SENATE BILL REPORT
SB 5643

As of February 26, 2025

Title: An act relating to expanding child fatality and near fatality reviews to include those in the care or custody of the department of children, youth, and families pursuant to chapter 13.40 RCW.

Brief Description: Expanding the purview of child fatality and near fatality reviews.

Sponsors: Senator Christian.

Brief History:
Committee Activity: Human Services: 2/10/25, 2/12/25 [DPS-WM].
Ways & Means: 2/20/25.

Brief Summary of First Substitute Bill

- Expands child fatality and near fatality reviews conducted by the Department of Children, Youth, and Families (DCYF) to include those in the care or custody of DCYF, including juvenile rehabilitation facilities.
- Directs DCYF to make near fatality reviews mandatory.
- Directs DCYF to grant the Office of Family and Children Ombuds physical access to state institutions serving children, youth, and individuals, and state licensed facilities or residences as well as unrestricted online access to the juvenile rehabilitation case management system.
- Provides that near fatalities includes an overdose of any controlled substance under Chapter 69.50 RCW.

SENATE COMMITTEE ON HUMAN SERVICES

Majority Report: That Substitute Senate Bill No. 5643 be substituted therefor, and the

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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: Alison Mendiola (786-7488)

SENATE COMMITTEE ON WAYS & MEANS

Staff: Josh Hinman (786-7281)

Background: Fatality Reviews. The Department of Children, Youth, and Families (DCYF) conducts a fatality review when a child dies and the family was involved in the child welfare system within the preceding 12 months of the child's death, or when the fatality occurred in a DCYF licensed, certified, or state operated facility.

In any case where it can not be determined whether a child's death is the result of suspected child abuse or neglect, DCYF is to consult with the Office and Family and Children's Ombuds (OFCO) to determine if a child fatality review should be conducted.

Upon the conclusion of a child fatality review, DCYF has six months following the fatality to issue a report on the results of the review, unless an extension has been granted by the Governor. Reports are distributed to the appropriate committees of the Legislature as well as posted on DCYF's website. Such reports are subject to public disclosure, with confidential information redacted.

Near Fatality Reviews. A near fatality occurs when a child is placed in serious or critical condition, as certified by a physician, and that near fatality is a result of alleged child abuse, or neglect, or both, and the family was involved in the child welfare system within the preceding 12 months or the near fatality occurred in a DCYF licensed, certified, or state-operated facility. DCYF is to promptly notify OFCO in the event of a near fatality of a child who is in the care of or receiving services from DCYF or a supervising agency or who has been in the care of or received services from DCYF or a supervising agency within one year preceding the near fatality. DCYF may conduct a review of the near fatality at its discretion or at the request of OFCO.

The fatality review committee consists of individuals with no prior involvement with the case, and typically includes DCYF staff, OFCO staff, and community professionals with expertise relevant to the case, such as a law enforcement officials, chemical dependency treatment providers, domestic violence providers, mental health treatment providers, child health providers, or social work practice specialists.

In any review of a child fatality or near fatality in which a child was placed with or received services from an agency pursuant to a contract with DCYF, DCYF and that the fatality review team is to have access to all records and files regarding the child or otherwise

relevant to the review that have been produced or retained by the agency.

A child fatality or near fatality review is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding, excepted as provided by statute.

A DCYF employee responsible for conducting a child fatality or near fatality review, or member of the child fatality or near fatality review team, may not be examined in a civil or administrative proceeding regarding: (1) the work of the team, (2) the incident under review, (3) the employee's statements, deliberations, thoughts, analyses, or impressions relating to the work of the child fatality or near fatality review team, or (4) any person who provided information to the child fatality or near fatality review team, relating to the work of the child fatality or near fatality review team or the incident under review.

