from the areas treated to determine the effectiveness of the mitigation strategies. WSDOT's Office of Enterprise Risk Management shares this information with management and the public through WSDOT's "The Gray Notebook," the agency's quarterly performance report. |

Source: JLARC analysis of Department of Transportation data.

## *In the Division of Community Corrections, the Department of Corrections Has Applied Four Enterprise Risk Management Principles, But the Agency Did Not Have a Policy to Ensure Consistent Application of One of the Principles*

Because lawsuits relating to the Community Corrections Divisions' (CCD) supervision of offenders accounted for 46 percent of the Department of Corrections' total tort payouts, JLARC reviewed risk management practices in this area. These practices were reviewed relative to the Department's goal of improving public safety. DOC's tort liability arises when individuals under supervision reoffend resulting in injury to, or the death of, members of the public.

DOC coordinates its risk management efforts through its Risk Management Office. As shown in Exhibit 5, below, DOC has applied four of the ERM principles, but we found DOC lacks a policy to ensure consistent application of the fifth principle (Review & Report).

**Exhibit 5 – In the Community Corrections Division, DOC Applies The First Four Enterprise Risk Management Principles, But Did Not Have a Policy to Ensure Consistency Relating to the "Reviewing and Reporting" Principle**

| ERM Principle | Applied Consistently? | Examples |
|---|---|---|
| Identify Risk | ✓ | The agency uses information gained from the Critical Incident Reviews discussed earlier in the report and also from reviews of closed tort cases. |
| Analyze Risk | ✓ | In conducting the reviews mandated under the Critical Incident Review process, the review team looks for cause and contributing factors. |
| Prioritize Risk | ✓ | DOC determined that priority risks were timely and effective notification of the Community Corrections Division when an offender is released from incarceration and the timeliness of the initial screening and intake process for offenders entering supervision. |
| Address Risk | ✓ | DOC implemented a new automated statewide notification system that provides electronic notice to community correction officers upon an offender's release from jail. |
| Review & Report | ? | DOC has measures for some of CCD's responses to identified risks. However, DOC does not have a policy to ensure consistent review and reporting within the agency or to the public on CCD's mitigation efforts or their effects. |

Source: JLARC analysis of Department of Corrections data.

In terms of **Review & Report,** DOC does have measures to allow for reviewing and reporting some of CCD's mitigation efforts. For example, the agency has measured compliance with a requirement to complete intake of offenders into the Community Supervision system within 30 days of their release from confinement. The compliance with this requirement has increased from 70 percent in 2009 to 90 percent in 2011.

However, DOC does not have a policy for measuring the effectiveness of CCD's responses to identified risks or for reporting on them within the agency or to the public. The policy addressing Critical Incident Reviews discusses the management review of the results of the reviews, but does not provide for the measurement or dissemination of this information. In its 2011-2017 Strategic Plan, the agency acknowledged that a "major challenge facing DOC was the lack of necessary tools to effectively measure and analyze the capacity and performance of its entire portfolio of activities

and programs."[5] DOC further indicated a need for management tools to aid in both monitoring and reporting capacity and performance for the agency.

**Recommendation 1**

**The Department of Corrections should develop and implement a policy for the consistent review of, and reporting on, the effects of actions taken in the Community Corrections Division to address risks.**

## *In the Children's Administration, the Department of Social and Health Services Has Applied Three Enterprise Risk Management Principles, But The Agency Did Not Consistently Apply Two of the Principles*

The most significant area of tort payouts in the Department of Social and Health Services relates to investigations of child abuse by Child Protective Services (CPS), a division of Children's Administration. The investigations occur when CPS receives an allegation that a child is subject to abuse. CPS either chooses not to conduct an investigation, or conducts an investigation and removes the child, or leaves the child in his or her current placement.

Claims may be brought on behalf of the child contending that, because of a faulty investigation, the child was not moved and suffered further abuse. The parents of the child may also bring an action alleging a child was removed from their custody as the result of a faulty investigation. One of the agency's goals is that children will be safe from abuse. As of September 30, 2010, Children's Administration had 11,625 children in its care.

[5] Washington Department of Corrections Strategic Plan 2011-2017 on p. 17.

