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Written Testimony to be Incorporated into the Record on SHB 1303

WRITTEN TESTIMONY ON SHB 1303

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE
Wednesday, March 25
John L. O'Brien Building, House Hearing Room E, 8:00 a.m.

Thank you for this opportunity to provide written testimony on Substitute House Bill 1303. My name is Mary Meinig and I am the Director of the Office of the Family & Children's Ombudsman (OFCO). Our office does not take a partisan position in favor of or opposition to particular legislation, but we appreciate this opportunity to testify on SHB 1303.

Substitute House Bill 1303 recognizes that child mortality reviews, or fatality reviews, help identify and address preventable causes of child deaths.

OFCO reviews all fatalities of children who have died while in the care of the Department of Social and Health Services or whose family had an open case to DSHS within a year of the child's death. We agree that conducting these reviews is essential to figuring out what went wrong and identifying how we can do better to keep these children safe. OFCO attends Executive Fatality Reviews convened by DSHS.

In our 2005 Annual report, we highlighted concerns that Washington State does not currently have a coordinated statewide fatality review process. *Additionally, there is no unified database to compare fatalities that Children's Administration (and OFCO) reviews with all child fatalities in the state. This means that we do not have the ability to compare rates of children dying within and without of the child welfare system. We have observed an increase in child fatalities where DSHS had some involvement, but do not have the ability to readily compare this to the larger state population to determine if this is part of an overall statewide trend.*

We also found in our 2005 annual report that investigative resources among counties were not equally matched*. This means that some children who die in a county with fewer or less sophisticated resources either did not have their death investigated or there was a lack of parity in the quality of the investigation and possibly in the conclusions that were drawn about the manner and cause of death.*

We support SHB 1303's directive to the Department of Health to:

1) Assist local health departments to collect the reports of any child mortality reviews conducted by local health departments and enter the reports into a database; [***We believe that if DOH established a statewide process, we would have more reliable information about what is happening across the state. We need reliable data in order to properly analyze and evaluate the problem. This requires technical expertise. SHB 1303 is a step in the right direction and addresses significantly the recommendation in our 2005 report that a coordinated effort between DOH and DSHS be reinstated to implement a statewide child fatality review process***].

2) Respond to requests for data from the database; and

3) Provide technical assistance to local health departments and child death review coordinators conducting such reviews and encourage communication among review teams.

In our 2005 annual report, we made two additional recommendations: 1) that a professional multidisciplinary technical team be established to assist DSHS in prioritizing and evaluating the usefulness of implementing recommendations from child fatalities; and 2) consistent methodology and terminology in the investigation of child deaths be implemented. Although SHB 1303 does not specifically provide for this, we believe it addresses the intent of our recommendations by calling for DOH to provide technical assistance to child death review coordinators, encouraging communication among child death review teams and providing for a unified database.

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