Documents prepared by or for a child fatality or near fatality review team are inadmissible and may not be used in a civil or administrative proceeding. Any documents that exists before its use or consideration in a child fatality or near fatality review, or that is created independently of such review, does not become inadmissible merely because it is reviewed or used by a child fatality or near fatality review team. A person is not available as a witness merely because the person has been interviewed by or has provided a statement for a child fatality or near fatality review, but if called as a witness, a person may not be examined regarding the person's interactions with the child fatality or near fatality review. A person can testify fully in any proceeding regarding his or her knowledge of the incident under review.

Restrictions related to a child fatality or near fatality review do not apply in licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend the license of any licensed professional based in whole or in part upon allegations of wrongdoing in connections with a minor's death or near fatality by a child fatality or near fatality review team.

In regards to a child fatality or near fatality review, DCYF shall:

- allow the ombuds or the ombud's designee to communicate privately with any child in the custody of DCYF, or any child who is part of a near fatality investigation by DCYF, in relation to OFCO's duties in a child fatality or near fatality review;
- permit the ombuds or the ombuds designee physical access to state institutions serving children, and state licensed facilities or residences for the purposes of carrying out its duties in a child fatality or near fatality review;
- upon the ombud's request, grant the ombuds or the ombud's designee the right to access, inspect, and copy all relevant information, records or documents in the possession or control of DCYF that the ombuds considers necessary in an investigation; and
- grant OFCO unrestricted online access to the child welfare case management information system, and the DCYF data information system.

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

OFCO does not have a duty related to children in the care of an Early Learning Program, a licensed child care center, or a licensed child care home.

Summary of Bill (First Substitute): Child fatality and near fatality reviews are expanded to include those in the care or custody of DCYF, including juvenile rehabilitation facilities. Near fatality reviews are mandatory. Additionally, DCYF must conduct a fatality or near fatality review suspected to be caused by abuse or neglect that happened while the child, youth, or individual was in a juvenile rehabilitation managed facility.

DCYF is to grant OFCO physical access to state institutions serving youth and individuals and unrestricted access to the juvenile rehabilitation case management system.

Child, youth, or individual includes any person in the state's care or in state-licensed facilities or residences and juvenile rehabilitation facilities who is receiving services from DCYF.

Near fatality means an act, including an overdose of any controlled substance under Chapter 69.50 RCW, that, as certified by a physician places the child, youth, or individual in serious or critical condition.

Abuse or neglect has the same meaning as in RCW 26.44.020.

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

DCYF shall also conduct a fatality or near fatality review suspected to be caused by abuse or neglect that happened while the child, youth, or individual was in a juvenile rehabilitation managed facility.

Appropriation: None.

Fiscal Note: Requested on February 4, 2025.

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: It is surprising to find out that DCYF is not conducting fatality and near fatality reviews on those in the

custody of JR. This bill will shed light on these issues.

OTHER: The Office of the Family and Children's Ombuds (OFCO) received several complaints about individuals placed at Green Hill School last year. Currently, OFCO's statutory authority does not clearly define OFCO's role in relation to youth and young adults in JR managed facilities. This bill clarifies OFCO's authority to respond to concerns about the welfare of both youth and young adults in JR facilities and most importantly it communicates to the residents of these facilities, their families, and the community that OFCO is a resource that can respond to their concerns in an independent objective and confidential manner. This bill expands the scope of child fatalities and near fatalities conducted by DCYF to include these critical incidents that occur at JR facilities and specifically those incidents that are caused by drug overdose. However, as the bill is currently written, this would include a fatality or near fatality that occurs 12 months after an individual is discharged from receiving services from JR and it's unclear if that was the actual intent of this legislation. Alternatively, those reviews might be limited to critical incidents that occur while a person is residing at a JR facility. JR does have a critical incident review team that currently reviews fatalities, near fatalities, and other critical incidents within JR facilities and this process might be modified to serve the goals of this bill rather than creating a separate and duplicate process. OFCO's ability to effectively respond to complaints about JR facilities and participate in additional critical incident reviews is contingent on additional staff resources.

Persons Testifying (Human Services): PRO: Senator Leonard Christian, Prime Sponsor.

OTHER: Patrick Dowd, Washington State Office of the Family and Children's Ombuds.

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