DSHS employs a Chief Risk Officer to oversee the agency's risk management efforts. The Field Operations Division of Children's Administration is also responsible for risk management. As shown in Exhibit 6 below, the Children's Administration is applying three of the ERM principles. However, we found examples where the agency is not consistently applying the fourth principle (Address Risk) and the fifth principle (Review & Report).

**Exhibit 6 – In the Children's Administration, DSHS Applies The First Three Enterprise Risk Management Principles, But Is Not Consistent In Its Use of the "Address Risk" and "Reviewing and Reporting" Principles**

| ERM Principle | Applied Consistently? | Examples |
|---|---|---|
| Identify Risk | ✓ | The agency uses information gained from the Child Fatality Reviews (CFR) and other critical incident reviews discussed earlier in the report to identify agency risks. DSHS worked jointly with OFM to conduct a review of incidents and lawsuits to identify risks relating to vulnerable children and adults. The project is entitled Reinforce the Safety of Vulnerable Persons (RSVP). |
| Analyze Risk | ✓ | Children's Administration sought assistance from the National Resource Center for Child Protective Services (NRCCPS) to analyze its processes and procedures relating to Child Fatality and Near Fatality Procedures and Reports, and Child Safety and Planning Processes. |
| Prioritize Risk | ✓ | An internal DSHS work group, along with the RSVP project team, established faulty Child Protective Services' (CPS) investigations of child abuse as a priority risk. |
| Address Risk | ✗ | Children's Administration has taken, and continues to take, steps internally to strengthen its Child Protective Services program as well as other child welfare programs to reduce the probability of abuse or neglect. However, DSHS has not completed the process of implementing risk assessment and mitigation strategies identified in the RSVP report. |
| Review & Report | ✗ | While Children's Administration has taken some steps to measure and report on changes addressing risk, the agency lacks a consistent approach. DSHS does not have a policy or consistent practice for reporting within the agency or to the public on Children's Administration mitigation efforts or their effects. |

Source: JLARC analysis of DSHS data.

**Address Risk** – In 2008, a DSHS internal workgroup determined that the areas of **licensing, placement**, and **investigations** of abuse presented significant risk. The agency took actions to address the **licensing** and **placement** issues, but did not similarly address the identified risks relating to faulty **investigations** of child abuse.

In April and May 2010, the Children's Administration updated its process and tools for reviewing samples of Child Protective Services cases to identify practice trends and develop and monitor action plans. However, in the fall of 2010, the joint OFM and DSHS RSVP project similarly identified risks relating to faulty child abuse investigations. The project recognized that failure to conduct an appropriate investigation had been the basis of many of the high payout tort actions against DSHS. While DSHS has deemed this to be a high priority area, the agency has not implemented a mitigation plan to address the identified risk.

**Review & Report** – While Children's Administration has taken some steps to measure and report on changes addressing risk, the agency lacks a consistent approach. For example, Children's Administration staff created a "Lessons Learned" training which highlights recurrent topics and solutions derived from Child Fatality Reviews. This training, however, is not mandatory or done on a regular schedule.

The lack of a comprehensive method for disseminating information was recognized by OFM in its RSVP report and by the National Resource Center for Child Protective Services report on Child Fatality and Near-Fatality procedures which was released on April 18, 2011.

**Recommendation 2**

**The Department of Social and Health Services should address the risks identified in the RSVP report regarding Children's Protective Services investigations and report its results to the Legislature by December 2011.**

**Recommendation 3**

**The Department of Social and Health Services should develop a method for reviewing and reporting on the effect of actions taken in the Children's Administration to address risks.**

# PART FOUR – CONCLUSIONS AND RECOMMENDATIONS

## Conclusions

Because of Washington's broad waiver of sovereign immunity, as well as other legal factors, Washington's state government has greater potential tort liability than other states. The Office of Financial Management provides general risk management services to all state agencies including facilitating the agencies' adoption of Enterprise Risk Management practices. The three state agencies with the highest tort payouts in Fiscal Years 2004-2010, the departments of Transportation, Corrections, and Social and Health Services all conduct post-incident reviews and have taken steps to implement Enterprise Risk Management principles.

