SENATE BILL REPORT
SB 5163

As of February 14, 2025

Title: An act relating to modernizing the child fatality statute.

Brief Description: Modernizing the child fatality statute.

Sponsors: Senators Orwall, Shewmake, Dhingra, Conway, Cleveland, Wellman, Hasegawa, Riccelli, Saldaña, Nobles, Valdez and Wilson, C..

Brief History:
Committee Activity: Human Services: 1/22/25, 1/29/25 [DPS-WM].
Ways & Means: 2/17/25.

Brief Summary of First Substitute Bill

- Allows local health department child fatality review teams to collect new sources of data and reports from medical providers, law enforcement, criminal justice, social services, and school records.
- Directs that records must be provided to local health departments when requested.
- Permits the child fatality review team to designate a member of the review team to report any current, unresolved concern about child abuse or neglect.
- Clarifies that individuals associated with child fatality reviews are not prohibited from testifying in civil, criminal, or administrative actions when they are doing so based on information or personal knowledge obtained independently of the child fatality review or relying on public information.

SENATE COMMITTEE ON HUMAN SERVICES

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

Majority Report: That Substitute Senate Bill No. 5163 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Wilson, C., Chair; Frame, Vice Chair; Christian, Ranking Member; Orwall and Warnick.

Staff: Will Trondsen (786-7552)

SENATE COMMITTEE ON WAYS & MEANS

Staff: Monica Fontaine (786-7341)

Background: The stated intent of the Legislature is to encourage child death reviews by local health departments so that preventable causes of child mortality can be identified and addressed in order to reduce the infant and child mortality rate in Washington State. The Department of Health (DOH) supports local health departments that conduct child mortality reviews.

According to DOH, child mortality reviews is a process used to prevent injury and death of children by identifying circumstances leading to the children's deaths, correcting and reporting accurate and uniform information, improving interagency coordination around children's health and safety issues, and identifying and implementing systems, policy and environmental changes to prevent children's deaths.

Child mortality reviews may include:

- a systematic review of medical, clinical, and hospital records;
- home interviews of parents and caretakers of children who have died; and
- analysis of individual case information and review of this information by a team of professionals in order to identify modifiable medical, socioeconomic, public health, behavioral, administrative, educational, and environmental factors associated with each death.

All healthcare information collected during a child fatality review is confidential and not subject to public disclosure. No identifying information related to the deceased child, the child's guardians, or anyone interviewed as part of the child mortality review may be disclosed. Any witness statements, documents collected from witnesses, or records created for the purposes of a child mortality review are not subject to public disclosure. Local health departments may publish statistical compilations and reports related to the mortality review without identifying individual cases and sources of information.

A person on the review team is not prohibited or restricted from reporting suspected child abuse or neglect, nor does it limit access to any records or information arising out of such a report and ensuing action.

DOH is to assist local health departments collect the reports of any child mortality reviews,

assist with entering the reports into a database, provide technical assistance and encourage communication among child death review teams using only federal and private funding.

Summary of Bill (First Substitute): The local health department that is conducting the child fatality review may request and receive data from specific fatalities, including:

- all medical records, autopsy reports, medical examiner reports, and coroner reports;
- school, criminal justice, law enforcement, and social services records;
- local health care providers and clinics;
- the Health Care Authority and its licensees and providers; and
- the Department of Social and Health Services and the Department of Children, Youth, and Families.

All requested records and data by the review team must be provided upon request by the review team.

Information submitted to DOH or local health departments is not subject to public disclosure, discovery, subpoena or introduction into evidence in any administrative, criminal, or civil proceeding related to the death of a child reviewed, excluding information that would require a disclosure in conflict with state or federal law.

Local health departments are allowed to retain identifiable information and geographic information on each case for the purpose of determining trends, performing analysis over time, and for quality improvement efforts. Information retained by local health departments that include identification and location of person is not subject to public disclosure.

The team may designate a member from the child fatality review team to report any current, unresolved concern about child abuse or neglect.

A person associated with child fatality reviews is allowed to testify about evidence being introduced in civil, criminal, or administrative actions when it is based on information or personal knowledge obtained independently of the child fatality review or relies on public information.

Reports may be published by DOH or local health departments so long as all identifiable information is redacted. These reports may be used to help develop and coordinate state-wide child fatality prevention strategies and interventions.

Children fatality reviews are increased to age 19 to capture 18-year-old individuals.

Replaces the existing language of mortality with fatality throughout the bill and strikes language that required use of only federal and private funding for child fatality reviews.

EFFECT OF CHANGES MADE BY HUMAN SERVICES COMMITTEE (First Substitute):

- Excludes disclosures from child fatality review teams that would violate Washington State law.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Original Bill (Human Services): *The committee recommended a different version of the bill than what was heard.* PRO: Stakeholders worked to update the bill over the interim. Establishing a clear process for mandated reporting that removes redundancy. This bill includes updates to data access and privacy restrictions, a slight change ensures that the review team receives all the information they need, and tightens up that confidentiality to protect child and family information that needs to remain confidential. Further balances and reinforces the balance needed with state partners. Technical issue was fixed with this proposal that while impacting a small area of prosecution it was important to fix. This bill does it.

OTHER: The purpose of child fatality reviews is to create policy and help prevent child deaths. This bill strengthens the ability for local health departments to do that and for the DOH to do their work. The updates will help make sure that that data is captured locally and used to analyze statewide trends. Everyone worked together to make this bill happen this session.

Persons Testifying (Human Services): PRO: Senator Tina Orwall, Prime Sponsor; Russell Brown, WA Association of Prosecuting Attorneys; Jaime Bodden, WSALPHO.

OTHER: Katie Eilers, Washington State Department of Health.

Persons Signed In To Testify But Not Testifying (Human Services): No one.