HOUSE BILL REPORT
ESHB 1126

As Passed Legislature

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, MacEwen, Tarleton, Walsh, Goodman, Senn, Gregerson and Ryu).

Brief History:
Committee Activity:
Early Learning & Human Services: 1/23/15, 1/30/15 [DPS];
Appropriations: 2/18/15, 2/25/15 [DPS(ELHS)].
Floor Activity:
Passed House: 3/4/15, 86-11.
Senate Amended.
Passed Senate: 4/15/15, 49-0.
House Concurred.
Passed House: 4/23/15, 90-8.
Passed Legislature.

Brief Summary of Engrossed Substitute Bill

- Requires the Department of Early Learning (DEL) to convene a child fatality review committee to conduct child fatality reviews when a child fatality, or in some cases near fatality, occurs in an early learning program or a licensed child care facility.
- Requires the DEL to issue a report on the results of the review to the Legislature, and post the report to a public website where all child fatality review committee reports must be posted and maintained.

HOUSE COMMITTEE ON EARLY LEARNING & HUMAN SERVICES

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 7 members: Representatives Kagi, Chair; Walkinshaw, Vice Chair; Walsh, Ranking Minority Member; Hawkins, Ortiz-Self, Sawyer and Senn.

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.

Minority Report: Do not pass. Signed by 3 members: Representatives Scott, Assistant Ranking Minority Member; Dent and McCaslin.

Staff: Ashley Paintner (786-7120).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The substitute bill by Committee on Early Learning & Human Services be substituted therefor and the substitute bill do pass. Signed by 26 members: Representatives Hunter, Chair; Ormsby, Vice Chair; Parker, Assistant Ranking Minority Member; Wilcox, Assistant Ranking Minority Member; Carlyle, Cody, Dunshee, Fagan, Haler, Hansen, Hudgins, S. Hunt, Jinkins, Kagi, Lytton, MacEwen, Magendanz, Pettigrew, Sawyer, Schmick, Senn, Springer, Stokesbary, Sullivan, Tharinger and Walkinshaw.

Minority Report: Do not pass. Signed by 7 members: Representatives Chandler, Ranking Minority Member; Buys, Condotta, Dent, G. Hunt, Taylor and Van Werven.

Staff: Catrina Lucero (786-7192).

Background:

The Department of Early Learning (DEL) licenses child care centers and family home providers in Washington. Licensing requirements are established by the Legislature and the DEL in rules. The stated purpose of licensing requirements is to promote the health and safety of children attending child care programs. Licensure components include requirements such as child development trainings, CPR and First Aid trainings, criminal background checks, and health and safety checks.

The DEL does not currently complete a child fatality review for a child fatality or near fatality that occurs in an early learning program or a licensed child care facility.

In 1996 the Legislature established the Office of the Family and Children's Ombuds (OFCO). The OFCO investigates complaints about agency actions or inactions, specifically complaints that involve a child at risk of abuse, neglect, or other harm or a child or parent involved with child protection or child welfare services. The OFCO collaborates with the Department of Health and Social Services (DSHS) and the Children's Administration (CA) to conduct child fatality or near fatality reviews when the cause of the fatality is suspected to involve child abuse or neglect of a minor in the care of the DSHS or a supervising agency. The child fatality reviews offer a systematic evaluation of the events and circumstances surrounding a child fatality or near fatality incident. After completion of a child fatality review, both the CA and the OFCO issue reports and recommendations to the Legislature. The child fatality review process is used to identify gaps in practice and make recommendations on improvements to promote the health and safety of children in the child welfare system.

Summary of Engrossed Substitute Bill:

Child Fatality Review.

The DEL must convene a child fatality review committee to conduct a review when a child fatality occurs in an early learning program or a licensed child care center or home. In the case of a near child fatality that occurs in an early learning program or a licensed child care center or home, the DEL must consult with the OFCO to determine if a review should be conducted. The child fatality review committee must be comprised of individuals with appropriate, including but not limited to experts from outside the DEL with knowledge of early learning licensing requirements and program standards, a law enforcement officer with investigative experience, a representative from a county or state health department, and a child advocate with expertise in child facilities. The DEL shall invite one parent or guardian for membership on the committee who had a child die in a child care setting. The DEL must ensure that the committee is made up of individuals who had no previous involvement in the case. While conducting the review, the DEL and the fatality review committee must have access to all relevant records regarding the child that have been produced or retained by the early learning program provider, licensed child care center provider, or licensed family home provider. Nothing in the act creates a duty for the OFCO as related to children in the care of an early learning program, a licensed child care, or a licensed child care home.