## Recommendations

This report includes recommendations to strengthen Enterprise Risk Management implementation at two of the agencies we reviewed. While the Department of Transportation Highway Safety Program is implementing all five Enterprise Risk Management principles, we found examples where the other two agencies were not consistently applying all of the principles. Based on these findings, we have one recommendation for the Department of Corrections and two recommendations for the Department of Social and Health Services.

### *Department of Corrections*

Because it is not consistently meeting the fifth ERM principle of reviewing and reporting to complete the risk management feedback loop, JLARC has one recommendation to the Department of Corrections.

**Recommendation 1**

**The Department of Corrections should develop and implement a policy for the consistent review of, and reporting on, the effects of actions taken in the Community Corrections Division to address risks.**

| | |
|---|---|
| **Legislation Required:** | None |
| **Fiscal Impact:** | JLARC assumes that this can be completed within existing resources. |
| **Implementation Date:** | December 2011 |

### *Department of Social and Health Services*

Because we found examples where the agency is not consistently addressing the fourth ERM principle of addressing risk and the fifth ERM principle of reviewing and reporting to complete the risk management feedback loop, JLARC has two recommendations to the Department of Social and Health Services.

**Recommendation 2**

**The Department of Social and Health Services should address the risks identified in the RSVP report regarding Children's Protective Services investigations and report its results to the Legislature by December 2011.**

| | |
|---|---|
| **Legislation Required:** | None |
| **Fiscal Impact:** | JLARC assumes that this can be completed within existing resources. |
| **Implementation Date:** | December 2011 |

**Recommendation 3**

**The Department of Social and Health Services should develop a method for reviewing and reporting on the effect of actions taken in the Children's Administration to address risks.**

| | |
|---|---|
| **Legislation Required:** | None |
| **Fiscal Impact:** | JLARC assumes that this can be completed within existing resources. |
| **Implementation Date:** | December 2011 |

# APPENDIX 1 – SCOPE AND OBJECTIVES

**WASHINGTON STATE'S RISK MANAGEMENT PRACTICES**

**SCOPE AND OBJECTIVES**

OCTOBER 20, 2010


STATE OF WASHINGTON
JOINT LEGISLATIVE AUDIT
AND REVIEW COMMITTEE

**STUDY TEAM**
Cynthia L. Forland
Stacia Hollar

**PROJECT SUPERVISOR**
Keenan Konopaski

**LEGISLATIVE AUDITOR**
Ruta Fanning

Joint Legislative Audit &
Review Committee
1300 Quince St SE
Olympia, WA 98504-0910
(360) 786-5171
(360) 786-5180 Fax

**Website:**
**www.jlarc.leg.wa.gov**
e-mail: neff.barbara@leg.wa.gov


## Why a Study of How Risk Management Practices Impact State Conduct and Tort Payouts?

Prior to 1961, opportunities to sue the state were limited. In that year, the Legislature acted to allow the state to be sued to the same extent as a private person or corporation. In fiscal year 2009, the state paid out $57.3 million for claims made against the state. With the goal of preventing such losses, the state engages in risk management practices.

The 2009-11 Operating Budget (ESHB 1244) requires the Joint Legislative Audit and Review Committee (JLARC) to review the effect of risk management practices on state conduct and tort payouts (i.e., payouts arising from lawsuits against the state for causing injury).

## A Brief History of Risk Management Legislation in Washington

In **1977**, the Legislature created a risk management office within the Department of General Administration. That same legislation defined "risk management" as the total effort and continuous step-by-step process of risk identification, measurement, minimization, assumption, transfer, and loss adjustment aimed at protecting state assets and revenues against accidental loss.

In response to increasing payouts for judgments and claims against the state, the Governor and Attorney General undertook a risk management initiative in **2001**. That effort included a task force which developed a set of recommendations. The Legislature enacted two of the task force's recommendations in **2002**:

1. Increase the visibility of statewide risk management by transferring those responsibilities from the Department of General Administration to the Office of Financial Management; and
2. Institute Loss Prevention Reviews whenever the death of a person, serious injury to a person, or other substantial loss is alleged or suspected to be caused at least in part by the conduct of a state agency.

