

STATE OF NEW YORK

6703--B

Cal. No. 733

IN SENATE

February 10, 2006

Introduced by Sens. SPANO, MEIER, LEIBELL -- read twice and ordered printed, and when printed to be committed to the Committee on Social Services, Children and Families -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- reported favorably from said committee, ordered to first and second report, ordered to a third reading, amended and ordered reprinted, retaining its place in the order of third reading

AN ACT to amend the social services law and the county law, in relation to fatality reviews in the deaths of abused children and children in the care of child protective services

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

1 Section 1. Section 422-b of the social services law, as added by chap-
2 ter 136 of the laws of 1999, is amended to read as follows:
3 § 422-b. Local and regional fatality review teams. 1. A fatality
4 review team may be established at a local or regional level, with the
5 approval of the office of children and family services, for the purpose
6 of investigating the death of any child whose care and custody or custo-
7 dy and guardianship has been transferred to an authorized agency, [~~or~~]
8 any child for whom child protective services has an open case, any child
9 for whom the local department of social services has an open preventive
10 services case, and in the case of a report made to the central register
11 involving the death of a child. A fatality review team may also investi-
12 gate any unexplained or unexpected death of any child under the age of
13 eighteen.
14 2. A local or regional fatality review team may exercise the same
15 authority as the office of children and family services with regard to
16 the preparation of a fatality report as set forth in paragraphs (b) and
17 (c) of subdivision five of section twenty of this chapter. Notwithstand-
18 ing any other provision of law to the contrary and to the extent
19 consistent with federal law, such local or regional fatality review team
20 shall have access to those client-identifiable records necessary for the
21 preparation of the report, as authorized in accordance with paragraph
22 (d) of subdivision five of section twenty of this chapter. A fatality

EXPLANATION--Matter in italics (underscored) is new; matter in brackets [~~-~~] is old law to be omitted.

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1 report prepared by a local or regional fatality review team and approved
2 by the office of children and family services satisfies the obligation
3 to prepare a fatality report as set forth in subdivision five of section
4 twenty of this chapter. Such report shall be subject to the same redis-
5 closure provisions applicable to fatality reports prepared by the office
6 of children and family services.

7 3. For the purposes of this section, a local or regional fatality
8 review team must include, but need not be limited to, representatives
9 from the child protective service, office of children and family
10 services, county department of health, or, should the locality not have
11 a county department of health, the local health commissioner or his or
12 her designee or the local public health director or his or her designee,
13 office of the medical examiner, or, should the locality not have a
14 medical examiner, office of the coroner, office of the district attorney
15 [~~or~~], office of the county attorney, local and state law enforcement,
16 [~~office of the medical examiner or coroner~~], emergency medical services
17 and a [~~physician or comparable medical professional~~] pediatrician or
18 comparable medical professional, preferably with expertise in the area
19 of child abuse and maltreatment or forensic pediatrics. A local or
20 regional fatality review team may also include representatives from
21 [~~public health agencies~~] local departments of social services, mental
22 health agencies, [~~schools and medical facilities, including hospitals or~~
23 ~~other appropriate agencies or institutions~~] domestic violence agencies,
24 substance abuse programs, hospitals, local schools, and family court.

25 4. A local or regional fatality review team established pursuant to
26 this section shall have access to all records, except those protected by
27 statutory privilege, within twenty-one days of receipt of a request.

28 5. Members of a local or regional fatality review team, persons
29 attending a meeting of a local or regional fatality review team, and
30 persons who present information to a local or regional fatality review
31 team shall have immunity from civil and criminal liability for all
32 reasonable and good faith actions taken pursuant to this section, and
33 shall not be questioned in any civil or criminal proceeding regarding
34 any opinions formed as a result of a meeting of a local or regional
35 fatality review team. Nothing in this section shall be construed to
36 prevent a person from testifying as to information obtained independen-
37 tly of a local or regional fatality review team or which is public infor-
38 mation.

