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**HOUSE BILL 2415**

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**State of Washington**

**69th Legislature**

**2026 Regular Session**

**By** Representatives Farivar, Penner, Scott, Simmons, Pollet, Reed, and Hill

Read first time 01/13/26. Referred to Committee on Early Learning & Human Services.

1 AN ACT Relating to unexpected fatalities of residents of  
2 department of social and health services facilities; amending RCW  
3 43.382.005; adding a new section to chapter 43.20A RCW; adding a new  
4 section to chapter 43.382 RCW; and creating a new section.

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

6 NEW SECTION. **Sec. 1.** A new section is added to chapter 43.20A  
7 RCW to read as follows:

8 (1)(a) The department shall conduct an unexpected fatality review  
9 upon the unexpected fatality of any resident of a department facility  
10 or in any case identified for an unexpected fatality review by the  
11 office of the developmental disabilities ombuds or the office of the  
12 patient rights ombuds.

13 (b) The department shall convene an unexpected fatality review  
14 team and determine the membership of the review team. The team shall  
15 comprise of individuals with appropriate expertise including, but not  
16 limited to, individuals whose professional expertise is pertinent to  
17 the dynamics of the case. The unexpected fatality review team shall  
18 include a representative from the health care authority, and either a  
19 representative from the office of the patient rights ombuds in cases  
20 of an unexpected fatality of a resident of a department facility that  
21 is not a residential habilitation center or state-operated living

1 alternative, or the developmental disabilities ombuds or the ombuds'  
2 designee in cases involving an unexpected fatality of a resident of a  
3 residential habilitation center or state-operated living alternative.  
4 The department shall ensure that the unexpected fatality review team  
5 is made up of individuals who had no previous involvement in the  
6 case.

7 (c) The primary purpose of the unexpected fatality review shall  
8 be the development of recommendations to the department and  
9 legislature regarding changes in practices or policies to prevent  
10 fatalities and strengthen safety and health protections for residents  
11 in department facilities. The unexpected fatality review must not  
12 take precedence over investigations being conducted by adult  
13 protective services, child protective services, residential care  
14 services, or law enforcement.

15 (d) Upon conclusion of an unexpected fatality review required  
16 pursuant to this section, the department shall, within 120 days  
17 following the fatality, issue a report on the results of the review,  
18 unless an extension has been granted by the governor. Prior to  
19 issuing a report, the review team must perform an internal review for  
20 accuracy and thoroughness of the report. The report must contain a  
21 record of each review team member's vote, participation, or comment  
22 in relation to the findings and recommendations. If the report  
23 concerns a person who was the subject of one or more reports of abuse  
24 or neglect within the last year, the report must also describe the  
25 nature of any abuse or neglect reports. Completed reports must be  
26 distributed to the appropriate committees of the legislature, and the  
27 department shall create a public website where all unexpected  
28 fatality review reports required under this section must be posted  
29 and maintained. An unexpected fatality review report completed  
30 pursuant to this section is subject to public disclosure and must be  
31 posted on the public website, except that confidential information  
32 must be redacted by the department consistent with the requirements  
33 of applicable state and federal laws.

34 (e) Within 10 days of completion of an unexpected fatality review  
35 under this section, the department shall develop an associated  
36 corrective action plan to address any concerns and implement any  
37 recommendations made by the review team in the unexpected fatality  
38 review report. Corrective action plans shall be implemented within  
39 120 days, unless an extension has been granted by the governor.  
40 Corrective action plans are subject to public disclosure, and must be

1 posted on the department's website in accordance with (d) of this  
2 subsection, except that confidential information must be redacted by  
3 the department consistent with the requirements of applicable state  
4 and federal laws.

5 (f) The department shall develop and implement procedures to  
6 carry out the requirements of this section.

7 (2) In any review of an unexpected fatality, the department and  
8 the unexpected fatality review team shall have access to all records  
9 and files regarding the person or otherwise relevant to the review  
10 that have been produced or retained by the department including, but  
11 not limited to, critical incident reviews, root cause analysis, and  
12 mortality review committee reports.

13 (3)(a) An unexpected fatality review completed pursuant to this  
14 section is subject to discovery in a civil or administrative  
15 proceeding, but may not be admitted into evidence or otherwise used  
16 in a civil or administrative proceeding except pursuant to this  
17 section.

