

# Senate Bill 832

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

## SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced**.

Declares purpose of Critical Incident Review Teams.

Defines "critical incident." Directs Department of Human Services to assign team within seven days after department becomes aware of critical incident. Modifies membership of team. Directs department to publish certain information regarding teams on department's website.

## A BILL FOR AN ACT

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

**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:**

**(1) The unexpected death of a child who was in the care or custody of the Department of Human Services at the time of death.**

**(2) The death of a child that the department has reasonable cause to believe may be the result of child abuse 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.**

**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**

**NOTE:** Matter in **boldfaced** type in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted. New sections are in **boldfaced** type.

1 child welfare systems.

2 (2) Reviews conducted by teams under sections 2 to 5 of this 2019 Act are in addition to  
 3 and separate from reviews conducted by county multidisciplinary child abuse teams formed  
 4 under ORS 418.747, statewide interdisciplinary teams formed under ORS 418.748 and the  
 5 department’s child welfare protocols regarding Notification and Review of Child Fatalities  
 6 and Notification and Review of Sensitive Issues.

7 **SECTION 4. Final report.** (1) Subject to subsection (2)(b) of this section, each Critical  
 8 Incident Review Team assigned under ORS 419B.024 shall submit a detailed, written final  
 9 report to the Department of Human Services upon the earlier of:

- 10 (a) The conclusion of the team’s critical incident case review; or
- 11 (b) The 60th day following the date the department assigned the team.

12 (2)(a) Prior to submitting a final report under this section, the team shall take into  
 13 consideration the following:

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

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

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

22 (b) The director may extend the deadline for submission of the final report if the director  
 23 determines that a delay is reasonable or if the report, even if modified, will compromise a law  
 24 enforcement agency investigation and the public interest does not outweigh the potential  
 25 consequences.

26 (3) Each final report must include, at a minimum:

- 27 (a) A description of the critical incident.
- 28 (b) The date of the critical incident.
- 29 (c) The date of the fatality.
- 30 (d) The date the department first became aware of the fatality.
- 31 (e) The date the department or a law enforcement agency caused an investigation to be  
 32 made under ORS 419B.020 to determine the nature and cause of the fatality.
- 33 (f) The date the findings in the case were entered under ORS 419B.026.
- 34 (g) The date the department assigned the team.
- 35 (h) The dates of, and number of members in attendance at, each meeting of the team.
- 36 (i) Whether the director assigned public members to the team.
- 37 (j) The date the team submitted the final report to the department.

38 (k) A description of all department contacts with the deceased child, the deceased child’s  
 39 siblings or the deceased child’s parents, foster parents or other caretakers. The description  
 40 of the department’s contacts under this paragraph must include a description of any prior  
 41 reports of abuse the department received involving the individuals identified in this para-  
 42 graph, the disposition of those reports, including whether the reports of abuse were assigned  
 43 for assessment or investigation, whether the department determined the reports to be  
 44 founded, unfounded or unable to be determined under ORS 419B.026, and any prior protective  
 45 custody actions involving the deceased child or the deceased child’s parents, foster parents

1 or other caretakers.

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

5 (m) Any recommendations for improvements in the administration and oversight of the  
6 child welfare system that are specific to the critical incident case reviewed by the team.

7 (n) A description of actions that are necessary to implement the recommendations and  
8 of timelines, tasks and responsible individuals to implement the recommendations.

9 (o) A description of methods to be used to evaluate the department's implementation of  
10 the team's recommendations and expected outcomes.

11 (4) A final report under this section may include the team's observations and recom-  
12 mendations regarding department personnel access to support, training and intervention of  
13 appropriate nature and duration to ensure the well-being of the personnel involved in re-  
14 sponding to critical incidents.

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

18 (a) The history of alleged abuse and neglect of the deceased child or other children in the  
19 deceased child's home.

20 (b) The exposure of the deceased child or any other children in the home to domestic  
21 violence or substance abuse.

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

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

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

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

34 (a) The date of the fatality and the age of the deceased child.

35 (b) Whether the child was in the care of the department at the time of the critical inci-  
36 dent or the fatality.

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

39 (d) The date the department assigned the team.

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

41 (2)(a) The department shall publish the final report on the department's website no later  
42 than 24 hours after the department receives the report from the team.

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

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

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

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

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

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

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

8 419B.024. (1) **When the Department of Human Services becomes aware of a critical inci-**  
9 **dent,** the department [*of Human Services*] shall assign a Critical Incident [*Response*] **Review Team.**  
10 [*after the department becomes aware of a child fatality that was likely the result of child abuse or*  
11 *neglect within timelines for assignment established by rules adopted by the department if:*]

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

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

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

19 [(d) *The child, the child's sibling or any other child living in the household with the child was the*  
20 *subject of a report of abuse or neglect made to the department or a law enforcement agency within the*  
21 *12 months preceding the fatality, whether or not the report was closed at screening without an inves-*  
22 *tigation being commenced.*]

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

25 (a) **Seven days after the department becomes aware of the fatality; or**

26 (b) **Three days after the department causes an investigation under ORS 419B.020 to be**  
27 **made into the nature and cause of the fatality.**

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

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

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

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

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

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

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

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

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

42 (D) **If the director determines it is appropriate to include one or more legislators as**  
43 **members of the team, up to one state Senator appointed by the President of the Senate and**  
44 **one state Representative appointed by the Speaker of the House of Representatives. A person**  
45 **is ineligible for appointment to a team under this subparagraph if the critical incident oc-**

1 **curred in the person's district, the person had prior contact with or knowledge of the de-**  
 2 **ceased child or the deceased child's family, or the person is a family member of any person**  
 3 **associated with the case.**

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

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

12 [(4)] **(5)(a)** All information and records available to the department [*of Human Services regarding*  
 13 *the incident that led to the fatality shall be provided to Critical Incident Response*] **regarding the**  
 14 **critical incident and the fatality shall be provided to** team members. Information and records  
 15 under this subsection include, but are not limited to, medical records, hospital records, records  
 16 maintained by any state, county or local agency, police investigative data, coroner or medical ex-  
 17 aminer investigative data and social services records, as necessary to complete a case review under  
 18 this section.

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

21 [(5)] **(6)** In reviewing the case to which the [*Critical Incident Response*] team has been assigned,  
 22 the team shall, with the assistance and cooperation of the department [*of Human Services*]:

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

26 (b) Document and make a part of the record of the case review all team conclusions and deci-  
 27 sions.

28 (c) Complete the case review even if:

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

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

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

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

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

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

1       [(A) A description of the incident that resulted in the fatality and of the events that led to the in-  
2 cident;]

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

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

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

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

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

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

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

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

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

24       [(b) The director may extend the deadline for submission of an initial report, a progress report or  
25 a final report if the director determines that a delay is reasonable or if the report, even if modified,  
26 will compromise a law enforcement agency investigation and the public interest does not outweigh the  
27 potential consequences.]

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

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

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

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

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

43       419B.022. ORS 419B.023 and [419B.024] **sections 2 to 5 of this 2019 Act** shall be known and  
44 may be cited as "Karly's Law."

45       **SECTION 8. Applicability.** Sections 2 to 5 of this 2019 Act and the amendments to ORS

1 419B.022 and 419B.024 by sections 6 and 7 of this 2019 Act apply to Critical Incident Review  
2 Teams assigned on or after the effective date of this 2019 Act.

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

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