SENATE BILL REPORT
ESHB 1126

As of April 1, 2015

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: Passed House: 3/04/15, 86-11.
Committee Activity: Human Services, Mental Health & Housing: 3/16/15, 3/24/15 [DPA-WM, w/oRec].
Ways & Means: 4/06/15.

SENATE COMMITTEE ON HUMAN SERVICES, MENTAL HEALTH & HOUSING

Majority Report: Do pass as amended and be referred to Committee on Ways & Means.
Signed by Senators O'Ban, Chair; Miloscia, Vice Chair; Darneille, Ranking Minority Member; Hargrove.

Minority Report: That it be referred without recommendation.
Signed by Senator Padden.

Staff: Alison Mendiola (786-7444)

SENATE COMMITTEE ON WAYS & MEANS

Staff: Breann Boggs (786-7433)

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 DSHS or a supervising agency, or the minor had been in care of DSHS or a supervising agency within one year preceding the minor's death. 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.

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.

Within 180 days of the fatality, 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. 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 Fatality Child Reviews. In the event of a near fatality of a minor in the care of or receiving services from DSHS or a supervising agency, or a minor who had been in the care or receiving services from DSHS or a supervising agency, within one year of the preceding near fatality, DSHS must notify the Office of the Family and Children's Ombuds (OFCO). DSHS may conduct a review at its discretion or at the request of OFCO.

A child fatality or near-fatality review is subject to discovery in a civil or administrative proceeding. However, any use or admission into evidence is limited as follows:

- Employees of DSHS cannot be questioned in a civil or administrative proceeding relating to the work of the child fatality review team, the incident under review, or the employee's statements, thoughts, or impressions or those of the review team members or others who provided information to the review team.
- A witness may not be examined regarding the witness's interactions with the child fatality or near-fatality review, including whether the person was interviewed during the review, questions asked during the review, and answers provided by the person.
- Documents prepared for a review team are inadmissible in a civil or administrative proceeding. Documents that existed before use or consideration by the review team or that were created independently of a fatality or near-fatality review may still be admissible. The limitation also does not apply to licensing or disciplinary proceedings relating to DSHS' efforts to revoke or suspend a license based on allegations of misconduct or unprofessional conduct connected with a near fatality or a fatality being reviewed.

OFCO. OFCO was created in 1996 to protect children and parents from harmful agency action or inaction, and to make agency officials and state policymakers aware of system-wide issues in the child protection and child welfare system. OFCO is part of the Governor's Office and operates independently from DSHS and other state agencies, acting as a neutral fact finder, not as an advocate. OFCO's responsibilities include investigating complaints related to child protective services or child welfare services, monitoring the procedures used by DSHS in delivering family and children's services, and providing information about the rights and responsibilities of individuals receiving family and children's services and the procedures for providing those services.

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

Summary of Bill (Recommended Amendments): 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, DEL must consult with OFCO to determine if a review should be conducted. 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.

The child fatality review committee must be comprised of individuals with appropriate, including but not limited to, experts from outside 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. DEL must invite one parent or guardian for membership on the committee who had a child die in a child care setting. DEL must ensure that the committee is made up of individuals who had no previous involvement in the case. While conducting the review, 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.

The child fatality review committee must coordinate with local law enforcement to ensure that the review does not interfere with any ongoing or potential criminal investigation.

The primary purpose of the fatality review must be the development of recommendations to DEL and the Legislature regarding changes in licensing requirements, practice, or policy to prevent fatalities and strengthen safety and health protections for children.

EFFECT OF CHANGES MADE BY HUMAN SERVICES, MENTAL HEALTH & HOUSING COMMITTEE (Recommended Amendments): It is clarified that nothing in this act creates a duty for OFCO to respond to complaints regarding children in the care of an early learning program, a licensed child care center, or a licensed child care home.

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 Engrossed Substitute House Bill (Human Services, Mental Health & Housing): PRO: Currently DEL has no authority to review fatalities or near fatalities that occur in the Early Childhood Education and Assistance Program or licensed child care centers and homes. There were two fatalities last year, one involved a constituent who lost a three-month-old baby from SIDS in daycare. Maybe the outcome would have been different if there were fatality reviews to develop best practices. It helps to have outside experts, like an accident review when a plane crashes.

OTHER: We support the intent. OFCO would review the fatalities and communicate whether a near fatality review should be done.

Persons Testifying (Human Services, Mental Health & Housing): PRO: Representative Kagi, prime sponsor.

OTHER: Patrick Dowd, OFCO.

Persons Signed in to Testify But Not Testifying: No one.