SENATE BILL REPORT
2SSB 5888

As Amended by House, 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: Human Services, Mental Health & Housing: 2/17/15, 2/19/15 [DPS-WM].
Ways & Means: 2/25/15, 2/27/15 [DP2S].
Passed Senate: 3/05/15, 48-0.
Passed House: 4/15/15, 98-0.

SENATE COMMITTEE ON HUMAN SERVICES, MENTAL HEALTH & HOUSING

Majority Report: That Substitute Senate Bill No. 5888 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators O'Ban, Chair; Miloscia, Vice Chair; Darneille, Ranking Minority Member; Hargrove and Padden.

Staff: Alison Mendiola (786-7444)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Second Substitute Senate Bill No. 5888 be substituted therefor, and the second substitute bill do pass.

Signed by Senators Hill, Chair; Braun, Vice Chair; Dammeier, Vice Chair; Honeyford, Vice Chair, Capital Budget Chair; Hargrove, Ranking Member; Keiser, Assistant Ranking Member on the Capital Budget; Ranker, Ranking Minority Member, Operating; Bailey, Becker, Billig, Brown, Conway, Fraser, Hasegawa, Hatfield, Hewitt, Kohl-Welles, O'Ban, Padden, Parlette, Rolfes, Schoesler and Warnick.

Staff: Breann Boggs (786-7433)

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.

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.

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 the 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's 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. The 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. The 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. The 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. To perform these duties, the OFCO has authority:

- to interview children in state care;
- to access, inspect, and copy all records, information, or documents in DSHS' possession that the OFCO considers necessary to conduct an investigation; and
- to have unrestricted online access to the case and management information system operated by DSHS.

The OFCO must issue an annual report to the Legislature on the implementation of the recommendations from reviews of child fatalities.

Summary of Second Substitute Bill: 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 receiving such care in the preceding three months of the near fatal incident, DSHS must notify OFCO and conduct a review of the near fatality.

When a social worker or other employee of DSHS responds to an allegation of child abuse or neglect and there is a subsequent allegation of abuse or neglect resulting in a near fatality within one year of the initial allegation that is screened in and open for investigation by DSHS, DSHS must immediately conduct a review of the social worker's and social worker's supervisor's files and actions taken during the initial report of alleged child abuse or neglect. The purpose of the review is to determine if there were any errors by the employees under DSHS policy, rule, or state statute. If any violations of policy, rule, or statute are found, DSHS must conduct a formal employee investigation. The review conducted by DSHS is subject to the same restrictions governing admissibility of evidence as the fatality reviews and near fatality reviews.

Near fatality means an act that, as certified by a physician, places the child in serious or critical condition.

The Act is to be known as Aiden's Act.

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 Original Bill (Human Services, Mental Health & Housing): PRO: Only fatality reviews are mandatory, near fatality reviews are optional although DSHS usually does them. There really is no good reason to not make near fatality reviews mandatory, it's about basic accountability. We need greater trust in our system. In the case of Aiden Barnum, the social worker was never investigated. Social workers have a difficult job and an injury doesn't mean they made a mistake, but it's not unreasonable to think the steps taken would be reviewed, to develop best practices. Because DSHS cares for our most vulnerable members of society we need transparency and accountability. In this specific case, absent a court order, DSHS claimed they owed no duty of care to Aiden and that no future harm would be done to him. The child didn't have to be removed, this is about

removing kids from the home, it's look at what options are available that are in the best interest of the child. The father could have left the home, the biological mother was able to care for Aiden, as were Aiden's grandparents. There were lots of tools in Child Protective Services' toolkit, but they didn't take advantage of these options. Not only was there no investigation into the social worker's actions but she was recently promoted.

OTHER: There should be language in the bill that a fatality or near fatality review doesn't interfere with a ongoing criminal investigation by law enforcement.

Persons Testifying (Human Services, Mental Health & Housing): PRO: Senator O'Ban, prime sponsor; Melissa and Bill Barnum, private citzens; Phil Talmadge, Talmadge Fitzpatrick Tribe for the Barnums.

OTHER: Mitch Barker, WA Assn. of Sheriffs and Police Chiefs; Patrick Dowd, OFCO.

Staff Summary of Public Testimony on Substitute (Ways & Means): None.

Persons Testifying (Ways & Means): No one.

House Amendment(s): Clarifying amendments specify that the employee review following a near fatality is triggered when an allegation of child abuse and neglect is screened in and open for review, and that the review is of the case worker's and case work supervisor's case files. The term case worker is substituted for social worker.