Z-0268.1

HOUSE BILL 1105

State of Washington 62nd Legislature 2011 Regular Session

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

Read first time 01/12/11. Referred to Committee on Early Learning & Human Services.

- AN ACT Relating to child fatality review in child welfare cases;
- amending RCW 74.13.640; and reenacting and amending RCW 68.50.105.
- 3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

6

7

8

10

11

12 13

14

15

- 4 **Sec. 1.** RCW 68.50.105 and 2007 c 439 s 1 and 2007 c 156 s 23 are each reenacted and amended to read as follows:
 - Reports and records of autopsies or post mortems shall be confidential, except that the following persons may examine and obtain copies of any such report or record: The personal representative of the decedent as defined in RCW 11.02.005, any family member, the attending physician or advanced registered nurse practitioner, the prosecuting attorney or law enforcement agencies having jurisdiction, public health officials, ((or to)) the department of labor and industries in cases in which it has an interest under RCW 68.50.103, or the secretary of the department of social and health services or his or her designee in cases being reviewed under RCW 74.13.640.
- The coroner, the medical examiner, or the attending physician shall, upon request, meet with the family of the decedent to discuss the findings of the autopsy or post mortem. For the purposes of this section, the term "family" means the surviving spouse, state registered

p. 1 HB 1105

- 1 domestic partner, or any child, parent, grandparent, grandchild,
- 2 brother, or sister of the decedent, or any person who was guardian of
- 3 the decedent at the time of death.

- Sec. 2. RCW 74.13.640 and 2009 c 520 s 91 are each amended to read as follows:
 - (1)(a) The department shall conduct a child fatality review in the event of ((an unexpected death)) a fatality suspected to be caused by child abuse or neglect of ((a)) any minor ((in the state)) who is in the care of the department or a supervising agency or receiving services described in this chapter ((74.13 RCW from the department or a supervising agency)) or who has been in the care of the department or a supervising agency or received services described in this chapter ((74.13 RCW from the department or a supervising agency)) within one year preceding the minor's death.
 - $((\frac{1}{2}))$ (b) The department shall consult with the office of the family and children's ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.
 - (c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case and whose professional expertise is pertinent to the dynamics of the case.
 - (d) Upon conclusion of a child fatality review required pursuant to ((subsection (1) of)) this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. Reports ((shall)) must be distributed to the appropriate committees of the legislature, and the department shall create a public web site where all child fatality review reports required under this section ((shall)) must be posted and maintained. A child fatality review completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 74.13.500 through 74.13.525 and 13.50.100, chapter 42.56 RCW, and other applicable state and federal laws.

 $((\frac{3}{3}))$ (e) The department shall develop and implement procedures

HB 1105 p. 2

to carry out the requirements of ((subsections (1) and (2) of)) this section.

((4) In the event a child fatality is the result of apparent abuse or neglect by the child's parent or caregiver, the department shall ensure that the fatality review team is comprised of individuals who had no previous involvement in the case and whose professional expertise is pertinent to the dynamics of the case.

(5)) (2) In the event of a near((-)) fatality of a child who is in the care of or receiving services described in this chapter from the department or a supervising agency or who has been in the care of or received services described in this chapter from the department or a supervising agency within one year preceding the near((-)) fatality, the department shall promptly notify the office of the family and children's ombudsman. The department may conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombudsman.

(3) In any review of a child fatality or near fatality in which the child was placed with or received services from a supervising agency pursuant to a contract with the department, the department and the fatality review team shall have access to all records and files regarding the child or otherwise relevant to the review that have been produced or retained by the supervising agency.

(4)(a) A child fatality or near fatality review completed pursuant to this section is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to this section.

(b) A department employee responsible for conducting a child fatality or near fatality review, or member of a child fatality or near fatality review team, may not be examined in a civil or administrative proceeding regarding (i) the work of the child fatality or near fatality review team, (ii) the incident under review, (iii) his or her statements, deliberations, thoughts, analyses, or impressions relating to the work of the child fatality or near fatality review team or the incident under review, or (iv) the statements, deliberations, thoughts, analyses, or impressions of any other member of the child fatality or near fatality review team, or any person who provided information to the child fatality or near fatality review team, relating to the work

p. 3 HB 1105

of the child fatality or near fatality review team or the incident under review.

1 2

3

4

5 6

7

8

9

10

11

12

13

14

15

16

17

18

19

2021

22

2324

fatality review team.

(c) Documents prepared by or for a child fatality or near fatality review team are inadmissible and may not be used in a civil or administrative proceeding, except that any document that exists before its use or consideration in a child fatality or near fatality review, or that is created independently of such review, does not become inadmissible merely because it is reviewed or used by a child fatality or near fatality review team. A person is not unavailable as a witness merely because the person has been interviewed by or has provided a statement for a child fatality or near fatality review, but if called as a witness, a person may not be examined regarding the person's interactions with the child fatality or near fatality review including, without limitation, whether the person was interviewed during such review, the questions that were asked during such review, and the answers that the person provided during such review. This section may not be construed as restricting the person from testifying fully in any proceeding regarding his or her knowledge of the incident under review. (d) The restrictions set forth in this section do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend the license of any licensed professional based in whole or in part upon allegations of wrongdoing in connection with a

--- END ---

minor's death or near fatality reviewed by a child fatality or near

HB 1105 p. 4