

Enrolled
Senate Bill 832

Sponsored by Senators GELSER, WAGNER, Representative STARK; Senators FAGAN, HEARD, Representatives BOSHART DAVIS, HAYDEN, KENY-GUYER, NOBLE, SPRENGER, WILDE, ZIKA

CHAPTER

AN ACT

Relating to child fatalities; creating new provisions; and amending ORS 419B.022 and 419B.024; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 419B.024 is added to and made a part of sections 2 to 5 of this 2019 Act.

SECTION 2. Definition. As used in sections 2 to 5 of this 2019 Act, “critical incident” means an incident that resulted in the death of a child if the Department of Human Services reasonably believes the death was the result of child abuse and:

- (1) The child was in the custody of the department at the time of death;**
- (2) The child, the child’s sibling or any other child living in the household with the child was the subject of a child protective services assessment by the department within the 12 months preceding the fatality;**
- (3) The child, the child’s sibling or any other child living in the household with the child had a pending child welfare or adoption case with the department within the 12 months preceding the fatality; or**
- (4) The child, the child’s sibling or any other child living in the household with the child was the subject of a report of abuse or neglect made to the department or a law enforcement agency within the 12 months preceding the fatality, whether or not the report was closed at screening without an investigation being commenced.**

SECTION 3. Policy statement. (1) The purpose of the Critical Incident Review Teams under sections 2 to 5 of this 2019 Act is to increase child safety by:

- (a) Rapidly drawing lessons from a particular critical incident for the improvement of systems administered by the Department of Human Services;**
- (b) Increasing the department’s accountability to the public;**
- (c) Evaluating and learning from cases designated as critical incidents;**
- (d) Ensuring timely responses by the department with respect to critical incidents and recommendations that result from critical incident reviews; and**
- (e) Increasing the department’s ability to address and recommend necessary changes to child welfare systems.**

(2) Reviews conducted by teams under sections 2 to 5 of this 2019 Act are in addition to and separate from reviews conducted by county multidisciplinary child abuse teams formed under ORS 418.747, statewide interdisciplinary teams formed under ORS 418.748 and the

department's child welfare protocols regarding Notification and Review of Child Fatalities and Notification and Review of Sensitive Issues.

SECTION 4. Final report. (1) Subject to subsection (2)(b) of this section, each Critical Incident Review Team assigned under ORS 419B.024 shall submit a detailed, written final report to the Department of Human Services no later than the 100th day following the date the department assigned the team.

(2)(a) Prior to publishing a final report under this section, the department shall take into consideration the following:

(A) Whether publication of the report is likely to compromise an ongoing investigation of a law enforcement agency, after the team has communicated with and obtained agreement of appropriate law enforcement agency representatives and the district attorney;

(B) Whether the report can be modified so as to permit publication of the report without compromising a law enforcement agency investigation; and

(C) Whether, as determined by the team with the advice and consultation of the Director of Human Services, the public interest outweighs the potential consequences to a law enforcement agency investigation as provided in ORS 192.345 (3).

(b) The director may extend the deadline for publication of the final report if the director determines that the report, even if modified, will compromise a law enforcement agency investigation and the public interest does not outweigh the potential consequences.

(3) Each final report must include, to the extent determined, at a minimum:

(a) A description of the critical incident.

(b) The date of the critical incident.

(c) The date the department first became aware of the fatality.

(d) The date the department or a law enforcement agency caused an investigation to be made under ORS 419B.020 to determine the nature and cause of the fatality.

(e) The date the findings in the case were entered under ORS 419B.026.

(f) The date the department assigned the team.

(g) The dates of, and number of members in attendance at, each meeting of the team.

(h) Whether the director appointed members of the public to the team.

(i) The date the team submitted the final report to the department.

(j) A description of all department contacts with the deceased child regarding the critical incident, including contacts with the deceased child's siblings or the deceased child's parents, foster parents or other caretakers. The description of the department's contacts under this paragraph must include a description of any relevant prior reports of abuse the department received involving the individuals identified in this paragraph. The description of relevant prior reports of abuse must include:

(A) A summary of the specific nature of any allegations of abuse;

(B) A summary of the assessment or investigation activities related to any allegations of abuse; and

(C) The disposition of the reports, including whether the reports were assigned for assessment or investigation.