## Legislature Directs JLARC to Analyze Post-Incident Reviews

One way of managing risk is to review serious incidents after they occur, which may be referred to as post-incident reviews. One specific type of post-incident review is the Loss Prevention Reviews established in statute in 2002.

The Director of Financial Management is responsible for determining whether an incident merits a Loss Prevention Review. To date, OFM has issued ten Loss Prevention Review reports and determined that 1,711 incidents did not merit a Loss Prevention Review.

## Study Scope

JLARC will review the statewide requirements for and the practice of post-incident reviews, including statutorily established Loss Prevention Reviews. JLARC will also identify more general statewide risk management requirements.

## Study Objectives

1) What are current post-incident review requirements and practices?
2) Have post-incident reviews impacted state conduct and tort payouts?
3) What other statewide risk management practices are focused on reducing serious incidents?
4) Have statewide risk management practices impacted state conduct and tort payouts?
5) What lessons can we learn from other states' approaches to reducing serious incidents?

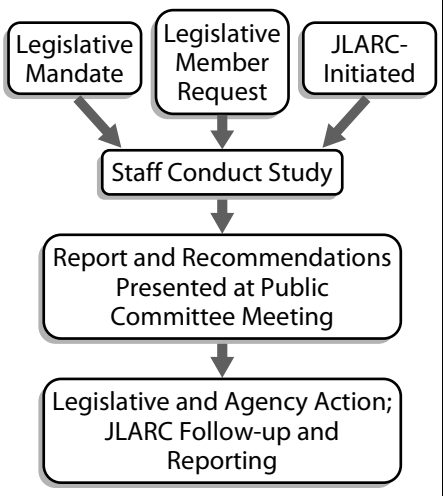
## Timeframe for the Study

Staff will present the preliminary and final reports at the JLARC May and June 2011 meetings, respectively.

## JLARC Staff Contact for the Study

Cynthia L. Forland (360) 786-5178 forland.cynthia@leg.wa.gov
Stacia Hollar (360) 786-5191 hollar.stacia@leg.wa.gov

### JLARC Study Process




**Criteria for Establishing JLARC Work Program Priorities**

- Is study consistent with JLARC mission? Is it mandated?
- Is this an area of significant fiscal or program impact, a major policy issue facing the state, or otherwise of compelling public interest?
- Will there likely be substantive findings and recommendations?
- Is this the best use of JLARC resources? For example:
  - Is JLARC the most appropriate agency to perform the work?
  - Would the study be nonduplicating?
  - Would this study be cost-effective compared to other projects (e.g., larger, more substantive studies take longer and cost more, but might also yield more useful results)?
- Is funding available to carry out the project?

# APPENDIX 2 – AGENCY RESPONSES

- Office of Financial Management
- Department of Corrections
- Department of Transportation
- Department of Social and Health Services
- Attorney General

STATE OF WASHINGTON
OFFICE OF FINANCIAL MANAGEMENT
*Insurance Building, PO Box 43113 • Olympia, Washington 98504-3113 • (360) 902-0555*

June 27, 2011

**TO:** Keenan Konopaski, Legislative Auditor
Joint Legislative Audit and Review Committee

**FROM:** Marty Brown MB
Director

**SUBJECT:** **STATE RISK MANAGEMENT PRACTICES IN WASHINGTON – PRELIMINARY REPORT**

Thank you for the opportunity to respond to your preliminary report titled: "State Risk Management Practices in Washington." Office of Financial Management staff appreciate the time the audit committee spent with them and reiterate the following concurrence with the three recommendations contained in the report:

| Recommendation | Agency Position | Comments |
|---|---|---|
| 1. The Department of Corrections should develop and implement a policy for the consistent review of, and reporting on, the effects of actions taken in the Community Corrections Division to address risks. | Concur | |
| 2. The Department of Social and Health Services should address the risks identified in the RSVP report regarding Children's Protective Services investigations and report its results to the Legislature by December 2011. (Revised wording.) | Concur | |
| 3. The Department of Social and Health Services should develop a method for reviewing and reporting on the effect of actions taken in the Children's Administration to address risks. | Concur | |

