SENATE BILL REPORT
SB 6110

As of February 3, 2024

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

Brief Description: Modernizing the child fatality statute.

Sponsors: Senators Keiser, Lovick, Nobles, Van De Wege, Wagoner and Wilson, C..

Brief History:
Committee Activity: Human Services: 1/25/24, 1/30/24 [DPS-WM].
Ways & Means: 2/03/24.

Brief Summary of First Substitute Bill

- Provides that if a child fatality team identifies a current, reportable, unresolved concern about child or neglect, it may designate a team member to make a report to the child abuse hotline. without making the team mandated reporters.
- Clarifies what data local health departments may request and receive in conducting a child fatality review.
- Provides that information provided to the Department of Health from child fatality reviews is not subject to public disclosure and may not be used as evidence in a legal proceeding related to the death of a child reviewed.

SENATE COMMITTEE ON HUMAN SERVICES

Majority Report: That Substitute Senate Bill No. 6110 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.
Signed by Senators Wilson, C., Chair; Kauffman, Vice Chair; Boehnke, Ranking Member; Frame, Nguyen, Warnick and Wilson, J..

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.

Staff: Alison Mendiola (786-7488)

SENATE COMMITTEE ON WAYS & MEANS

Staff: Monica Fontaine (786-7341)

Background: It is the stated intent of the Legislature to encourage child death reviews by local health departments so that preventable causes of child mortality can be identified and addressed in order to reduce the infant and child mortality rate in Washington State.

A child fatality review is a process authorized by a local health department for examining factors that contribute to the deaths of children. 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 a 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.

All information collected in a child mortality review is confidential; no identifying information related to the deceased child, the child's guardians, or anyone interviewed as part of the child mortality review may be disclosed. Identifying information is to be redacted from any records produced as part of the view. However, local health departments may publish statistical compilations and reports related to the child mortality review without identifying individual cases and sources of information.

A person is not prohibited or restricted from reporting suspected child abuse or neglect, nor does it limit access to any records or information arising out of such a report and ensuing action.

The Department of Health (DOH) is to assist local health departments collect the reports of any child mortality reviews, assist with entering the reports into a database, provide technical assistance and encourage communication among child death review teams using only federal and private funding.

Summary of Bill (First Substitute): Local health departments and DOH may retain identifiable 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 jurisdiction, their respective office, or staff, that reveals the identification and location of any person or persons being the subject of review shall not be made public in accordance with state law.

If the child fatality team identifies a current, reportable, and unresolved concern about child abuse or neglect, it may designate a team member to make a report to the child abuse hotline. This does not impose the duty of being a mandated reporter.

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, criminal justice, law enforcement, and social services records; and
- request and receive this data from health care providers, health care facilities, clinics, schools, criminal justice, law enforcement, laboratories, medical examiners, coroners, professions and facilities licensed by DOH, local health departments, 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, criminal justice, law enforcement, laboratories, medical examiners, coroners, professions and facilities licensed by DOH, local health departments, the Health Care Authority and its licensees and providers, DSHS and its licensees and providers, DCYF and its licensees and providers must all 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 review to the local health department. Data described in copies of birth and death records issue from the state vital records system are to be provided at no charge.

Information submitted to DOH and local health jurisdictions is not subject to public disclosure, discovery, subpoena, or introduction into evidence in any administrative, civil, or criminal proceeding related to the death of a child reviewed.

Language limiting DOH to provide assistance to local health departments in entering reports into a database, providing technical assistance, and encourage communication among child fatality review teams using only federal and private funding is struck.

DOH or local health departments may use these reports, including statistical compilations, in the development and coordination of statewide child fatality prevention strategies and interventions.

Child mortality reviews are renamed child fatality reviews. References to mortality and death are changed to fatality.

EFFECT OF CHANGES MADE BY HUMAN SERVICES COMMITTEE (First Substitute):

If the child fatality team identifies a current, reportable, and unresolved concern about child abuse or neglect, it may designate a team member to make a report to the child abuse hotline. Data described in copies of birth and death records issue from the state vital records system are to be provided at no charge. Clarifying, non-substantive changes made.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Original Bill (Human Services): *The committee recommended a different version of the bill than what was heard.* PRO: These reviews were put into place a few years ago, and when seeing if our policies are aligned with national standards, our policies are a little out of sync. This bill addresses those concerns and aligns us with federal standards and tightens child privacy. There are 17 teams, it's great they are able to meet with one another. When a child dies of a preventable cause, reviews help identify ways to prevent similar deaths in the future and can lead to campaigns and awareness of suicide, safe sleep, identifying gaps in services and needs in communities. We should be able to go up to age 19 as there are 18-year-olds in high school. Some minor changes are needed.

OTHER: There is value in this legislation as it contributes to children thriving. This work allows us to the honor the lives we've lost while working towards prevention of child fatalities in the future.

Persons Testifying (Human Services): PRO: Senator Karen Keiser, Prime Sponsor; Jaime Bodden, WSALPHO; LaRhonda Osborn, Tacoma-Pierce County Health Department; Erica Whares, Kitsap Public Health District; Lisa Ostler, Thurston County Health and Human Services.

OTHER: Katie Eilers, Washington State Department of Health.

Persons Signed In To Testify But Not Testifying (Human Services): No one.

Staff Summary of Public Testimony on First Substitute (Ways & Means): PRO: Provides important modernization updates to our child fatality statute. We've identified where our statute is out of step with national practice and standards. This bill aligns that work for our state. There is no local fiscal note for this bill because teams are currently funded through foundational public health services funding. There are 17 local programs currently. We've worked with advocates to improve this bill further and we'll submit suggested changes.

OTHER: In support of the proposal and policy, but there are provisions in the bill that we would suggest removing. That includes prohibiting materials being involved in a criminal proceeding. in 2013, a child was tortured and starved to death. That report came through a child fatality review from DCYF. DCYF has a statute that is slightly different and only

restricts civil or administrative proceedings, it doesn't restrict it in a criminal matter. Not trying to get the work product, but if there is material that was reviewed that would be helpful in a current and reportable matter then it should not be restricted from a criminal case.

Persons Testifying (Ways & Means): PRO: Senator Karen Keiser, Prime Sponsor; Jaime Bodden, WSALPHO.

OTHER: Russell Brown, WA Association of Prosecuting Attorneys.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.