Vulnerable adult fatality reviews. (1) The department shall conduct a vulnerable adult fatality review in the event of a death of a vulnerable adult when the department has reason to believe that the death of the vulnerable adult may be related to the abuse, abandonment, exploitation, or neglect of the vulnerable adult, or may be related to the vulnerable adult's self-neglect, and the vulnerable adult was:

(a) Receiving home and community-based services in his or her own home or licensed or certified settings, described under chapters 74.39, 74.39A, 18.20, 70.128, and 71A.12 RCW, within sixty days preceding his or her death; or

(b) Living in his or her own home or licensed or certified settings described under chapters 74.39, 74.39A, 18.20, 70.128, and 71A.12 RCW and was the subject of a report under this chapter received by the department within twelve months preceding his or her death.

(2) When conducting a vulnerable adult fatality review of a person who had been receiving hospice care services before the person's death, the review shall provide particular consideration to the similarities between the signs and symptoms of abuse and those of many patients receiving hospice care services.

(3) All files, reports, records, communications, and working papers used or developed for purposes of a fatality review are confidential and not subject to disclosure pursuant to RCW 74.34.095.

(4) The department may adopt rules to implement this section.

[2016 c 172 § 4; 2008 c 146 § 10.]

Finding—2016 c 172: See note following RCW 43.382.005.

Findings—Intent—Severability—2008 c 146: See notes following RCW 74.41.040.