Again, thank you for the opportunity to comment. Please don't hesitate to contact Lucy Isaki of my staff at 902-3058 with any questions.

cc: Stan Marshburn, Deputy Director, OFM
Lucy Isaki, Senior Assistant Director, Risk Management Division, OFM
Drew Zavatsky, Loss Prevention Program Coordinator, OFM
Kim Haggard, Research Analyst, OFM

**Washington State Department of Transportation**
**Paula J. Hammond, P.E.**
Secretary of Transportation

**Transportation Building**
310 Maple Park Avenue S.E.
P.O. Box 47300
Olympia, WA 98504-7300

360-705-7000
TTY: 1-800-833-6388
www.wsdot.wa.gov

June 23, 2011

Mr. Keenan Konopaski, Legislative Auditor
Joint Legislative Audit and Review Committee
1300 Quince St SE
Olympia, WA 98504-0910

Dear Mr. Konopaski:

Thank you for the opportunity to respond to the Joint Legislative Audit and Review Committee's (JLARC) Audit of the *State Risk Management Practices in Washington.* We reviewed the report and have provided our formal response below.

We appreciate JLARC's review of our agency's work in this area. Such feedback is important in helping the Washington State Department of Transportation (WSDOT) to identify areas of risk and to mitigate those risks. Also, we would like to thank you and your staff for the work put into this report.

We are pleased JLARC found that WSDOT used all five Enterprise Risk Management Principles, which JLARC identified as a best practice approach to risk management, throughout its entire highway safety program.

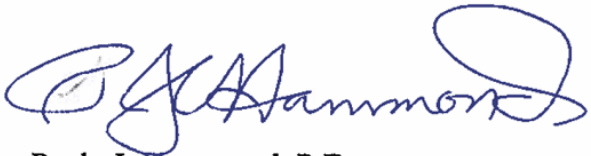
One aspect of the report we would like to comment on looked at costs directly associated with post-incident reviews. As mentioned in the audit report, WSDOT considers its entire safety program as a tort reduction activity.

Thus, in addition to direct investigation costs provided by the Department of Corrections and the Department of Social and Health Services for this report, WSDOT also provided the costs it feels are directly related to its comprehensive and effective enterprise risk and safety management activities. These costs include the cost to analyze crash data to identify locations, corridors or system wide projects that might exhibit greater than average observed crash histories and/or have the potential to proactively address potential crashes across the system (e.g., identifying the type of location that would benefit from rumble strips). It has also included the costs associated with determining the contributing factors, the development of potential mitigation strategies, the prioritization of those strategies and the performance of preliminary design (scoping).

The Department's efforts are paying off in saving money, and most importantly saving lives and preventing injuries to Washington drivers and passengers. In 2005 there were more than 53,000 crashes on State Routes. That number dropped in 2009 to just over 43,000, almost a 20% reduction. In that same period, fatal crashes declined by 23%. With support from the Office of Financial Management and the Attorney General's Office, we make enterprise risk management a part of everything we do, everyday. We will continue to be a national leader with your continued investments.

Please call me at 360-705-7054, or Steve McKerney at 360-705-7004, if you have any questions or need more information.

Sincerely,



Paula J. Hammond, P.E.
Secretary of Transportation

PJH/jd

cc: Steve Reinmuth, Chief of Staff, WSDOT
Dave Dye, Deputy Secretary, WSDOT
Amy Arnis, Assistant Secretary, WSDOT
Jerry Lenzi, Assistant Secretary, WSDOT
Bill Ford, Assistant Secretary, WSDOT
David Moseley, Assistant Secretary, WSDOT
John Milton, Director of Enterprise Risk Management, WSDOT
Streator Johnson, Administrative Risk Manager, WSDOT
Dillon Auyoung, Director of Government Relations, WSDOT
Steve Pierce, Director of Communications, WSDOT
Steve McKerney, Director of Internal Audit, WSDOT
Stacia Hollar, Project Team, JLARC
John Woolley, Project Supervisor, JLARC
Drew Zavatsky, OFM

