SENATE BILL REPORT
SHB 1105

As of March 31, 2011

Title: An act relating to child fatality review in child welfare cases.

Brief Description: Addressing child fatality review in child welfare cases.

Sponsors: House Committee on Early Learning & Human Services (originally sponsored by Representatives Kagi, Walsh, Kenney, Maxwell and Roberts; by request of Department of Social and Health Services).

Brief History: Passed House: 2/25/11, 97-0.
Committee Activity: Human Services & Corrections: 3/10/11.

SENATE COMMITTEE ON HUMAN SERVICES & CORRECTIONS

Staff: Jennifer Strus (786-7316)

Background: Reports and records of autopsies are confidential. The following persons or entities may examine and obtain copies of the reports or records:

- the personal representative of an estate;
- a family member;
- the attending physician or advanced registered nurse practitioner;
- the prosecuting attorney or law enforcement agencies having jurisdiction;
- public health officials; and
- the Department of Labor and Industries.

The Department of Social and Health Services (DSHS) must conduct a child fatality review (CFR) on the unexpected death of a child who is in the care of DSHS or a supervising agency at the time of the death. A CFR must also be conducted if the child had been in the custody of or received services from DSHS within the 12 months preceding the child's death.

At the conclusion of a CFR, DSHS must issue a report on the results of the review within 180 days unless an extension is granted by the Governor. DSHS must create a public website where all CFRs required under this section are to be posted and maintained. If the fatality is the result of apparent abuse or neglect by the child's parent or caregiver, DSHS must ensure that the fatality team is comprised of individuals who had no previous involvement in the case and whose expertise is pertinent to the dynamics of the case.

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

DSHS must notify the Office of the Family and Children's Ombudsman (OFCO) in the event a child in its care, or who had been in its care or received services within the last 12 months, has been involved in a near fatality.

Summary of Bill: DSHS is added as an agency that has access to confidential autopsy reports and records.

DSHS must conduct a CFR when there is a fatality of a child, suspected to be caused by abuse or neglect, who (1) is in the care of or receiving services from DSHS or a supervising agency at the time of the fatality; or (2) during the preceding year, was receiving care or services from DSHS or a supervising agency. DSHS must consult with OFCO to determine whether a CFR should be conducted in any case in which it is not clear that the fatality was caused by abuse or neglect. DSHS must ensure that a CFR team is comprised of individuals with no previous involvement in the case. The composition of the CFR must include individuals whose professional expertise is pertinent to the dynamics of the case.

A CFR report on the DSHS website is subject to public disclosure except that DSHS may redact confidential information. Confidentiality of post mortem and autopsy reports must be taken into account when child fatality reports are redacted for public disclosure.

DSHS may conduct a review of a near fatality at its discretion or at the request of OFCO. The near fatality review process applies also to near fatalities that occurred while in the care of or receiving services from a supervising agency.

In any CFR of a fatality or near fatality of a child placed with or receiving services from a supervising agency, DSHS and the child fatality team have access to all records and files regarding the child or that are otherwise relevant to the review that was produced or retained by the supervising agency.

A CFR is subject to discovery in a civil or administrative proceeding but cannot be admitted into evidence or otherwise used in a civil or administrative proceeding. A DSHS employee responsible for conducting a CFR or a near fatality review cannot be examined in a civil or administrative proceeding regarding the following:

- the work of the child fatality or near fatality review team;
- the incident under review;
- the employee's statements, deliberations, thoughts, analyses, or impressions of any other member of the review team or any person who provided information to the review team relating to the work of the review or incident under review; and
- the statements, deliberations, thoughts, analyses or impressions of any other member of the review team or any person who provided information to the review team related to the work of the review team.

Documents prepared by or for a CFR or near fatality review are inadmissible and cannot be used in a civil or administrative proceeding. Any document that existed before its use or consideration in a CFR or near fatality review, or that is created independently of such review, does not become inadmissible simply because it was reviewed or used by the review team.

If a person was interviewed by, or provided a statement for the review team, this alone does not make the person unavailable as a witness. But if called as a witness, a person cannot be examined regarding the person's interactions with the review team. The person may testify fully in any proceeding regarding his or her knowledge of the incident under review.

The above restrictions do not apply in a licensing or disciplinary proceeding arising from an agency's effort to suspend or revoke the license of any professional based upon allegations of wrongdoing in connection with the minor's death or near fatality reviewed by the review team.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

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

Staff Summary of Public Testimony: PRO: This bill will permit DSHS to have access to autopsy reports which will assist them in conducting fatality reviews. It also relieves DSHS from conducting fatality reviews in situations in which the death of a child in care was expected (usually because of health issues). DSHS will be able to conduct more near fatality reviews than they currently do. OFCO will continue to monitor and request CFRs by DSHS. DSHS is fine with the changes made by the House.

OTHER: OFCO has observed instances where lack of access to autopsies or postmortem reports inhibited the review teams' work, and this provision will promote comprehensive reviews of child fatalities in a timely manner. Under this bill, DSHS would review deaths that are suspected to be caused by child abuse or neglect; and this shift in criteria will decrease the number of deaths DSHS must review; and allow them to better focus its resources on those deaths. Reviewing near-fatalities of children involved with the child welfare system is a worthwhile practice that will yield valuable lessons and opportunities for meaningful reform.

Persons Testifying: PRO: Becky Smith, DSHS.

OTHER: Mary Meinig, OFCO.