39 6. All meetings conducted and all reports and records made and main-
40 tained, and books and papers obtained, by a local or regional fatality
41 review team shall be confidential and not open to the general public
42 except by court order and except for an annual report or a fatality
43 report, if the fatality review team chooses to complete such an annual
44 report or fatality report. The release of any fatality report prepared
45 by a local or regional fatality review team shall be governed by the
46 provisions of subdivision five of section twenty of this chapter. Any
47 such annual report or fatality report shall not contain any individually
48 identifiable information and shall be provided to the office of children
49 and family services upon completion. The office of children and family
50 services shall forward copies of any such report to all other local or
51 regional fatality review teams established pursuant to this section, to
52 all citizen review panels established pursuant to section three hundred
53 seventy-one-b of this chapter, and to the governor, the temporary presi-
54 dent of the senate and the speaker of the assembly.

55 § 2. Section 418 of the social services law, as amended by chapter 136
56 of the laws of 1999, is amended to read as follows:

1 § 418. Mandatory reporting to and post-mortem investigation of deaths
2 by medical examiner or coroner. Any person or official required to
3 report cases of suspected child abuse or maltreatment, including workers
4 of the local child protective service, as well as an employee of or
5 official of a state agency responsible for the investigation of a report
6 of abuse or maltreatment of a child in residential care, who has reason-
7 able cause to suspect that a child died as a result of child abuse or
8 maltreatment shall report that fact to the appropriate medical examiner
9 or coroner. The medical examiner or coroner shall accept the report for
10 investigation and shall issue a preliminary written report of his or her
11 finding within sixty days of the date of death, absent extraordinary
12 circumstances, and his or her final written report promptly, absent
13 extraordinary circumstances, to the police, the appropriate district
14 attorney, the local child protective service, the office of children and
15 family services, and, if the institution making the report is a hospi-
16 tal, the hospital. The office of children and family services shall
17 promptly provide a copy of [~~such a report~~] the preliminary and final
18 reports to the statewide central register of child abuse and maltreat-
19 ment.

20 § 3. Paragraph (a) of subdivision 5 of section 20 of the social
21 services law, as amended by chapter 136 of the laws of 1999, is amended
22 to read as follows:

23 (a) In the case of the death of a child whose care and custody or
24 custody and guardianship has been transferred to an authorized agency,
25 or the death of a child for whom any local department of social services
26 has an open child protective services or preventive services case, or in
27 the case of a report made to the central register involving the death of
28 a child, the office of children and family services shall (i) investi-
29 gate or provide for an investigation of the cause of and circumstances
30 surrounding such death, (ii) review such investigation, and (iii)
31 prepare and issue a report on such death, except where a report is
32 issued by an approved local or regional fatality review team in accord-
33 ance with section four hundred twenty-two-b of this chapter.

34 § 4. Subdivision 8 of section 677 of the county law, as added by chap-
35 ter 136 of the laws of 1999, is amended to read as follows:

36 8. The coroner, coroner's physician or medical examiner shall
37 promptly, but in no event later than sixty days from the date of death,
38 absent extraordinary circumstances, provide the office of children and
39 family services with copies of any autopsy report, toxicological report
40 or any report of any examination or inquiry prepared with respect to any
41 death occurring to a child whose care and custody or custody and guardi-
42 anship has been transferred to an authorized agency, a child for whom
43 child protective services has an open case, a child for whom the local
44 department of social services has an open preventive services case, or a
45 child reported to the statewide central register of child abuse and
46 maltreatment. If the toxicological report is prepared pursuant to any
47 agreement or contract with any person, partnership, corporation or
48 governmental agency with the coroner or medical examiner, such report
49 shall be promptly, but in no event later than sixty days from the date
50 of death, absent extraordinary circumstances, provided to the office of
51 children and family services by such person, partnership, corporation or
52 governmental agency. Where the death involves a child reported to the
53 statewide central register of child abuse and maltreatment, the reports
54 referred to in this subdivision shall also be promptly, but in no event
55 later than sixty days from the date of death, absent extraordinary
56 circumstances, provided to the local child protective service investi-

1 gating the report pursuant to section four hundred twenty-four of the
2 social services law.
3 § 5. This act shall take effect on the one hundred twentieth day after
4 it shall have become a law.