(k) A description of any concerns the team has regarding actions taken or not taken by the department or law enforcement agencies in response to the critical incident or to the events that led to the critical incident.

(L) Any recommendations for improvements in the administration and oversight of the child welfare system that are specific to the critical incident and any historical information reviewed by the team.

(4) A final report under this section may include the team's recommendations regarding training and intervention to support the department personnel involved in responding to critical incidents.

(5) Each final report shall be written in a manner that respects the dignity of the child, the child's family and those involved in the critical incident case. Details about individuals involved in the case may not be included in the report unless the details are relevant to:

(a) The history of alleged abuse and neglect of the deceased child and the history of relevant alleged abuse and neglect of other children in the deceased child's home at the time of the critical incident and the deceased child's siblings.

(b) The exposure of the deceased child or any other children in the deceased child's home at the time of the critical incident to domestic violence or substance abuse.

(c) The history of the department's involvement with the family.

(d) The goal of constructively informing public policy related to child welfare, which may include public policies related to health care coordination, public health, suicide prevention, mental health and addiction services, poverty, law enforcement, chronic neglect, prevention services or other issues that affect the safety and well-being of Oregon families.

(6) A final report may not include the names of any person assigned to the team or any personally identifiable information regarding any person involved in the critical incident case, including but not limited to employees of the department, the Oregon Health Authority or law enforcement.

(7) Any statements contained in a final report or document created solely for the critical incident review process that are or may be construed as an admission of error, liability or violation of law, policy or practice are not admissible as evidence in any civil or administrative proceeding. This restriction does not apply to any document that existed prior to its use and consideration in a critical incident review or that is created independently of the critical incident review process.

SECTION 5. Website content. (1) After assigning a Critical Incident Review Team under ORS 419B.024, the Department of Human Services shall immediately make the following information regarding the critical incident available on the department's website:

(a) The date of the critical incident and the age of the deceased child.

(b) Whether the child was in the custody of the department at the time of the critical incident or the fatality.

(c) Whether there was an open abuse investigation under ORS 419B.020 regarding the child at the time of the critical incident or the fatality.

(d) The date the department assigned the team.

(e) The due date for the team's final report under section 4 of this 2019 Act.

(2)(a) The department shall publish the final report on the department's website no later than 10 days after the department receives the report from the team.

(b) The department may redact the final report for purposes of publication only as necessary to remove any confidential information or records that may not be disclosed under state or federal law.

(c) If the Director of Human Services delays the publication of a final report under section 4 (2)(b) of this 2019 Act, the department shall publish on the department's website:

(A) The status of and expected publication date for the report.

(B) Any information in the report that the department determines:

(i) Will not compromise a law enforcement agency investigation.

(ii) Does not require redaction under paragraph (b) of this subsection.

SECTION 6. ORS 419B.024 is amended to read:

419B.024. (1) **When the Department of Human Services becomes aware of a critical incident**, the department [of Human Services] shall assign a Critical Incident [Response] Review Team. [after the department becomes aware of a child fatality that was likely the result of child abuse or neglect within timelines for assignment established by rules adopted by the department if:]

[(a) The child was in the custody of the department at the time of death;]

[(b) The child, the child's sibling or any other child living in the household with the child was the subject of a child protective services assessment by the department within the 12 months preceding the fatality;]

[(c) The child, the child's sibling or any other child living in the household with the child had a pending child welfare or adoption case with the department within the 12 months preceding the fatality; or]

[(d) The child, the child's sibling or any other child living in the household with the child was the subject of a report of abuse or neglect made to the department or a law enforcement agency within the 12 months preceding the fatality, whether or not the report was closed at screening without an investigation being commenced.]

