Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Early Learning & Human Services Committee

HB 2415

Brief Description: Concerning unexpected fatalities of residents of department of social and health services facilities.

Sponsors: Representatives Farivar, Penner, Scott, Simmons, Pollet, Reed and Hill.

Brief Summary of Bill

- Requires the Department of Social and Health Services (DSHS) to convene an unexpected fatality review team to conduct a review upon the unexpected death of any resident of a DSHS facility.
- Requires the DSHS to produce a report to the Legislature documenting all deaths of DSHS facility residents occurring on or after July 1, 2015, that would have qualified as unexpected fatalities.

Hearing Date: 1/20/26

Staff: Omeara Harrington (786-7136).

Background:

Department of Social and Health Services Mortality Review Policies.
The Department of Social and Health Services (DSHS) maintains policies requiring a quality assurance review when a client served by a DSHS-operated residential or treatment facility, state hospital, or institution dies. The process requires:
- timely reporting of the death to the appropriate DSHS personnel;
- a preliminary review, within one business day, to determine if the death was expected, unexpected, or suspicious;

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- maintenance of accurate and complete records of the death investigation;
- a report to the appropriate DSHS assistant secretary or deputy assistant secretary no more than 30 days after the death and subsequent follow-up reports as needed until the final report is submitted; and
- a final report to the Secretary of the DSHS and the appropriate assistant secretary or deputy assistant secretary.

If a death is unexpected, meaning it did not result from a diagnosed terminal illness or other debilitating or deteriorating illness or condition where death was anticipated, the reporting administration or division must initiate a thorough internal review of the circumstances surrounding the death. The internal review must include background events and apparent cause of death, an independent medical evaluation, and a review of available records of any acute care hospital or community health care provider related to the death. Additional requirements apply if a death is deemed suspicious, including a contracted independent review.

The DSHS must initiate corrective action when warranted, including identifying remedial measures necessary to prevent reoccurrence of contributing circumstances, and evaluating and implementing the recommendations resulting from the review.

Certain divisions of the DSHS have adopted more prescriptive policies that must be followed in the event of the death of residents of certain facilities.

<u>Office of the Developmental Disabilities Ombuds</u>.
The Office of the Developmental Disabilities Ombuds (DD Ombuds) is an independent office that serves myriad functions related to persons with developmental disabilities. Among the duties and responsibilities of the DD Ombuds are providing information to persons accessing developmental disabilities services, investigating complaints regarding administrative actions, and monitoring and recommending changes related to DSHS procedures and facilities.

<u>Office of the Patient Rights Ombuds</u>.
The Office of the Patient Rights Ombuds (Patient Rights Ombuds) is an office within the DSHS that reports to the DSHS Office of the Secretary. The Patient Rights Ombuds monitors and works to ensure compliance of the Behavioral Health and Habilitation Administration with relevant requirements regarding the civil rights of patients at the state hospitals, the Special Commitment Center, and other involuntary mental health treatment facilities operated by the DSHS. The Patient Rights Ombuds additionally investigates complaints, conducts reviews, and makes recommendations regarding patient rights at DSHS facilities.

Summary of Bill:

<u>Fatality Reviews of Unexpected Deaths of Department of Social and Health Services Facility Residents</u>.
The DSHS must conduct an unexpected fatality review (review) upon the unexpected death of any resident of a DSHS facility or in any case identified for a review by the DD Ombuds or the

Patient Rights Ombuds. The primary purpose of the review is to develop recommendations to the DSHS and Legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for residents in DSHS facilities. Reviews must not take precedence over investigations being conducted by adult protective services, child protective services, residential care services, or law enforcement.

Scope of Reviews.
The DSHS facilities included in the review requirement include all facilities operated by the DSHS that provide care on a residential or inpatient basis. This includes residential habilitation centers, state-operated living alternatives, transitional care facilities, state hospitals, the Child Study and Treatment Center, the Special Commitment Center, secure community transition facilities, and other DSHS facilities that provide inpatient services to individuals who are placed in the care of the DSHS under the provisions governing involuntary treatment, competency to stand trial, and not guilty by reason of insanity commitment.

An unexpected fatality includes any death of a resident of a DSHS facility, regardless of where the death actually occurred, that was not the result of a diagnosed or documented terminal illness or other debilitating or deteriorating illness or condition where the death was anticipated, or that occurred within one year of a report of abuse or neglect of the resident.

Review Team.
The DSHS must convene an unexpected fatality review team (review team) made up of individuals with appropriate expertise who do not have previous involvement in the case. The review team must include a representative from the Health Care Authority. If the unexpected fatality concerns a resident of a residential habilitation center or state-operated living alternative, the review team must include the DD Ombuds or their designee. For unexpected fatalities of persons not residing in either of these settings, the review team must include a representative from the Office of the Patient Rights Ombuds.

During the course of the review, the DSHS and the review team must have access to all records and files regarding the person or otherwise relevant to the review that have been produced or retained by the DSHS including, but not limited to, critical incident reviews, root cause analysis, and mortality review committee reports.

Reports and Corrective Action Plans.
The DSHS must issue a report to the Legislature on the results of the review within 120 days following the fatality, unless an extension has been granted by the Governor. Prior to issuing a report, the review team must perform an internal review for accuracy and thoroughness of the report. The report must contain a record of each review team member's vote, participation, or comment in relation to the findings and recommendations. If the report concerns a person who was the subject of one or more reports of abuse or neglect within the last year, the report must also describe the nature of any reports of abuse or neglect.

Within 10 days of completion of a review, the DSHS must develop an associated corrective

action plan to address any concerns and implement any recommendations made by the review team in the unexpected fatality review report. Corrective action plans must be implemented within 120 days, unless an extension has been granted by the Governor.

The DSHS must create a public website where all unexpected fatality review reports and corrective action plans are posted and maintained, with confidential information redacted.

Other Proceedings.
Unexpected fatality reviews are subject to discovery in civil and administrative proceedings, but review team members may not be examined regarding their participation in the review, and documents prepared for or by a review team are inadmissible.

Retrospective Fatalities Report.
The DSHS must identify all fatalities of residents of DSHS facilities that occurred on or after July 1, 2015, that would qualify as unexpected fatalities, and report to the Legislature and the Governor by November 1, 2027. To the extent possible, the DSHS must identify the root cause or causes of each included fatality along with a description of any corrective action or other measures taken to address the cause of the fatality.

Appropriation: None.

Fiscal Note: Requested on January 13, 2026.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.