**NEW YORK STATE SENATE
INTRODUCER'S MEMORANDUM IN SUPPORT
submitted in accordance with Senate Rule VI. Sec 1**

BILL NUMBER: S6703B

SPONSOR: SPANO

TITLE OF BILL:

An act to amend the social services law and the county law, in relation to fatality reviews in the deaths of abused children and children in the care of child protective services

PURPOSE:

In relation to local and regional fatality review teams, expands the scope of review of the teams to include deaths of children for whom there is an open child protective services case or a child preventive services case, enlarges the composition of local and regional fatality review teams, provides access to records and subpoena power to the fatality review teams, provides members of the review teams with immunity from civil and criminal liability, maintains confidentiality of information obtained by the review teams, and provides for the sharing of any annual report or fatality report released by a review team with other local or regional fatality review teams, citizen review panels, the governor and the legislature. Also allows a review team, in its discretion, to expand its review to all unexplained or unexpected deaths of children under the age of 18.

In relation to the office of children and family services, expands the scope of review to include deaths of children for whom there is an open child protective services case or a child preventive services case. In relation to medical examiner and coroner reports, requires the report of the findings of the investigation of the death of a child suspected of child abuse or maltreatment to be in writing and issued within thirty days of the date of death, and requires the autopsy report and other reports of any examination prepared with respect to the death of a child in foster care, for whom there is an open child protective services case or a child preventive services case, or is reported to the central register of child abuse and maltreatment to be provided no later than thirty days of the date of death.

SUMMARY OF PROVISIONS:

Section one amends section 422-b of the social services law by expanding the review of local or regional fatality review teams to include the deaths of children for whom there is an open child protective services case or a child preventive services case in addition to the deaths of children whose care or custody and guardianship has been transferred to

an authorized agency or who have been reported to the central register. A review team may also, in its discretion, further expand its review to include all unexplained or unexpected deaths of children under the age of 18. In addition, section 422-b of the social services law is amended to add to the list of representatives required as members of a fatality review team health officials, representatives of the office of the county attorney, state law enforcement and emergency medical services, and pediatricians preferably with expertise in the area of child abuse and maltreatment or forensic pediatrics. The list of representatives that may be included as members of a review team is also expanded to include representatives from local departments of social services, domestic violence agencies, substance abuse programs, local schools, and family court. This section further provides that a fatality review team established pursuant to section 422-b of the social services law will have access to all records within twenty-one days of a request, and in the event access to records is not provided within such twenty-one day period, the power to subpoena witnesses and require the production of books and papers in connection with any matter within the scope of inquiry being conducted by the fatality review team. Additionally, this section provides members of a fatality review team and persons attending a meeting of, or presenting information to, a review team with immunity from civil and criminal liability regarding information presented in a meeting of a fatality review team, except that a person may not be prevented from testifying as to information obtained independently of the fatality review team or which is public information. All meetings conducted, all reports and records made, and all information obtained, by the fatality review team shall be confidential and not open to the general public except for an annual report or fatality report, if the team wishes to complete one. If an annual report or fatality report is completed, it shall not contain any individually identifiable information and it shall be provided to the office of children and family services. The office of children and family services shall forward copies of any such report to all other fatality review teams established pursuant to section 422-b of the social services law, all citizen review panels established pursuant to section 371-b of the social services law, the governor and the legislature.

Section two requires the medical examiner or coroner who shall accept for investigation a report of abuse or maltreatment of a child pursuant to section 418 of the social services law, to issue a written report of his or her findings within thirty days of the date of death.

Section three amends section 20 of the social services law to expand the review of the office of children and family services to include the deaths of children for whom there is an open child protective services case or a child preventive services case in addition to the deaths of children whose care or custody and guardianship has been transferred to an authorized agency or who have been reported to the central register.

Section four requires the coroner, coroner's physician or medical examiner to provide copies of any autopsy report, toxicological report or any report of any examination prepared with respect to the death of a child in foster care, for whom there is an open child protective services case or a child preventive services case, or is reported to the central register of child abuse and maltreatment, to be provided no later than thirty days of the date of death.