18 (b) A department employee responsible for conducting an  
19 unexpected fatality review, or a member of an unexpected fatality  
20 review team, may not be examined in a civil or administrative  
21 proceeding regarding: (i) The work of the unexpected fatality review  
22 team; (ii) the incident under review; (iii) his or her statements,  
23 deliberations, thoughts, analyses, or impressions relating to the  
24 work of the unexpected fatality review team or the incident under  
25 review; or (iv) the statements, deliberations, thoughts, analyses, or  
26 impressions of any other member of the unexpected fatality review  
27 team, or any person who provided information to the unexpected  
28 fatality review team relating to the work of the unexpected fatality  
29 review team or the incident under review.

30 (c) Documents prepared by or for an unexpected fatality review  
31 team are inadmissible and may not be used in a civil or  
32 administrative proceeding, except that any document that exists  
33 before its use or consideration in an unexpected fatality review, or  
34 that is created independently of such review, does not become  
35 inadmissible merely because it is reviewed or used by an unexpected  
36 fatality review team. A person is not unavailable as a witness merely  
37 because the person has been interviewed by, or has provided a  
38 statement for, an unexpected fatality review, but if the person is  
39 called as a witness, the person may not be examined regarding the  
40 person's interactions with the unexpected fatality review including,

1 without limitation, whether the person was interviewed during such  
2 review, the questions that were asked during such review, and the  
3 answers that the person provided during such review. This section may  
4 not be construed as restricting the person from testifying fully in  
5 any proceeding regarding his or her knowledge of the incident under  
6 review.

7 (d) The restrictions set forth in this section do not apply in a  
8 licensing or disciplinary proceeding arising from an agency's effort  
9 to revoke or suspend the license of any licensed professional based  
10 in whole or in part upon allegations of wrongdoing in connection with  
11 an unexpected fatality reviewed by an unexpected fatality review  
12 team.

13 (4) For the purposes of this section:

14 (a) "Department facilities" include facilities operated by the  
15 department that provide care on a residential or inpatient basis,  
16 including:

17 (i) Residential habilitation center facilities under chapter  
18 71A.20 RCW;

19 (ii) State-operated living alternatives as defined in RCW  
20 71A.10.020;

21 (iii) Transitional care facilities as defined in RCW 43.43.837;

22 (iv) State hospitals under chapter 72.23 RCW;

23 (v) The child study and treatment center as identified in RCW  
24 71.34.380;

25 (vi) The special commitment center and secure community  
26 transition facilities under chapter 71.09 RCW; and

27 (vii) Other facilities that provide inpatient services to  
28 individuals who are placed in the care of the department under  
29 chapter 71.05, 71.34, or 10.77 RCW.

30 (b) "Residents of a department facility" do not include residents  
31 of facilities licensed or certified by the department of health  
32 including, but not limited to, 23-hour crisis relief centers and  
33 evaluation and treatment facilities.

34 (c) "Unexpected fatality" means a death of any resident of a  
35 department facility, regardless of where the death actually occurred,  
36 that:

37 (i) Was not the result of a diagnosed or documented terminal  
38 illness or other debilitating or deteriorating illness or condition  
39 where the death was anticipated; or

1 (ii) Occurred within one year of a report of abuse or neglect of  
2 the resident.

3 (d) "Unexpected fatality review" means a review of any unexpected  
4 fatality. A review must include an analysis of the root cause or  
5 causes of the unexpected fatality, and an associated corrective  
6 action plan for the department to address identified root causes and  
7 recommendations made by the unexpected fatality review team under  
8 this section.

9 NEW SECTION. **Sec. 2.** (1) The department of social and health  
10 services shall identify all fatalities of residents of department  
11 facilities that occurred on or after July 1, 2015, and before the  
12 effective date of this section, that would qualify as unexpected  
13 fatalities. To the extent possible, the department of social and  
14 health services must additionally identify the root cause or causes  
15 of each included fatality along with a description of any corrective  
16 action or other measures taken to address the cause of the fatality.  
17 The department of social and health services shall, in compliance  
18 with RCW 43.01.036, compile the information identified in this  
19 section into a report and submit the report to the governor and the  
20 legislature by November 1, 2027. Confidential information must be  
21 redacted from the report consistent with the requirements of  
22 applicable state and federal laws.

23 (2) For purposes of this section, "department facilities" and  
24 "unexpected fatalities" have the same meaning as in section 1 of this  
25 act.

