FINAL BILL REPORT
SHB 2984

C 36 L 04
Synopsis as Enacted

Brief Description: Requiring child fatality reviews for children involved in the child welfare system.

Sponsors: By House Committee on Children & Family Services (originally sponsored by Representatives Shabro, Kagi, Bush, Darneille, Dickerson, Roach, Rodne, Bailey, Boldt, Campbell, Nixon, McDonald, Kenney, Armstrong, Woods, Chase and Hunter).

House Committee on Children & Family Services
Senate Committee on Children & Family Services & Corrections

Background:

Local health departments are authorized by law to conduct child mortality reviews. A child mortality review consists of a process for examining factors that contribute to deaths of children under 18 years of age. The process may include the following:
- 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 the death.

Separate from the child mortality review, the Children's Administration (CA) of the Department of Social and Health Services (DSHS) conducts internal child fatality reviews when any of the following criteria are met with reference to the death of a child:
- The child's family had an open case with the CA at the time of death;
- The child's family received any services from the CA within the 12 months preceding the death, including a referral for services that did not result in an open case; or
- The death occurred in a home or facility licensed to care for children.

The purpose of the CA's child fatality review process is to conduct an examination of the handling of a case to determine whether or not agency policies, procedures, and practices were properly followed.

Summary:

The DSHS is required to conduct a child fatality review in the event of an unexpected death of a minor in the state who is in the care of, or receiving child welfare services from, the DSHS or has been in care of, or receiving child welfare services from, the DSHS within one year preceding the death.

Upon conclusion of the child fatality review, the DSHS is required to issue a report on the results of the review to the appropriate committees of the Legislature and to make copies of the report available to the public upon request.

The DSHS is required to develop and implement procedures to carry out these requirements.

Votes on Final Passage:

House 93 0
Senate 47 0

Effective: June 10, 2004