HOUSE BILL REPORT
ESSB 6110

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

Title: An act relating to modernizing the child fatality statute.

Brief Description: Modernizing the child fatality statute.

Sponsors: Senate Committee on Human Services (originally sponsored by Senators Keiser, Lovick, Nobles, Van De Wege, Wagoner and Wilson, C.).

Brief History:
Committee Activity:
Human Services, Youth, & Early Learning: 2/20/24, 2/21/24 [DPA].

Brief Summary of Engrossed Substitute Bill
(As Amended by Committee)

- Modifies various provisions related to child mortality reviews, including renaming these as child fatality reviews, expanding these reviews to include children up to age 19, and requiring various entities to provide records and data requested for specific child fatality reviews to the local health department.
- Prohibits information submitted in child fatality reviews from public disclosure, discovery, subpoena, or introduction into evidence in any administrative, criminal, or civil proceeding.

HOUSE COMMITTEE ON HUMAN SERVICES, YOUTH, & EARLY LEARNING

Majority Report: Do pass as amended. Signed by 6 members: Representatives Senn, Chair; Cortes, Vice Chair; Callan, Goodman, Ortiz-Self and Taylor.

Minority Report: Do not pass. Signed by 5 members: Representatives Rule, Vice Chair; Eslick, Ranking Minority Member; Couture, Assistant Ranking Minority Member; Dent and

---

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

Walsh.

Staff: Luke Wickham (786-7146).

Background:

A "child mortality review" is a process authorized by a local health department for examining factors that contribute to the death of children less than 18 years of age. The process may include a systematic review of medical, clinical, and hospital records; home interviews of parents and caretakers of children who have died; 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.

The purpose of child mortality reviews is to identify and address preventable causes of child mortality. All health care information collected as part of these child mortality reviews is confidential. No identifying information related to the deceased child, the deceased child's guardians, or anyone interviewed as part of the review may be disclosed.

The Department of Health (DOH) must assist local health departments to collect the reports of any child mortality reviews conducted by local health departments and assist with entering those reports into a database. In addition, the DOH must provide technical assistance to local health departments and encourage communication among child death review teams.

The DOH or local health departments may publish statistical compilations and reports related to a child mortality review, but identifying information must be redacted.

Local health department officials or employees may not be be examined in an administrative, civil, or criminal proceeding as to the existence or contents of documents assembled, prepared, or maintained for purposes of a child mortality review.

Summary of Amended Bill:

Local health department "child mortality reviews" are changed to "child fatality reviews." The scope of these reviews is expanded to include examining factors that contribute to deaths of children up to 19 years of age (instead of children under 18).

Local health departments and the Department of Health (DOH) are authorized to retain identifiable information and geographic information on each case for the purpose of determining trends, performing analysis over time, and for quality improvement efforts.

Information and records prepared, owned, used, or retained by the local health departments,

their respective offices, or staff that reveals the identification and location of the subject of a review may not be made public.

If the team of professionals involved in the child fatality review process identifies a current, reportable, and unresolved concern about child abuse or neglect, it may designate one member to make a report to the child abuse hotline, but these individuals are not mandated reporters of child abuse and neglect.

To aid in a child fatality review, the local health department may:

- request and receive data for specific fatalities including but not limited to: all medical records related to the child death, autopsy reports, medical examiner reports, coroner reports, and school, the criminal justice system, law enforcement, and social services records; and
- request and receive data described above from: health care providers, health care facilities, clinics, schools, the criminal justice system, law enforcement, laboratories, medical examiners, coroners, professions and facilities licensed by the DOH, local health departments, the Health Care Authority (HCA) and its licensees and providers, the Department of Social and Health Services (DSHS) and its licensees and providers, and the Department of Children, Youth, and Families (DCYF) and its licensees and providers.

Upon request by the local health department, health care providers, health care facilities, clinics, schools, the criminal justice system, law enforcement, laboratories, medical examiners, coroners, professions and facilities licensed by the DOH, local health departments, the HCA and its licensees and providers, the DSHS and its licensees and providers, and the DCYF and its licensees and providers must provide all medical records related to the child, autopsy reports, medical examiner reports, coroner reports, social services records, and other data requested for specific child fatality reviews to the local health department. Data described in certifications and informational copies of birth and death records issued from the state vital records system must be provided at no charge.

All information submitted to the DOH and local health departments as part of a child fatality review is not subject to public disclosure, discovery, subpoena, or introduction into evidence in any administrative, criminal, or civil proceeding.

The restriction on the DOH only using federal and private funding to assist local health departments to collect the reports of child fatality reviews and enter those into a database is removed.

Amended Bill Compared to Engrossed Substitute Bill:

The amended bill restores current law prohibiting witness statements or documents collected from witnesses, or summaries or analyses of those statements or records prepared exclusively for a child fatality review from being introduced into evidence in a criminal

proceeding.

The amended bill restores current law prohibiting local health department officials, their employees, and members of technical committees established to perform case reviews of selected child deaths from being examined in a criminal proceeding as to the existence or contents of documents assembled, prepared, or maintained for purposes of a child fatality review.

The amended bill prohibits all information submitted to the Department of Health and local health departments as part of a child fatality review from being introduced into evidence in a criminal proceeding related to the death of a child reviewed.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended 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 Pierce County's child mortality review team consists of experts from many backgrounds such as public health, healthcare, social services, law enforcement, and Tacoma schools. This team convenes with the goal of understanding child fatalities and to reducing future child fatalities by implementing prevention plans and practices. This review team helps identify the risk factors and trends in child deaths, identify specific barriers and system issues, and examine local programs, policies, and procedures that serve families to identify gaps and areas for improvement. This team also collaboratively examines the circumstances around different types of fatalities and opportunities for prevention.

Our state statute is out of step with other child death reviews across the country. This bill aligns our state's process with other review processes, including expanding these reviews to include children through age 19. This bill also updates data access and confidentiality restrictions so teams can access pertinent information while protecting the child and the child's family.

The bill also establishes a clear process for mandating reporting of suspected child abuse and neglect cases, removing redundant reports to the Department of Social and Health Services and the Department of Children, Youth, and Families (DCYF).

This update to the statute further balances and reinforces the importance of statewide prevention strategies. Children are the future of the community and everyone plays a key

role in keeping them safe and helping them thrive.

(Opposed) None.

(Other) There is a concern about the amendment that was taken on the Senate floor. As passed, the bill allows information, like witness statements, from being introduced as evidence in a criminal proceeding.

Currently, the process is that if a prosecutor or a defense attorney wants to access records as part of a criminal investigation, they can go through existing public disclosure practices. In this area of law, there are clear exemptions for what can be redacted. If the DCYF shares information with local public health entities conducting these reviews, there are fewer redactions of sensitive and confidential information because this sharing of information is with another government entity, but if this information is shared in a criminal proceeding, that is a much more public venue.

Allowing these records to be admitted as discovery in criminal proceedings would expose certain categories of DCYF client information which are sensitive. This confidential information is currently protected from disclosure. These records could be turned over and exposed without redaction. These minimally redacted records could be improperly used or disclosed further, resulting in serious consequences.

This bill would allow the sharing of minimally redacted information that would place confidential information in jeopardy.

Persons Testifying: (In support) LaRhonda Osborn, Tacoma-Pierce County Health Department, Washington State Association of Local Public Health Officials.

(Other) Allison Krutsinger, Department of Children, Youth, and Families.

Persons Signed In To Testify But Not Testifying: None.