HOUSE BILL REPORT
HB 1105

As Reported by House Committee On:
Early Learning & Human Services

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

Brief Description: Addressing child fatality review in child welfare cases.

Sponsors: Representatives Kagi, Walsh, Kenney, Maxwell and Roberts; by request of Department of Social and Health Services.

Brief History:
Committee Activity:
Early Learning & Human Services: 2/4/11, 2/8/11 [DPS].

Brief Summary of Substitute Bill

- Requires the Department of Social and Health Services (DSHS) to conduct a child fatality review when a fatality of a minor is suspected of being caused by abuse or neglect, and the child has been in the care of or received services from the DSHS or a supervising agency within one year before the child's death.
- Requires the DSHS to consult with the Office of the Family and Children's Ombudsman to determine whether a review should be conducted, where it is not clear that a child's death is the result of abuse or neglect.
- Requires that the child fatality review team is composed of members who have no previous involvement in the case being reviewed and that the review team include members with professional expertise that is pertinent to the dynamics of the case under review.
- Requires that the DSHS post the results of a child fatality review on a public website with confidential information redacted.
- Allows the DSHS to conduct a review of a near fatality of a child at its discretion or at the request of the Office of Family and Children's Ombudsman.
- Prohibits questioning of employees of the DSHS in a civil or administrative proceeding regarding the work of the child fatality review team and

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examination of witnesses regarding his or her interactions with the child fatality or near fatality review process.

- Prohibits the admissibility at a civil or administrative proceeding of documents prepared for the child fatality or near fatality review team.
- Allows the admissibility of documents prepared for the child fatality or near fatality review team in licensing or disciplinary proceeding relating to the DSHS's efforts to revoke or suspend a license pursuant to allegations of misconduct related to the underlying review.
- Authorizes the Secretary of the DSHS to receive an autopsy report for the purpose of conducting a required child fatality review.

HOUSE COMMITTEE ON EARLY LEARNING & HUMAN SERVICES

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 8 members: Representatives Kagi, Chair; Roberts, Vice Chair; Walsh, Ranking Minority Member; Hope, Assistant Ranking Minority Member; Dickerson, Goodman, Johnson and Orwall.

Minority Report: Do not pass. Signed by 1 member: Representative Overstreet.

Staff: Linda Merelle (786-7092).

Background:

Child Fatality Reviews.

State law requires the Department of Social and Health Services (DSHS) to conduct a child fatality review of an unexpected death of a child who, within the last 12 months, had been in the custody of, or receiving services from, the DSHS. At the conclusion of the review, 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 report of the child fatality review to the appropriate legislative committees and post all reports of the review to a public website maintained by the DSHS. In the case of a near fatality, the DSHS may conduct a review; it is not mandatory.

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 operated by the DSHS.

The OFCO is required to issue an annual report to the Legislature on the implementation of the recommendations from reviews of child fatalities.

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 postmortem examinations are confidential and are released only by statutory authority. The Secretary of the DSHS is not presently authorized to receive a report of an autopsy for purposes of conducting a required child fatality review.

Summary of Substitute Bill:

Child Fatality Reviews.

The DSHS must conduct a child fatality review when a fatality of a child is suspected of being caused by abuse or neglect. The DSHS must consult with the OFCO to determine if a review should be conducted if it is not clear whether a child's death was the result of child abuse or neglect. The DSHS must assure that persons assigned to a child fatality review team have no previous involvement in the child's case and that the review team includes individuals who have professional expertise pertinent to the dynamics of the case under review.

A child fatality review report is subject to public disclosure and must be posted on the public website. The DSHS is expressly authorized to redact confidential information contained in a review report according to existing state and federal laws protecting the privacy of victims of child abuse and neglect, including laws regarding the confidentiality of postmortem and autopsy reports.

Near Child Fatality Reviews.

In the event of a near fatality of a child, the DSHS must promptly notify the OFCO. The DSHS may conduct a review at its discretion or at the request of the OFCO.

Access to Files.

The DSHS and the fatality review team will have access to all records and files from a supervising agency that provided services to the child while under contract with the DSHS.

Civil or Administrative Proceedings.

A child fatality or near fatality review is subject to discovery in a civil or administrative proceeding. However, any use or admission into evidence is limited as follows:

- Employees of the DSHS can not be questioned in a civil or administrative proceeding relating to the work of the child fatality review team, the incident under review, the employee's statements, thoughts, or impressions or those of the review team members or others who provided information to the review team.
- A witness may not be examined regarding his or her interactions with the child fatality or near fatality review, including whether the person was interviewed during the review, questions asked during the review, and answers provided by the person.
- Documents prepared for a review team are inadmissible in a civil or administrative proceeding. Documents that existed before use or consideration by the review team or that were created independently of a fatality or near fatality review may still be admissible. The limitation also does not apply 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.

Autopsy Report.

The Secretary of the DSHS is authorized to receive a report of an autopsy for purposes of conducting a required child fatality review. The information in the autopsy is part of the confidential information that must be redacted when the report is released as a result of a public disclosure request.

Substitute Bill Compared to Original Bill:

The substitute bill adds a reference to a statute that requires confidentiality of postmortem and autopsy reports to be taken into account when child fatality review reports are redacted for public disclosure. The substitute bill clarifies that the review report, rather than the review, is subject to public disclosure. The substitute bill clarifies that the composition of the fatality review team must include, but is not limited to, individuals whose professional expertise is pertinent to the dynamics of the case.

Appropriation: None.

Fiscal Note: Available.

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) By limiting the required fatality reviews to those where abuse or neglect are suspected, the DSHS can conduct more near-fatality reviews and can have a more meaningful review of these cases.

(With concerns) The coroners and medical examiners welcome this bill, and they appreciate that it is explicit about when confidential reports may be released. At the conclusion of the fatality review, the medical examiners want to make sure that the information contained in the medical examiner's or coroner's report remains confidential.

(Neutral) The intent of this legislation is to strengthen the fatality review process while promoting accountability and transparency. Having the postmortem reports allows for a more robust review.

(Opposed) None.

Persons Testifying: (In support) Representative Kagi, prime sponsor; and Becky Smith, Children's Administration, Department of Social and Health Services.

(With concerns) Debbie Wilke, Washington Association of Coroners and Medical Examiners.

(Neutral) Mary Meinig, Office of the Family and Children's Ombudsman.

Persons Signed In To Testify But Not Testifying: None.