Mr. Keenan Konopaski, Legislative Auditor
Joint Legislative Audit and Review Committee
WSDOT Response to JLARC Report: *State Risk Management Practices in Washington*
June 23, 2011
Page 3 of 3

**Recommendation 1:** *The Department of Corrections should develop and implement a policy for the consistent review of, and reporting on, the effects of actions taken in the Community Corrections Division to address risks.*

**Agency Position:** Recommendation is directed to the Department of Corrections

**Recommendation 2:** *The Department of Social and Health Services should address the risks identified in conducting Children's Protective Services investigation and report its results to the Legislature by December 2011.*

**Agency Position:** Recommendation is directed to the Department of Social and Health Services

**Recommendation 3:** *The Department of Social and Health Services should development a method for reviewing and reporting on the effect of actions taken in the Children's Administration to address risk.*

**Agency Position:** Recommendation is directed to the Department of Social and Health Services

STATE OF WASHINGTON
**DEPARTMENT OF CORRECTIONS**
**OFFICE OF THE SECRETARY**
P. O. Box 41101 • Olympia, Washington 98504-1101 • Tel (360) 725-8200
FAX (360) 664-4056

June 30, 2011

Joint Legislative Audit & Review Committee
Eastside Plaza Building #4
1300 Quince Street SE
Olympia, Washington 98504-0910

Re: Response to the Study on State Risk Management Practices

Dear Committee:

The Department of Corrections (DOC) expresses thanks to you, and particularly to Stacia Hollar, for the study on State Risk Management Practices in Washington. I appreciate the opportunity to respond to the recommendations.

In general, DOC concurs with the report and recommendations. We will work to clarify Department policy expectations as outlined in recommendation 1.

Sincerely,

Eldon Vail
Secretary

cc: John Scott Blonien, Assistant Secretary
Kathy Gastreich, Director of Risk Management

*"Working Together for SAFE Communities"*

RECEIVED
JUN 29 2011
JLARC

**STATE OF WASHINGTON**
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

June 27, 2011

Keenan Konopaski
Joint Legislative Audit and Review Committee
PO Box 40910
Olympia, WA 98504-0910

Dear Mr. Konopaski,

Thank you again for JLARC's detailed review of our Department's risk management activities. Below is our response to recommendations in the Preliminary Report on State Risk Management Practices in Washington.

| JLARC Recommendation | Agency Position | Comments |
|---|---|---|
| #2 - The Department of Social and Health Services should address the risks identified in the RSVP report regarding Children's Protective Services investigations and report its results to the Legislature by December 2011. | Concur | Children's Administration has taken, and continues to take, steps internally to strengthen its Child Protective Services program as well as other child welfare programs to reduce the probability of abuse or neglect. |
| #3 – The Department of Social and Health Services should develop a method for reviewing and reporting on the effect of actions taken in the Children's Administration to address risks. | Concur | Children's Administration agrees that further development and strengthening of internal systems are needed to report on identified risks, trends, how they are being addressed to improve practice and how the changes in policies or practice are improving outcomes for children. |

The Department will prepare a detailed response to the recommendations by September 30, 2011.

If you have any questions, please contact Kevin Krueger at 902-7794 or Kevin.Krueger@dshs.wa.gov.

Sincerely,

SUSAN N. DREYFUS
Secretary

c: Denise Revels Robinson
Kevin Krueger

Rob McKenna
ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE • PO Box 40100 • Olympia WA 98504-0100

June 30, 2011

Keenan Konopaski
Legislative Auditor
Joint Legislative Audit and Review Committee
P.O. Box 40910
Olympia, WA 98504

**RE: JLARC Report On: State Risk Management Practices In Washington**

Dear Mr. Konopaski:

Thank you for the opportunity to review the June 23, 2011 Preliminary Report – State Risk Management Practices in Washington.

We have no comments on the content of the report, but would like to commend the efforts of you and your staff in its development.

Thank you.