(2) The department shall assign the team required under subsection (1) of this section no later than the earlier of:

(a) Ten days after the department becomes aware of a fatality that the department reasonably believes is the result of child abuse; or

(b) Seven days after the department causes an investigation under ORS 419B.020 to be made into the nature and cause of a fatality when the department reasonably believes the fatality is the result of child abuse.

[(2)(a)] **(3)(a)** Members of the *[Critical Incident Response]* team shall include, at a minimum, the following:

(A) The Director of Human Services or a deputy director of the department;

(B) The lead department *[of Human Services]* personnel responsible for the administration and oversight of the child welfare system within the department or the lead personnel's deputy; and

(C) The department personnel responsible for media and communications.

(b) *[The following may be assigned to a Critical Incident Response Team:]* Members of the team may include:

(A) Members of the public, appointed by the director *[of Human Services]*, as appropriate;

(B) A juvenile court judge appointed by the Chief Justice of the Supreme Court; *[and]*

[(C) A state Senator appointed by the President of the Senate and a state Representative appointed by the Speaker of the House of Representatives.]

(C) A member of a local citizen review board established under ORS 419A.090 whose service area does not include the location where the critical incident occurred; or

(D) If the director determines it is appropriate to include one or more legislators as members of the team, up to one state Senator appointed by the President of the Senate and one state Representative appointed by the Speaker of the House of Representatives. A person is ineligible for appointment to a team under this subparagraph if the critical incident occurred in the person's district, the person had prior contact with or knowledge of the deceased child or the deceased child's family, or the person is a family member of any person associated with the case.

[(3)(a)] **(4)(a)** During the course of its review of the case, the *[Critical Incident Response]* team may include or consult with the district attorney from the county in which the **critical** incident *[resulting in the fatality]* occurred.

(b) All members of the team must attend meetings of the team in person, by telephone or by other two-way electronic communication device. A team member may not send a delegate to meetings of the team to appear on the member's behalf. Notwithstanding the provisions of this paragraph, a meeting of the team may be convened and held even if one or more members are unable to attend the meeting.

[(4)] **(5)(a)** All information and records available to the department *[of Human Services regarding the incident that led to the fatality shall be provided to Critical Incident Response]* **regarding the critical incident shall be provided to** team members. Information and records under this subsection include, but are not limited to, medical records, hospital records, records maintained by any state, county or local agency, police investigative data, coroner or medical examiner investigative data and social services records, as necessary to complete a case review under this section.

(b) Information and records provided to team members are confidential and may be disclosed only as necessary to carry out the purposes of the team's case review.

[(5)] (6) In reviewing the case to which the [*Critical Incident Response*] team has been assigned, the team shall, with the assistance and cooperation of the department [*of Human Services*]:

(a) Review [*and investigate*] the case with the primary focus on **the history of the safety and well-being of the child who was involved in the critical incident [*that led to the fatality*]** and any other children who may be impacted by the circumstances surrounding the **critical incident**.

(b) Document and make a part of the record of the case review all team conclusions and decisions.

(c) Complete the case review even if:

(A) The team concludes that the **critical incident [*that led to the fatality*]** was the result of the actions of one or more department employees or staff and that such actions were inconsistent with department policy or administrative rule[.]; **or**

(B) **The department's investigation into the critical incident results in a finding that the report of child abuse is unfounded or cannot be determined, as described in ORS 419B.026.**

(d) **Prepare and submit the final report required under section 4 of this 2019 Act.**

[(d) *Subject to subsection (6) of this section, submit an initial written report to the department that includes information about the team's case review status, team conclusions and recommendations at the time of the initial report and identification of systemic issues that the team has concluded led to the fatality. The initial report may not contain confidential information or records that may not be disclosed to members of the public. The initial report must be submitted as soon as possible but no later than 60 days following assignment of the team under this section.*]

[(e) *Subject to subsection (6) of this section and if the team's case review is not complete prior to preparation of an initial report, submit a progress report to the department every 30 days following submission of the initial report.*]

[(f) *Subject to subsection (6) of this section, submit a detailed final written report to the department upon conclusion of the team's case review that includes, but is not limited to:*]