26 NEW SECTION. **Sec. 3.** A new section is added to chapter 43.382  
27 RCW to read as follows:

28 (1) The ombuds or the ombuds' designee shall serve as a member of  
29 the unexpected fatality review team as required under section 1 of  
30 this act.

31 (2) The department of social and health services shall:

32 (a) Permit the ombuds or the ombuds' designee physical access to  
33 department of social and health services facilities for the purposes  
34 of carrying out its duties under section 1 of this act; and

35 (b) Upon the ombuds' request, grant the ombuds or the ombuds'  
36 designee the right to access, inspect, and copy all relevant  
37 information, records, or documents in the possession or control of

1 the department of social and health services that the ombuds  
2 considers necessary in a review.

3 **Sec. 4.** RCW 43.382.005 and 2016 c 172 s 5 are each amended to  
4 read as follows:

5 (1) There is created an office of the developmental disabilities  
6 ombuds. The department of commerce shall contract with a private,  
7 independent nonprofit organization to provide developmental  
8 disability ombuds services. The department of commerce shall  
9 designate, by a competitive bidding process, the nonprofit  
10 organization that will contract to operate the ombuds. The selection  
11 process must include consultation of stakeholders in the development  
12 of the request for proposals and evaluation of bids. The selected  
13 organization must have experience and the capacity to effectively  
14 communicate regarding developmental disabilities issues with  
15 policymakers, stakeholders, and the general public and must be  
16 prepared and able to provide all program and staff support necessary,  
17 directly or through subcontracts, to carry out all duties of the  
18 office.

19 (2) The contracting organization and its subcontractors, if any,  
20 are not state agencies or departments, but instead are private,  
21 independent entities operating under contract with the state.

22 (3) The governor or state may not revoke the designation of the  
23 organization contracted to provide the services of the ombuds except  
24 upon a showing of neglect of duty, misconduct, or inability to  
25 perform duties.

26 (4) The department of commerce shall ensure that the ombuds staff  
27 has access to sufficient training or experience with issues relating  
28 to persons with developmental disabilities and the program and staff  
29 support necessary to enable the ombuds to effectively protect the  
30 interests of persons with developmental disabilities. The office of  
31 the developmental disabilities ombuds shall have the powers and  
32 duties to do the following:

33 (a) Provide information as appropriate on the rights and  
34 responsibilities of persons receiving developmental (~~disability~~  
35 ~~[disabilities]~~) disabilities administration services or other state  
36 services, and on the procedures for providing these services;

37 (b) Investigate, upon its own initiative or upon receipt of a  
38 complaint, an administrative act related to a person with  
39 developmental disabilities alleged to be contrary to law, rule, or

1 policy, imposed without an adequate statement of reason, or based on  
2 irrelevant, immaterial, or erroneous grounds; however, the ombuds may  
3 decline to investigate any complaint;

4 (c) Monitor the procedures as established, implemented, and  
5 practiced by the department to carry out its responsibilities in the  
6 delivery of services to a person with developmental disabilities,  
7 with a view toward appropriate preservation of families and ensuring  
8 health and safety;

9 (d) Review periodically the facilities and procedures of state  
10 institutions which serve persons with developmental disabilities and  
11 state-licensed facilities or residences;

12 (e) Recommend changes in the procedures for addressing the needs  
13 of persons with developmental disabilities;

14 (f) Participate in unexpected fatality reviews as required in  
15 section 1 of this act;

16 (g) Submit annually, by November 1st, to the governor and  
17 appropriate committees of the legislature a report analyzing the work  
18 of the office, including recommendations;

19 ~~((g))~~ (h) Establish procedures to protect the confidentiality  
20 of records and sensitive information to ensure that the identity of  
21 any complainant or person with developmental disabilities will not be  
22 disclosed without the written consent of the complainant or person,  
23 or upon court order;

24 ~~((h))~~ (i) Maintain independence and authority within the bounds  
25 of the duties prescribed by this chapter, insofar as this  
26 independence and authority is exercised in good faith and within the  
27 scope of contract; and

28 ~~((i))~~ (j) Carry out such other activities as determined by the  
29 department of commerce within the scope of this chapter.

30 (5) The developmental disabilities ombuds must consult with  
31 stakeholders to develop a plan for future expansion of the ombuds  
32 into a model of individual ombuds services akin to the operations of  
33 the long-term care ombuds. The developmental disabilities ombuds  
34 shall report its progress and recommendations related to this  
35 subsection to the governor and appropriate committees of the  
36 legislature by November 1, 2019.

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