Sincerely,

ROBERT K. COSTELLO
Deputy Attorney General

RKC:eg

# APPENDIX 3 – COMPARISON OF SELECTED STATES' LIABILITY LAWS

Part One of this report discusses the provisions of Washington's tort liability laws that distinguish it from other states. Based on the combination of these factors, Washington has broader liability than the other states JLARC staff reviewed. Exhibit 7 on page 41 provides a summary of this review as it relates to the six factors which demonstrate the difference between Washington and other states in the area of tort liability. JLARC reviewed 11 western states and states in the other three regions of the country. Of the states reviewed, two states (Delaware and Ohio) had three of six factors in common with Washington. The remaining states reviewed had two or less factors in common.

## Exhibit 7 –Comparison of Selected States' Liability Laws

| Legend: | Category matches WA |
|---|---|
| | State matches WA in 3 categories |

| State | Type of Immunity Waiver (Broad or Limited) | Defenses/ Discretionary Immunity | Duty to Supervise Offenders Based on Special Relationship | Procedural Limitations | Damage Caps | Joint and Several Liability |
|---|---|---|---|---|---|---|
| **Western Region** | | | | | | |
| **Washington** | **Broad** | **No** | **Yes** | **No** | **No** | **Yes** (for faultless plaintiff) |
| Alaska | Limited | Yes | **Yes** | **No** | Yes | No |
| Arizona | Limited | Yes | | Yes | **No** | No |
| California | Limited | Yes | | **No** | **No** | Modified |
| Colorado | Limited | Yes | | Yes | Yes | Modified |
| Hawaii | **Broad** | Yes | | Yes | **No** | Modified |
| Idaho | Limited | Yes | **Yes** | Yes | Yes | Modified |
| Montana | Limited | Yes | **Yes** | **No** | Yes | Modified |
| Nevada | Limited | Yes | | **No** | Yes | Modified |
| New Mexico | Limited | Yes | | Yes | Yes | Modified |
| Oregon | Limited | Yes | | Yes | Yes | Modified |
| **Northeast Region** | | | | | | |
| Connecticut | Limited | Yes | **Yes** | Yes | **No** | No |
| Maine | Limited | Yes | | Yes | Yes | Modified |
| Massachusetts | Limited | Yes | | **No** | Yes | **Yes** |
| New Hampshire | Limited | Yes | | Yes | Yes | Modified |
| New Jersey | Limited | Yes | | Yes | **No** | No |
| New York | **Broad** | Yes | | Yes | **No** | Modified |

| Legend: | Category matches WA |
|---|---|
| | State matches WA in 3 categories |

| State | Type of Immunity Waiver (Broad or Limited) | Defenses/ Discretionary Immunity | Duty to Supervise Offenders Based on Special Relationship | Procedural Limitations | Damage Caps | Joint and Several Liability |
|---|---|---|---|---|---|---|
| **Midwest Region** | | | | | | |
| Illinois | Limited | Yes | | Yes | Yes | Modified |
| Indiana | Limited | Yes | | Yes | Yes | No |
| Iowa | Limited | Yes | | **No** | **No** | Modified |
| Kansas | Limited | Yes | | **No** | Yes | No |
| Michigan | Limited | Yes | | Yes | **No** | No |
| Minnesota | Limited | Yes | | Yes | Yes | Modified |
| Missouri | Limited | Yes | | **No** | Yes | Modified |
| Nebraska | Limited | Yes | | Yes | Yes | Modified |
| North Dakota | Limited | Yes | | Yes | Yes | Modified |
| **Ohio** | **Broad** | **No** | | Yes | **No** | Modified |
| **Southern Region** | | | | | | |
| Arkansas | Limited | Yes | | Yes | Yes | No |
| **Delaware** | Limited | Yes | | **No** | **No** | **Yes** |
| Florida | Limited | Yes | | **No** | Yes | No |
| Georgia | Limited | Yes | | Yes | Yes | **Yes** |
| Kentucky | Limited | Yes | | Yes | Yes | No |
| Louisiana | **Broad** | Yes | | Yes | Yes | Modified |
| Maryland | Limited | Yes | | Yes | Yes | **Yes** |
| Mississippi | Limited | Yes | | Yes | Yes | Modified |
| North Carolina | Limited | **No** | | Yes | Yes | **Yes** |
| Oklahoma | Limited | Yes | | Yes | Yes | Modified |

Source: JLARC analysis of other states' liability laws.