Child Fatality Review Report.
When a child fatality or near fatality review is conducted, the DEL must issue a report on the results of the review within 180 days, unless an extension is granted by the Governor. The report must be submitted to the appropriate committees of the Legislature, and posted to a public website where all child fatality review reports must be posted and maintained. The DEL may redact confidential information from the public report. The child fatality review committee must develop recommendations to the DEL and the Legislature regarding changes in licensing requirements, practice, or policy to prevent fatalities and strengthen safety and health protections for children in child care.

Civil Proceedings.
The child fatality or near fatality review is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence. Documents prepared by the child fatality review committee are inadmissible and may not be used in a civil or administrative proceeding. Individuals responsible for conducting the review, including members of the child fatality review committee and the DEL employees, may not be examined in a civil or administrative proceeding regarding the following: (1) the work of the child fatality review committee; (2) the incident under review; or (3) employee's or member's statements, deliberations, thoughts, analyses, or impressions relating to the incident under review. A person is not unavailable as a witness merely because he or she was interviewed by the child fatality review committee, but as a witness the person may not be examined regarding interactions with the child fatality review. The civil and administrative proceeding restrictions outlined do not apply in licensing or disciplinary proceedings arising from allegations of wrongdoing in connection with a child fatality or near fatality review.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony (Early Learning & Human Services):

(In support) The process of a child fatality review allows all the parties to come together, analyze what happened, listen to experts in the field, and develop recommendations for how to avoid child fatalities in the future. One of the critical components of the child fatality review process is that individuals can speak frankly and openly during the review and that information will not be used against them in court. Additionally, the child fatality review will help the DEL understand what the experts are saying should be done to address safety issues in child care.

(Neutral) The OFCO supports the intent to establish a system where the DEL would conduct child fatality reviews when a child fatality occurs in a state licensed child care facility. Currently, the OFCO conducts an administrative, in-house review when the child is in custody of the CA or when the family has had contact with the CA in the past year. Additionally, the CA conducts executive fatality reviews when the death of the child is expected to be due to abuse or neglect and the child is in the care of the DSHS or receiving services at the time of the death or in the year prior. If it is not clear whether or not the death was attributed to abuse or neglect, the CA consults with the OFCO to determine if a review should be conducted. The purpose of these reviews is not to simply identify what went wrong or who is at fault, it's actually much broader around how safety can be improved for children in custody of the DSHS.

The child fatality review process with the CA has been a driving force for system improvement in the child welfare system. After an executive child fatality review is conducted, the CA has a Continuous Quality Improvement Committee, which reviews and prioritizes the recommendations for implementation and does follow-up work on progress. The OFCO is required to report annually to the Legislature on the efforts of the DSHS to implement recommendations and the progress of implementation.

The infant safe sleep recommendations have had a significant impact on the safety and welfare of children within the DSHS. The child fatality reviews identified that there were unsafe sleep practices occurring and the DSHS was able to submit recommendations to improve safe sleep practices. Recommendations have also impacted the way adoptive parents are screened and have helped improve post-adoption strategies. Another issue that is often addressed through the child fatality review is developing recommendations to improve community partnerships between the DSHS and other entities such as the Department of Corrections (DOC), law enforcement, and federally recognized tribes.

In the 2014 annual report, the OFCO found that 73 percent of the recommendations coming from the child fatality reviews have been implemented or are in the course of being implemented. There is follow-through by the DSHS and it is having a systematic and positive impact on the child welfare system. Just as these reviews are warranted in the child welfare system, those benefits would also arise from child fatality reviews conducted by the DEL. There are not a lot of fatalities that occur in licensed child care, but that doesn't minimize the benefits for system improvement.

The bill would require the OFCO to partner with the DEL to determine if a near child fatality review is necessary, yet the bill in its current form is silent as to whether or not the OFCO

would have access to the DEL records. The OFCO should be granted authority to have access to these records. The OFCO does have authority with the DSHS to access records for the purposes of fatality review. This bill creates a fatality review system that would mirror current review practices being conducted in the CA.

(With concerns) The bill needs to include some form of clarifying amendment that stipulates the review shall be conducted after the criminal investigation. There is a concern that family members who have participated in the child fatality review process may not wish to be interviewed further for the purposes of a criminal investigation. There appears to be a general sense that the two processes occurring at the same time with different outcomes may cause confusion. There may be other alternative amendments that could address this issue.

(Opposed) None.

Staff Summary of Public Testimony (Appropriations):

(In support) None.

(Opposed) None.

Persons Testifying (Early Learning & Human Services): (In support) Representative Kagi, prime sponsor.

(Neutral) Patrick Dowd, Office of the Family and Children's Ombuds.

(With concerns) James McMahan, Washington Association of Sheriffs and Police Chiefs.

Persons Testifying (Appropriations): None.

Persons Signed In To Testify But Not Testifying (Early Learning & Human Services): None.

Persons Signed In To Testify But Not Testifying (Appropriations): None.