[(A) *A description of the incident that resulted in the fatality and of the events that led to the incident;*]

[(B) *A description of any concerns raised by actions taken or not taken by the department or law enforcement agencies in response to the incident or to the events that led to the incident;*]

[(C) *Recommendations for improvements in the administration and oversight of the child welfare system that are specific to the case reviewed by the team;*]

[(D) *A description of actions that are necessary to implement the recommendations and of timelines, tasks and responsible individuals to implement the recommendations; and*]

[(E) *Methods to evaluate implementation of the recommendations and expected outcomes.*]

[(g) *Prepare a version of the final written report described in paragraph (f) of this subsection that does not contain confidential information or records that may not be disclosed and that may be made accessible to members of the public.*]

[(6)(a) *Prior to submitting an initial report, a progress report or a final report to the department as described in subsection (5) of this section, the Critical Incident Response Team shall take into consideration the following:*]

[(A) *Whether submission of the report is likely to compromise an ongoing investigation of a law enforcement agency, after the team has communicated with and obtained agreement of appropriate law enforcement agency representatives and the district attorney;*]

[(B) *Whether the report can be modified so as to permit submission of the report to the department without compromising a law enforcement agency investigation; and*]

[(C) *Whether, as determined by the team with the advice and consultation of the Director of Human Services, the public interest outweighs the potential consequences to a law enforcement agency investigation as provided in ORS 192.345 (3).*]

[(b) *The director may extend the deadline for submission of an initial report, a progress report or a final report if the director determines that a delay is reasonable or if the report, even if modified,*

will compromise a law enforcement agency investigation and the public interest does not outweigh the potential consequences.]

[(c) If the director delays the submission of a report under this subsection, the department's website must reflect the status of and expected submission date for the report.]

(7) If the [Critical Incident Response] team concludes that the **critical** incident [that led to the fatality] involves personnel matters relevant to the department [of Human Services], the [team] **department** shall refer the matters to the human resources or personnel divisions of the department.

(8) The [Critical Incident Response] team may meet, upon conclusion of a criminal investigation or prosecution arising out of a child fatality to which the team was assigned for review, with members of law enforcement that investigated the child fatality or with the prosecuting attorneys who prosecuted the case for the purpose of reviewing the conclusions and recommendations of the team and the reports prepared and submitted by the team.

(9) The department [of Human Services] shall adopt rules necessary to carry out the provisions of [this section] **sections 2 to 5 of this 2019 Act**. The rules adopted by the department shall substantially conform with the department's child welfare protocol regarding Notification and Review of Critical Incidents.

SECTION 7. ORS 419B.022 is amended to read:

419B.022. ORS 419B.023 and [419B.024] **sections 2 to 5 of this 2019 Act** shall be known and may be cited as "Karly's Law."

SECTION 8. Applicability. Sections 2 to 5 of this 2019 Act and the amendments to ORS 419B.022 and 419B.024 by sections 6 and 7 of this 2019 Act apply to Critical Incident Review Teams assigned on or after the effective date of this 2019 Act.

SECTION 9. Captions. The section captions used in this 2019 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2019 Act.

SECTION 10. (1) Sections 2 to 5 of this 2019 Act and the amendments to ORS 419B.022 and 419B.024 by sections 6 and 7 of this 2019 Act become operative on October 1, 2019.

(2) The Department of Human Services may take any action before the operative date specified in subsection (1) of this section that is necessary for the department to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the department by sections 2 to 5 of this 2019 Act and the amendments to ORS 419B.022 and 419B.024 by sections 6 and 7 of this 2019 Act.

SECTION 11. This 2019 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2019 Act takes effect on its passage.

Passed by Senate June 13, 2019

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Lori L. Brocker, Secretary of Senate

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Peter Courtney, President of Senate

Passed by House June 19, 2019

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Tina Kotek, Speaker of House

Received by Governor:

.....M,....., 2019

Approved:

.....M,....., 2019

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Kate Brown, Governor

Filed in Office of Secretary of State:

.....M,....., 2019

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Bev Clarno, Secretary of State