H-0240.1

HOUSE BILL 1074

State of Washington 67th Legislature 2021 Regular Session

By Representatives Peterson and Rude

Prefiled 01/04/21.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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