SENATE BILL REPORT

SB 5409

As Reported By Senate Committee On:
Health & Long-Term Care, February 18, 1997
Ways & Means, March 10, 1997

Title: An act relating to child death review and prevention.

Brief Description: Modifying child death review.

Sponsors: Senators Long, Thibaudeau, Kohl, Wojahn, Kline and Winsley; by request of Governor Lowry.

Brief History:
Committee Activity: Health & Long-Term Care: 2/7/97, 2/18/97 [DPS-WM].
Ways & Means: 3/10/97 [DPS (HEA)].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 5409 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.
Signed by Senators Deccio, Chair; Wood, Vice Chair; Benton, Fairley and Franklin.

Staff: Don Sloma (786-7319)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Substitute Senate Bill No. 5409 as recommended by Committee on Health & Long-Term Care be substituted therefor, and the substitute bill do pass.
Signed by Senators West, Chair; Deccio, Vice Chair; Strannigan, Vice Chair; Bauer, Brown, Fraser, Hochstatter, Kohl, Long, Loveland, McDonald, Rossi, Schow, Sheldon, Snyder, Spanel, Swecker, Thibaudeau, Winsley and Zarelli.

Staff: Susan Lucas (786-7711)

Background: In 1994, 920 Washington State children (defined as under the age of 18) died from a variety of causes, including congenital abnormalities, problems relating to pregnancy, Sudden Infant Death Syndrome, injuries, and various diseases. Of these, 115 died unexpectedly from Sudden Infant Death Syndrome (SIDS), and 289 died of intentional or unintentional injuries.

The State Department of Health has concluded that many of these unexpected deaths are preventable if a more comprehensive understanding of their causes can be developed. In its November 1995 report, **A Strategy to Answer, Why Do Children Die?–**, the department developed a public health model which has been used by some local health jurisdictions in our state, and adopted in other states as a tool for conducting comprehensive, multi-

disciplinary reviews of unexpected child deaths. According to the report, the recent discovery that infants' sleeping positions may cause SIDS came, in part, from studying the results of child death reviews conducted under the auspices of the Seattle/King County Health Department in the early 1990s.

Under current law, local health jurisdictions have authority to conduct child death reviews. However, concerns have been raised about the prevalence and consistency of the practice, and about the comparability of child death review findings across jurisdictions.

Summary of Substitute Bill: Current child mortality review activities retain their current legal protections until December 31, 1997. After that time, state and local health jurisdictions are authorized to engage in a number of similar, but more consistent child death review activities as specified in the bill.

The state Department of Health, in cooperation with local health departments, is authorized to consolidate and integrate child death review activities; review child deaths; approve protocols for conducting death reviews developed by local health departments; collect data, including development of a centralized child death review data base; report strategies to reduce child deaths; provide technical assistance to state and local death review teams; and incorporate, as appropriate, recommendations of state and local death review teams into agency operations.

Local health departments are the appointing authorities for local child death review teams. Their membership may include professionals in law enforcement, medicine, mental health, coroners/medical examiners, education, social services, chemical dependency treatment, child welfare, tribal governments, military, public health, social work, foster parenting, and the public.

Local health departments have primary responsibility to assure that these teams review child deaths, especially unexpected deaths, so long as these reviews are not concurrent with, and do not interfere with law enforcement investigations. Local child death review team duties are specified. Local teams have access to a wide variety of records, including autopsy records and the confidential portion of a birth certificate. The teams may access law enforcement records, so long as this does not impair a law enforcement investigation or violate federal laws governing access to alcohol and drug abuse patient information. Records accessed by local teams are not subject to public disclosure by virtue of their use in the child death review process.

The state Department of Health is the appointing authority for the state child death review team. Its membership may include the same list of professionals as local teams with the addition of the state child, youth and family ombudsman and the state health officer. The state team must provide consultation and training to local teams as requested, compile data, consider recommendations of local teams, recommend strategies to state agencies regarding child deaths, and review cases identified by local teams.

Records and documents reviewed or summaries or analyses produced by state and local teams are confidential and not subject to discovery or subpoena in any administrative, civil or criminal proceeding. Local and state team employees or members of technical committees

established by the teams may not be examined in any administrative, civil or criminal proceeding regarding the contents of child death reviews.

The Department of Health may adopt rules to implement the act. The act does not supercede local ordinances that exceed its scope.

The act contains a severability clause. If specific funding for the act is not provided, the act is null and void.

Substitute Bill Compared to Original Bill: Current child death review activities are clearly authorized to continue with current confidentiality protections until the act becomes effective on January 1, 1998.

The state health department is identified as the appointing authority for the state child death review team, and as the lead state agency on child death review. The state health officer may serve on the state child death review team.

Local health departments are identified as the appointing authorities for local child death review teams.

Child death review protocols must be developed locally and approved by the state.

Records named in the bill as those which may be included in the review are expanded to include autopsy records and the confidential portion of the birth certificate. Records access is limited by the terms of federal law as it may apply to alcohol and drug abuse patient information.

All records supplied to state and local teams, as well as any summaries, analyses or other information generated by the teams in the course of their reviews are confidential, and not subject to subpoena pursuant to their use in these reviews. Death review team staff and expert advisors are similarly protected from examination in civil, administrative or criminal proceedings. Only aggregate data on child death reviews, as defined in the bill, may be reported.

Child death reviews may not impair or occur concurrently with law enforcement investigations.

The authority to adopt rules under the act is removed from DSHS, consistent with the proposed substitute bill's effort to place authority for child death review at the state level primarily with the department of health.

It is specified that the act does not supercede local ordinances which may be more expansive in scope.

If portions of the act are found to be invalid, the remainder of the act is not affected.

A provision is added such that if funds are not specifically provided for this act by June 30, 1997, in the omnibus appropriations act, this act is null and void.

Appropriation: None.

Fiscal Note: Available.

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

Testimony For: The bill is needed to assure that child death review occurs statewide, and that it occurs in a consistent manner. This will allow data to be collected and analyzed to determine the causes of unexpected deaths among children. Some local jurisdictions have engaged in comprehensive, multi-disciplinary death reviews like those called for in this bill. The results have included greater understanding about SIDS and how to prevent it. Expanding access to records by child death review teams, improving the confidentiality of information collected and developed by the teams, providing for training and technical assistance and establishing a state child death review team that can review selected local investigations will all improve our ability to prevent child deaths.

Testimony Against: No one testified in opposition to the bill; however, several concerns were expressed about the way in which certain provisions had been drafted. The bill, as presented to the committee might undermine current child death reviews by making it unclear whether some of the information collected by current teams would be kept confidential. The original bill is not clear whether child death reviews can occur during law enforcement investigations. If they can, they might impede such investigations. It is not clear in the original bill who appoints state and local teams, which state agency has primary authority over death reviews, whether coroners/medical examiners or health officers can be members of the teams, what protection may exist from examination or subpoena for staff, technical experts or confidential reports generated by the teams, what might occur if parts of the bill are found to be invalid, or whether the bill will have to be implemented if funding is not provided.

Testified: PRO: Rita Schmidt, DOH; Jennifer Strus, DSHS; Darrell Russell, WAPA; Amira El-Bastawissi, SKCDPH; Martha Ree, WACME.