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TESTIMONY ON HB 2165
Concerning Department of Early Learning Fatality Reviews

HOUSE COMMITTEE ON EARLY LEARNING & HUMAN SERVICES

Thursday, January 16, 2014

House Hearing Room C

John L. O'Brien Building, 10:00 a.m.

Good morning Madame Chair Kagi and members of the committee, my name is Mary Meinig and I am the Director of the Office of the Family & Children's Ombuds ("OFCO").

While OFCO remains neutral on specific proposed legislation, we support the intent of this legislation to establish a system whereby the Department of Early Learning (DEL) must conduct a child fatality review if a child fatality occurs in an early learning program, a licensed child care center, or a licensed child care home.

Currently, OFCO internally reviews child fatalities when the child is identified as having had history with Children's Administration (CA) within the last calendar year. CA is statutorily required to conduct a child fatality review when the death of a child was suspected to be caused by child abuse or neglect, and the child was in the care of or receiving services from CA at the time of death, or in the year prior.¹ If it is not clear whether a child's death was the result of abuse or neglect, CA must consult with OFCO to determine if a review should be conducted. The CA Assistant Secretary convenes an Executive Child Fatality Review (ECFR) team comprised of professionals with relevant expertise who have no prior involvement in the case.

¹ See RCW 74.13.640. Prior to the passage of SHB 1105 in 2011, CA was required to review any unexpected deaths of children who were in the care of or receiving services from CA, or had received care or services in the last year.

The purpose of reviewing child fatalities is to increase the agency's understanding of the circumstances around the child's death and to evaluate practice, programs, and systems to improve the health and safety of children.² The department must issue a report on child fatality review results within 180 days following the fatality, unless granted an extension by the Governor.³ These reports are subject to public disclosure and must be posted on the department's public website. The department is authorized to redact confidential information contained in these reports to protect the child's privacy.⁴

OFCO actively participates on the ECFR and releases an annual report as to the implementation status of recommendations made in child fatality reviews conducted by CA.⁵

At this time, child fatalities that occur in DEL programs, licensed centers, or licensed child care homes are not investigated or reviewed by an external committee, even if there is an allegation of abuse or neglect related to the fatality. This legislation would close that gap. Just as we learn valuable—albeit heartbreaking—lessons when, as a community, we conduct a review in response to a child death when the child is involved with CA, we should endeavor to learn lessons when a child death occurs in a child care program, facility, or home licensed by the State of Washington.

In OFCO's experience, the number of child deaths and near deaths that occur annually in licensed DEL facilities are very few. In fact, over the last two years (2012 and 2013) there have been *zero* near fatalities in DEL facilities. As for fatalities, in 2012 there were two, and in 2013 there were three. Fatalities and near fatalities are a rare occurrence—however, when these tragedies do occur, OFCO believes it is important to share critical information with the community given what is at stake for the thousands of children and families who utilize DEL licensed facilities.

The bill outlines the role and composition of the DEL child fatality review committee. It also requires DEL to consult with OFCO to determine whether a review should be conducted in cases of *near* fatalities. This is a role that OFCO already fulfills with CA and is prepared to take on in collaboration with DEL.

² See DSHS CA Operations Manual, Section 5200 at http://www.dshs.wa.gov/ca/pubs/mnl_ops/chapter5.asp#5200.

³ *Id.*

⁴ Individual child fatality reports are available at: www.dshs.wa.gov/ca/pubs/fatalityreports.asp.

⁵ OFCO's most recent report on the implementation of child fatality recommendations was published in June 2013 and can be found here: http://www.governor.wa.gov/ofco/reports/implementation_recommendations_2013.pdf.

Ultimately, this bill creates a fatality review system that mirrors what CA has been doing for several years. OFCO supports the notion that child deaths should be reviewed when they occur under a state agency's watch—whether that be CA or DEL.

Thank you for the opportunity to provide you with our testimony on this legislation.