SENATE BILL REPORT
SHB 2165

As Reported by Senate Committee On:
Human Services & Corrections, February 27, 2014

Title: An act relating to department of early learning fatality reviews.

Brief Description: Concerning department of early learning fatality reviews.

Sponsors: House Committee on Early Learning & Human Services (originally sponsored by Representatives Kagi, Lytton, Morrell, Jinkins and Haigh).

Brief History: Passed House: 2/11/14, 93-5.
Committee Activity: Human Services & Corrections: 2/20/14, 2/27/14 [DPA].

SENATE COMMITTEE ON HUMAN SERVICES & CORRECTIONS

Majority Report: Do pass as amended.
Signed by Senators O'Ban, Chair; Pearson, Vice Chair; Darneille, Ranking Member; Hargrove and Padden.

Staff: Joan Miller (786-7784)

Background: In 1996 the Legislature established the Office of the Family and Children's Ombuds (OFCO). Some of the duties of OFCO include the following: providing information on the rights and responsibilities of individuals receiving family and children services; periodically reviewing the facilities and procedures of state institutions serving children; and recommending procedural changes in addressing the needs of children.

OFCO also collaborates with the Department of Social and Health Services (DSHS) Children's Administration (CA) to complete child fatality reviews or near child fatality reviews when a fatality is suspected to be caused by child abuse or neglect of any minor in the care of DSHS or a supervising agency. Child fatality reviews offer a systemic evaluation of the events and circumstances surrounding a fatality or near-fatality incident. CA and OFCO use the child fatality review process to identify gaps in practice and make improvements to the child welfare system. After the completion of a child fatality review, both CA and OFCO issue reports and recommendations to the Legislature.

The Department of Early Learning (DEL) licenses child care centers and family home providers in Washington. Licensing requirements are established by the Legislature and by

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DEL through rulemaking. The components of the licensure process include child development trainings, first aid and CPR training, criminal background checks, and health and safety checks on child care centers and homes. The purpose of licensing requirements is to promote the health and safety of children attending child care programs.

Currently DEL does not have a legal duty to complete any child fatality reviews for a fatality or a near fatality that occurs in a licensed child care facility or early learning program.

Summary of Bill (Recommended Amendments): DEL must complete child fatality reviews if a child fatality occurs in a licensed child care center, licensed child care home, or an Early Childhood Education and Assistance Program. In completing the reviews, DEL must convene a Child Fatality Review Committee and determine committee membership. The Review Committee membership must include at least one expert from outside DEL with knowledge of early learning licensing requirements and program standards. The Review Committee may consult with the coroner or medical examiner, or the coroner or examiner's designee, of the county in which fatality or near fatality occurred. The primary purpose of the fatality review is to develop recommendations for DEL and the Legislature to strengthen health and safety protection for children. Within 180 days following the fatality, DEL must issue a report to the appropriate committees of the Legislature and publish the reports to a public website.

In the event of a near child fatality, DEL must consult with OFCO to determine if a review should be conducted. Near fatality means an act that, as certified by a physician, places the child in serious or critical condition. DEL and the Review Committee must have access to all records and files produced or retained by the child care or early learning provider that pertain to the child and are relevant to the review. Reviews are subject to discovery in a civil or administrative proceeding but may not be admitted into evidence.

A DEL employee responsible for conducting a review or a member of the Review Committee may not be examined in a civil or administrative proceeding regarding the following: the work of the Review Committee; the incident under review; or committee member statements, deliberations, analyses, or impressions relating to the work of the Review Committee. A person is not available as a witness merely because the person was interviewed or provided a statement during a review. But if called as a witness, a person may not be examined regarding the person's interactions with the child fatality or near-fatality review. These restrictions do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend a license based in whole or in part upon allegations of wrongdoing in connection with a minor's death or near fatality.

EFFECT OF CHANGES MADE BY HUMAN SERVICES & CORRECTIONS COMMITTEE (Recommended Amendments): The Review Committee may consult with the coroner or medical examiner, or the coroner or examiner's designee, of the county in which fatality or near fatality occurred. The term near fatality is defined.

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 on Substitute House Bill: PRO: Before coming to the Legislature, I participated in three child fatality reviews of children who died in child welfare. Those reviews called on outside experts as well as people in the department to look at the circumstances that led to the child's death. In each case, the reviews resulted in significant recommendations to the department and the Legislature, including the creation of OFCO. These reviews are an objective, powerful tool for making sure we carefully review the circumstances surrounding a child's death. When a recent death of sudden infant death syndrome (SIDS) occurred in a facility where there was a previous SIDS death 12 years ago, DEL told me it did not have the same authority as DSHS to conduct a child fatality review. More importantly, DEL does not have the liability protection that allows people to come together and frankly discuss the circumstances of the incident without having that information discloseable. Child fatalities in licensed child care are rare, but when they do happen, DEL does an informal internal review of policies and procedures. This bill, however, adds transparency to our work and gives us the right amount of coverage to make sure we are allowed to do these reviews and post the results online. DEL stands ready to implement this bill.

CON: This bill is not needed. DSHS has been doing child day care deaths for at least 15 years. This bill gives DEL the authority to investigate itself, and child fatality reviews should be independent. The Legislature must decide what to do on behalf of children and parents in regard to managers neglecting their duties under the law. This bill will not do that.

OTHER: While OFCO remains neutral on specific legislation, it supports the intent of this bill. Currently OFCO internally reviews child fatalities when the child has had a history of involvement with DSHS or CA within the last calendar year. DSHS is statutorily required to conduct child fatality reviews when it is suspected that child abuse or neglect caused the death. At this time, child fatalities that occur in DEL programs, licensed centers, or licensed homes are not investigated or reviewed by an external committee, even if there is an allegation of abuse or neglect related to the fatality. This bill would close that gap and create a fatality review system that mirrors what DSHS has been doing for years. The purpose of reviewing child fatalities is to increase the agency's understanding of the circumstances around the death and to evaluate practice, programs, and systems to improve the health and safety of children. There are very few fatalities and near fatalities in licensed DEL facilities, but when these tragedies do occur, it is important to share critical information with the community.

Persons Testifying: PRO: Representative Kagi, prime sponsor; Amy Blondin, DEL.

CON: Mary Logan, Child Care Consulting.

OTHER: Mary Meinig, OFCO.