Section five defines the effective date as the one hundred twentieth day

after it shall have become law.

JUSTIFICATION:

The death of a child is a tragic event, especially tragic is a death of a child that may have been prevented. The purpose of a child fatality review team is to investigate the cause of and circumstances surrounding the death. Fatality review can be a powerful tool for defining underlying causes and scope of fatalities from child abuse and neglect, identifying gaps and breakdowns in agencies and systems designed to protect children and determining strategies for preventing child deaths in the future, as well as uncovering patterns and trends in child deaths. In order to prevent deaths, a more complete picture of why children die must be obtained. A significant number of deaths is missed when review of child deaths is limited to deaths of children who were in foster care or were reported to the central register. By requiring local and regional fatality review teams as well as the office of children and family services to review the deaths of children for whom there is an open child protective services case or a child preventive services case, we will be better able to identify deficiencies in the child welfare system so that preventive measures may be developed and implemented. This bill also allows the review teams to expand the scope of review further, if so determined by the review team, to review all unexplained or unexpected deaths of children under the age of 18. For a fatality review team to be effective, its members must come from multiple disciplines to share and discuss comprehensive information on the circumstances leading to the death of a child and the response to that death. No one agency or discipline has all the information regarding the death of a child. It is therefore important to include representatives from the departments, agencies and organizations vested in the protection of children to identify the cause and circumstances of a child's death to enable an effective system response to a death of a child and to identify prevention strategies. The comprehensive review of pertinent information regarding a child's death will result in a more accurate determination of the cause of death and its preventability. If desired records cannot be obtained through cooperation, a fatality review team cannot require an agency to turn over records unless it requests a subpoena through a district attorney. Providing the review team with access to records within a specified time period and in the absence of such access, subpoena power, will facilitate the review team in obtaining necessary information more efficiently. To ensure a candid and open discussion of the facts and circumstances of a child's death, it is vital that the members of the review team are comfortable in serving, confident of a mutual trust and collaboration among the members without concern that the performance of a particular individual or agency is at issue. Members must be able to engage in their investigation, unhampered by fear of litigation, subpoena or legal jeopardy regarding information presented to, opinions or recommendations of, or reports prepared by, the review team. Nothing in the bill, however, will prevent a person from testifying as to information obtained independently of the review team or which is public information. Similarly, it is important to ensure that meetings conducted, reports and records made, and books and papers obtained, by a review team remain confidential, except for an annual report or fatality report if the review team chooses to complete and release one. If an annual report or fatality report is prepared by a review team, the report, which shall not contain any individually identifiable information, shall be provided to the office of children and family services. Since one of the objectives of a fatality review team is to gain information from a child's death to identify gaps in the

system to prevent the death of another child, it is essential that the information gained from the investigation be shared with other review teams established in the state, the governor and the legislature, in addition to the office of children and family services. Currently the law requires that the office of children and family services or a local or regional fatality review team that investigates a child's death must prepare and issue a report on such death within six months of the date of death. The review of the report of the medical examiner or the coroner is crucial to enabling the review team to carry out a comprehensive investigation of a child's death. Yet often the report of the medical examiner or the coroner is not available or will not be released in a prompt manner thereby hindering the timely completion of an investigation. Presently there is no time frame within which the medical examiner or coroner who has accepted a report of suspected child abuse or maltreatment for investigation required under section 418 of the social services law must report his or her findings. Similarly, there is no time frame within which the coroner, coroner's physician or medical examiner must provide to the office of children and family services with copies of any autopsy report, toxicological report or any report of any examination or inquiry prepared with respect to any death occurring to a child whose care and custody or custody and guardianship has been transferred to an authorized agency or a child reported to the central register. This bill would amend social services law and county law to require the issuance of such reports in both circumstances to be made within thirty days of the date of death.

LEGISLATIVE HISTORY:

This is a new bill.

FISCAL IMPLICATION:

None.

EFFECTIVE DATE:

This bill shall take effect on the one hundred twentieth day after it shall have become law.
