HOUSE BILL REPORT
2SSB 5888

As Passed House - Amended:
April 15, 2015

Title: An act relating to near fatality incidents of children who have received services from the department of social and health services.

Brief Description: Concerning near fatality incidents of children who have received services from the department of social and health services.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators O'Ban and Miloscia).

Brief History:
Committee Activity:
Early Learning & Human Services: 3/24/15, 3/26/15 [DPA];
Appropriations: 4/6/15, 4/7/15 [DPA(ELHS & APP)].
Floor Activity:
Passed House - Amended: 4/15/15, 98-0.

Brief Summary of Second Substitute Bill
(As Amended by House)

- Requires the Department of Social and Health Services (DSHS) to conduct a review in the event of a near fatality of a child who is in the care of or receiving services from the DSHS, who has been in the care of or received services from the DSHS within three months preceding the near fatality, or who was the subject of an investigation by the DSHS for possible abuse or neglect.
- Requires the DSHS to conduct a review when a case worker responds to an allegation of child abuse or neglect and there is a subsequent allegation resulting in a near fatality within one year, and to conduct an employee investigation if any violations are found.

HOUSE COMMITTEE ON EARLY LEARNING & HUMAN SERVICES

Majority Report: Do pass as amended. Signed by 11 members: Representatives Kagi, Chair; Walkinshaw, Vice Chair; Walsh, Ranking Minority Member; Scott, Assistant Ranking Minority Member; Dent, Hawkins, Kilduff, McCaslin, 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.

Staff: Ashley Paintner (786-7120).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass as amended by Committee on Early Learning & Human Services as further amended by Committee on Appropriations. Signed by 32 members: Representatives Hunter, Chair; Ormsby, Vice Chair; Chandler, Ranking Minority Member; Parker, Assistant Ranking Minority Member; Wilcox, Assistant Ranking Minority Member; Buys, Carlyle, Cody, Condotta, Dent, Dunshee, Fagan, Haler, Hansen, Hudgins, G. Hunt, S. Hunt, Jinkins, Kagi, Lytton, MacEwen, Magendanz, Pettigrew, Sawyer, Senn, Springer, Stokesbary, Sullivan, Taylor, Tharinger, Van Werven and Walkinshaw.

Staff: Mary Mulholland (786-7391).

Background:

Child Fatality Reviews.
The Department of Social and Health Services (DSHS) must conduct a child fatality review when a fatality is suspected of being caused by abuse or neglect of a minor who is in the care of or receiving services from the DSHS or a supervising agency, or the minor had been in care of the DSHS or a supervising agency within one year preceding the minor's death. The DSHS must consult with the Office of the Family and Children's Ombuds (OFCO) to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.

The DSHS must assure that persons assigned to a child fatality review team have no previous involvement in the child's case and that the review team includes individuals who have professional expertise pertinent to the dynamics of the case under review. Within 180 days of the fatality, the DSHS must issue a report of the results of the review. Reports must be distributed to the Legislature and posted online. A child fatality review report is subject to public disclosure. The DSHS is expressly authorized to redact confidential information contained in a review report according to existing state and federal laws protecting the privacy of victims of child abuse and neglect, including laws regarding the confidentiality of postmortem and autopsy reports.

Near Child Fatality Reviews.
The DSHS must notify the OFCO in the event of a near fatality under the following circumstances:

- a near fatality of a child who is in the care of or receiving services from the DSHS or a supervising agency; or
- a near fatality of a child who had been in the care or receiving services from DSHS or a supervising agency within one year preceding the near fatality.

The DSHS may conduct a review of the near fatality at its discretion or at the request of the OFCO.

The Office of the Family and Children's Ombuds.

In 1996 the Legislature established the 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 DSHS 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 DSHS and the OFCO issue reports and recommendations to the Legislature. The stated purpose of the child fatality review process is 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 Amended Bill:

The DSHS must conduct a near fatality review and notify the OFCO under the following circumstances:

- a near fatality of a child who is in the care of or receiving services from the DSHS or a supervising agency;
- a near fatality of a child who has been in the care of or received services from the DSHS or a supervising agency within three months preceding the near fatality; or
- a near fatality of a child who was the subject of an investigation by the DSHS for possible abuse or neglect.

A near fatality is defined as an act that, as certified by a physician, places the child in serious or critical condition.

The DSHS must conduct a review when a DSHS case worker or other employee responds to an allegation of child abuse or neglect that is screened in and open for investigation and there is a subsequent allegation of abuse or neglect that is screened in and open for investigation resulting in a near fatality within one year of the initial allegation. The DSHS's review must examine the case worker's and case worker's supervisor's case files and actions taken during the initial report of alleged abuse or neglect. The stated purpose of this review is to determine if there were any errors by the employees under the DSHS policy, rule, or state statute. If violations of policy, rule, or statute are found through the initial review, the DSHS must conduct a formal employee investigation.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: 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) When there is a near child fatality that involves a child in the care of the DSHS, this bill would require a mandatory review of that case. Requiring a near fatality review would give the public more confidence in the DSHS and their ability to care for the state's

most vulnerable children. The bill requires employee reviews after a second allegation of abuse or neglect. However, if the DSHS does not find any violations during the employee review, nothing further would happen. The near fatality review and the employee review will provide opportunities for the agency to improve and will allow for a review process that adds more transparency and accountability.

(With concerns) The bill requires a near child fatality review when the child has been in the care of or received services from the DSHS within three months preceding the near fatality. This would likely add only two or three additional near child fatality reviews to the DSHS caseload. The current language that refers to the social worker's and supervisor's files could easily be interpreted to mean both case files and personnel files. If this language could be clarified to include just case files, the DSHS would be more comfortable with the bill. Additionally, there are concerns around the timing of the investigations that could potentially raise arbitration issues due to the length of time between the incident and the employee investigation. Another possible concern the DSHS has is around employee investigations and disciplinary actions. It appears that an employee could be investigated twice for the same issue under this bill and the DSHS is prohibited from disciplining an employee twice for the same error. The DSHS will work with members to provide possible revisions.

(Opposed) None.

Staff Summary of Public Testimony (Appropriations):

(In support) None.

(Opposed) None.

Persons Testifying (Early Learning & Human Services): (In support) Senator O'Ban, prime sponsor.

(With concerns) David DelVillar Fox, Children's Administration.

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.