STATE OF WASHINGTON
OFFICE OF THE FAMILY AND CHILDREN'S OMBUDSMAN
6720 FORT DENT WAY, SUITE 240
TUKWILA, WA 98188
(206) 439-3870 • (800) 571-7321 • FAX (206) 439-3877

WRITTEN TESTIMONY ON SB 5043
SENATE COMMITTEE ON HUMAN SERVICES & CORRECTIONS
January 20, 2011
Senate Hearing Room 1, J.A. Cherberg Building, 10:00a.m.

Good morning Senator Hargrove and Members of the Committee. My name is Mary Meinig and I am the Director of the Office of the Family & Children's Ombudsman ("OFCO"). We welcome the opportunity to submit this written testimony on SB 5043.

In its capacity as a watchdog of the child protection and welfare system, OFCO routinely reviews child fatalities and near fatalities across the state in cases where the child was in the care of, or receiving child welfare services from, DSHS CA at the time of death, within one year of his or her death, or who died while in state licensed care.[1] Currently, CA conducts its own review of fatalities using the above criteria but limits such reviews to *unexpected* fatalities.

OFCO supports the intent of this legislation, which is to strengthen DSHS CA child fatality reviews, while promoting accountability and transparency in the process.

We think it is important that this legislation:

- **Allows the secretary of the department of social and health services or his or her designee to examine and obtain copies of confidential reports and records of autopsies or post mortems.**

    - OFCO has observed instances where lack of access to autopsies or post mortem reports inhibited the review teams' work. We believe that this provision will promote comprehensive review of child fatalities in a timely manner.

- **Narrows the criteria regarding which child deaths DSHS shall review.** Rather than conduct a review in "the event of an unexpected death," under this proposal, DSHS would now review deaths that are "suspected to be caused by child abuse or neglect".

[1] OFCO reports summarizing fatality and near fatality reviews are available at: http://www.governor.wa.gov/ofco/reports/default.asp

- We anticipate that this shift in criteria will decrease the number of deaths DSHS CA must review, and should allow DSHS CA to better focus its resources on deaths suspected to be caused to child abuse and neglect.

- OFCO will continue to monitor and review ***all*** child fatalities across the state where the child was in the care of, or receiving child welfare services from, DSHS CA at the time of death, within one year of his or her death, or who died while in state licensed care. If OFCO finds child abuse or neglect concerns regarding a fatality that DSHS CA did not, we retain the authority to request that DSHS CA conduct a thorough review. OFCO may also conduct its own independent review of the child's death.

- **Provides that the department shall consult with OFCO to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.**

    - Currently, DSHS CA does consult with OFCO on a case-by-case basis to determine whether a child fatality should be reviewed if it is not clear whether the incident meets DSHS CA review criteria at the outset. This measure promotes accountability in the review process.

- **Provides that the department may conduct a review of any near-fatality at its discretion or at the request of the OFCO.**

    - We believe that reviewing near-fatalities of children who are involved with the child welfare system is a worthwhile practice that will yield valuable lessons and opportunities for meaningful reform. But for emergency medical intervention, many near-fatalities would have been child fatalities.

    - Although this measure does not require DSHS CA to review near-fatalities at OFCO's request, it does promote accountability. If DSHS CA declines to conduct a review of a near-fatality at OFCO's request, OFCO retains the authority to conduct its own independent review of the near-fatality.

- **Provides that a child fatality review completed by the department is subject to public disclosure and must be posted on the public website.**

- This section both protects individual privacy as confidential information may be redacted as required by state laws, and promotes transparency of the review process and the conduct of the child welfare system.

- **Provides that in any review of a child fatality or near-fatality in which the child was placed with or received services from a supervising agency pursuant to a contract with the department, the department and the fatality review team shall have access to all records and files regarding the child or otherwise relevant to the review that have been produced or retained by the supervising agency.**

    - In light of the new 2106 legislation, and movement towards privatizing child welfare services, this provision could become central to obtaining the necessary records to conduct quality reviews in a timely manner.

Thank you for this opportunity to provide this written testimony on this proposal.