
HOUSE BILL 1074

State of Washington

67th Legislature

2021 Regular Session

By Representatives Peterson, Rude, Leavitt, Wylie, Kloba, Ortiz-Self, Callan, Riccelli, Davis, and Pollet

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1 AN ACT Relating to overdose and suicide fatality reviews; and
2 adding a new section to chapter 70.05 RCW.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

4 NEW SECTION. **Sec. 1.** A new section is added to chapter 70.05
5 RCW to read as follows:

6 (1) The legislature finds that the mortality rate in Washington
7 state due to overdose and suicide is unacceptably high and that such
8 mortality may be preventable. The legislature further finds that,
9 through the performance of overdose or suicide fatality reviews,
10 preventable causes of mortality can be identified and addressed,
11 thereby reducing the number of overdose and suicide fatalities in
12 Washington state.

13 (2)(a) A local health department may establish multidisciplinary
14 overdose and suicide fatality review teams to review overdose or
15 suicide deaths and to develop strategies for the prevention of
16 overdose and suicide fatalities.

17 (b) The department shall assist local health departments to
18 collect the reports of any suicide or overdose fatality reviews
19 conducted by local health departments and assist with entering the
20 reports into a database to the extent that the data is not protected
21 under subsection (3) of this section. Notwithstanding subsection (3)

1 of this section, the department shall respond to any requests for
2 data from the database to the extent permitted for health care
3 information under chapter 70.02 RCW. In addition, the department
4 shall provide technical assistance to local health departments and
5 suicide and overdose fatality review teams conducting suicide or
6 overdose fatality reviews and encourage communication among suicide
7 and overdose fatality review teams.

8 (3)(a) All health care information collected as part of an
9 overdose or suicide fatality review is confidential, subject to the
10 restrictions on disclosure provided for in chapter 70.02 RCW. When
11 documents are collected as part of an overdose or suicide fatality
12 review, the records may be used solely by local health departments
13 for the purposes of the review.

14 (b) Information, documents, proceedings, records, and opinions
15 created, collected, or maintained by the overdose and suicide
16 fatality review team or the local health department in support of the
17 review team are confidential and are not subject to public inspection
18 or copying under chapter 42.56 RCW and are not subject to discovery
19 or introduction into evidence in any civil or criminal action.

20 (c) Any person who was in attendance at a meeting of the review
21 team or who participated in the creation, collection, or maintenance
22 of the review team's information, documents, proceedings, records, or
23 opinions may not be permitted or required to testify in any civil or
24 criminal action as to the content of such proceedings, or the review
25 team's information, documents, records, or opinions. This subsection
26 does not prevent a member of the review team from testifying in a
27 civil or criminal action concerning facts which form the basis for
28 the panel's proceedings of which the review team member had personal
29 knowledge acquired independently of the panel or which is public
30 information.

31 (d) Any person who, in substantial good faith, participates as a
32 member of the review team or provides information to further the
33 purposes of the review team may not be subject to an action for civil
34 damages or other relief as a result of the activity or its
35 consequences.

36 (e) All meetings, proceedings, and deliberations of the overdose
37 and suicide fatality review team may, at the discretion of any
38 overdose and suicide fatality review team, be confidential and may be
39 conducted in executive session.

1 (4) This section does not prevent a local health department from
2 publishing statistical compilations and reports related to the
3 overdose or suicide fatality review. Any portions of such
4 compilations and reports that identify individual cases and sources
5 of information must be redacted.

6 (5) To aid in an overdose or suicide fatality review, the local
7 health department has the authority to:

8 (a) Request and receive data for specific overdose or suicide
9 fatalities including, but not limited to, all medical records,
10 autopsy reports, medical examiner reports, coroner reports, schools,
11 criminal justice, law enforcement, and social services records; and

12 (b) Request and receive data as described in (a) of this
13 subsection from health care providers, health care facilities,
14 clinics, schools, criminal justice, law enforcement, laboratories,
15 medical examiners, coroners, professions and facilities licensed by
16 the department of health, local health jurisdictions, the health care
17 authority and its licensees and providers, the department of health
18 and its licensees, the department of social and health services and
19 its licensees and providers, and the department of children, youth,
20 and families and its licensees and providers.

21 (6) Upon request by the local health department, health care
22 providers, health care facilities, clinics, schools, criminal
23 justice, law enforcement, laboratories, medical examiners, coroners,
24 professions and facilities licensed by the department of health,
25 local health jurisdictions, the health care authority and its
26 licensees and providers, the department of health and its licensees,
27 the department of social and health services and its licensees and
28 providers, and the department of children, youth, and families and
29 its licensees and providers must provide all medical records, autopsy
30 reports, medical examiner reports, coroner reports, social services
31 records, and other data requested for specific overdose or suicide
32 fatalities to perform an overdose or suicide fatality review to the
33 local health department.

34 (7) For the purposes of this section, "overdose or suicide
35 fatality review" means a process to review minor or adult suicide or
36 overdose deaths as identified through a death certificate; by a
37 medical examiner or coroner; or by a process defined by the local
38 department of health. The process may include a systematic review of
39 medical, clinical, and hospital records; interviews; analysis of
40 individual case information; and review of this information by a team

1 of professionals in order to identify modifiable medical,
2 socioeconomic, public health, behavioral, administrative,
3 educational, and environmental factors associated with each death.

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