HOUSE BILL REPORT
HB 2959

As Reported by House Committee On:
Early Learning & Children's Services

Title: An act relating to child fatality review in child welfare cases.

Brief Description: Concerning child fatality reviews in child welfare cases.

Sponsors: Representatives Kagi and Kenney; by request of Department of Social and Health Services.

Brief History:
Committee Activity:
Early Learning & Children's Services: 1/28/10, 1/29/10 [DPS].

Brief Summary of Substitute Bill

- Requires the Department of Social and Health Services (DSHS) to consult with the Office of the Family and Children's Ombudsman in determining whether a child fatality review (CFR) is required in a case where it can not be determined whether the child's death was the result of suspected child abuse or neglect.
- Specifies that CFRs are required in cases where the death resulted from suspected child abuse or neglect.
- Requires that CFR teams are comprised of persons with no previous involvement in the case and who have professional expertise relevant to the dynamics of the case to be reviewed.
- Expressly permits the redaction of confidential information from CFR reports that are subject to public disclosure.
- Clarifies the DSHS's right to access case information from a supervising agency in the case of a death of a child being provided child welfare services under contract with the DSHS.
- Limits the scope of examination in civil and administrative proceedings of a DSHS employee who convenes a CFR.
- Limits admissibility in civil and administrative proceedings of certain documentation prepared for a CFR or review of a near fatality.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

HOUSE COMMITTEE ON EARLY LEARNING & CHILDREN'S SERVICES

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 7 members: Representatives Kagi, Chair; Roberts, Vice Chair; Haler, Ranking Minority Member; Walsh, Assistant Ranking Minority Member; Angel, Goodman and Seaquist.

Staff: Sydney Forrester (786-7120).

Background:

Child Fatality Reviews.
State law requires the Department of Social and Health Services (DSHS) to conduct a child fatality review (CFR) in the case of an unexpected death of a child who, within the last 12 months, has been in the custody of, or receiving services from, the DSHS. At the conclusion of the CFR, the DSHS must issue a report on the results within 180 days of the date of the child's death. The Governor may extend the due date. The DSHS must distribute the CFR report to the appropriate Legislative committees and must post all CFR reports to a public website maintained by the DSHS. In the case of a near fatality, the DSHS may conduct a review.

The Office of the Family and Children's Ombudsman.
The Office of the Family and Children's Ombudsman (OFCO) was created in 1996 to protect children and parents from harmful agency action or inaction, and to make agency officials and state policy makers aware of system-wide issues in the child protection and child welfare system. The OFCO is part of the Governor's Office and operates independently from the DSHS and other state agencies, acting as a neutral fact-finder, not as an advocate.

The OFCO's responsibilities include investigating complaints related to child protective services or child welfare services, monitoring the procedures used by the DSHS in delivering family and children's services, and providing information about the rights and responsibilities of individuals receiving family and children's services and the procedures for providing those services. To perform these duties the OFCO has authority:

- to interview children in state care;
- to access, inspect, and copy all records, information, or documents in the DSHS's possession that the OFCO considers necessary to conduct an investigation; and
- to have unrestricted on-line access to the case and management information system (CAMIS) operated by the DSHS.

The DSHS must notify the OFCO:

- in the event of a near-fatality of a child who is, or was within the past 12 months, in the care of or receiving services from the DSHS; and
- whenever a referral of child abuse or neglect constitutes the third founded referral on the same child or family within a 12-month period.

Autopsy Report.

Reports of autopsies or post mortem examinations are confidential and are to be released only as statutorily authorized. The Secretary of the DSHS is not presently authorized to receive a report of an autopsy for purposes of conducting a required CFR.

Supervising Agency.
In 2009 the Legislature enacted Second Substitute House Bill 2106, which requires the DSHS to contract in two demonstration sites for the provision of child welfare case management services. The entities with whom the DSHS will contract in these demonstration sites are defined as *supervising agencies* for purposes of state and federal laws.

Summary of Substitute Bill:

Child Fatality Reviews and Near Fatality Reviews.
A CFR is required in cases where the death is suspected to be caused by child abuse or neglect. The DSHS must assure that persons assigned to a CFR team have no previous involvement in the child's case and that they have professional expertise pertinent to the dynamics of the case under review. When responding to a request for public disclosure of a CFR report, the DSHS is expressly authorized to redact confidential information, according to existing state and federal laws protecting the privacy of victims of child abuse and neglect.

A reference to *supervising agency* is added to the statute governing CFRs for the purposes of including children served by supervising agencies in those for whom a CFR is required if services are provided within 12 months of a child's death. The DSHS and the CFR team are granted access to all relevant records in the possession of the supervising agency.

In the case of a child fatality where it is not clear whether the death resulted from suspected child abuse or neglect, the DSHS must consult with the OFCO in determining whether a CFR is required.

Employees of the DSHS can not be questioned in a civil or administrative proceeding relating to the work of the CFR team, the incident under review, the employees' statements, thoughts, or impressions, or those of the CFR team members or others who provided information to the CFR. Documents prepared for a CFR team also are inadmissible in a civil or administrative proceeding. The limitation does not apply, however, to licensing or disciplinary proceedings relating to the DSHS's efforts to revoke or suspend a license based on allegations of misconduct or unprofessional conduct connected with a near fatality or a fatality being reviewed by a CFR team.

Autopsy Report.
The Secretary of the DSHS is authorized to receive a report of an autopsy for purposes of conducting a required CFR.

Substitute Bill Compared to Original Bill:

The substitute bill clarifies that a completed CFR report is subject to public disclosure regardless of whether the completed CFR report has been posted to the website yet.

Appropriation: None.

Fiscal Note: Not requested.

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

Staff Summary of Public Testimony:

(In support) The death of any child is a tragedy and the DSHS Children's Administration (CA) takes its responsibilities toward children seriously, including our responsibility to investigate where it appears a child's death resulted from abuse or neglect. The DSHS currently is having some problems getting access to autopsy information in a timely way. There is inconsistency from county to county in whether and how we get access to the information needed to conduct the required CFR. Having access to the autopsy report helps the DSHS make a determination as to whether a CFR is required.

(In support with amendment) Allied Daily Newspapers of Washington applauds this bill. We would like to offer an amendment to clarify that public disclosure of a CFR report.

We also believe that the near fatality reports are just as important as the CFR report and we would like to see these subject to public disclosure as well.

(Available for questions) In its capacity as a watchdog of the child protection and welfare system, the OFCO routinely reviews child fatalities across the state in cases where the child was in the care of, or receiving child welfare services from, the CA at the time of death, within one year of his or her death, or who died while in state licensed care. Currently, the CA conducts its own review of fatalities using the above criteria but limits such reviews to unexpected fatalities. The OFCO supports the intent of this legislation, which is to strengthen the CFR process while promoting accountability and transparency in the process.

We think it is important that this legislation allows the Secretary of the DSHS to examine and obtain copies of confidential reports and records of autopsies or post mortems. The OFCO has observed instances where lack of access to autopsies or post mortem reports inhibited the CFR team's work. We believe that this provision will promote comprehensive review of child fatalities in a timely manner. We also support narrowing the criteria regarding when CFRs are required. The DSHS will now review deaths that are suspected to be caused by child abuse or neglect. We anticipate that this shift in criteria will decrease the number of CFRs, allowing the CA to better focus its resources on reviewing child deaths suspected to be caused by abuse and neglect.

The OFCO will continue to monitor and review all child fatalities across the state where the child was in the care of, or receiving child welfare services from, the CA at the time of death,

within one year of his or her death, or who died while in state licensed care. If the OFCO finds child abuse or neglect concerns regarding a fatality, we retain the authority to request a CFR be conducted. The OFCO may also conduct its own independent review of the child's death. Currently, the CA does consult with the OFCO on a case-by-case basis to determine whether a child fatality should be reviewed if it is not clear whether the incident meets DSHS CA review criteria at the outset. This bill would promote accountability in the review process.

We also believe that reviewing near-fatalities of children who are involved with the child welfare system is a worthwhile practice that will yield valuable lessons and opportunities for meaningful reform. But for emergency medical intervention, many near-fatalities would have been child fatalities. Although this measure does not require the CA to review near-fatalities at OFCO's request, it does promote accountability. If the CA declines to conduct a review of a near-fatality at OFCO's request, the OFCO retains the authority to conduct its own independent review of the near-fatality.

Finally, the OFCO supports making it clear that information in the possession of a supervising agency will be provided to any CFR team reviewing the fatality of a child receiving services by that agency.

(With concerns) The Association of Coroners and Medical Examiners welcomes the clear statutory language to release the autopsy reports to the Secretary of the DSHS as needed for the CFRs. We would like to be assured that there is no further dissemination of the autopsy information because we see no public value to that level of detailed information.

(Opposed) None.

Persons Testifying: (In support) Denise Revels Robinson, Department of Social and Health Services, Children's Administration.

(In support with amendment) Rowland Thompson, Allied Daily Newspaper.

(Available for questions) Mary Meinig, Office of the Family and Children's Ombudsman.

(With concerns) Debbie Wilke, Washington Association of Coroner's and Medical Examiners.

Persons Signed In To Testify But Not Testifying: None.