House
Legislative
Analysis
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ACCESS TO CHILD ABUSE INFO.

AS ENROLLED

House Bill 4731 as enrolled
Public Act 225 of 1995
Sponsor: Rep. James Ryan
First House Committee: Judiciary and Civil Rights
Second House Committee: Human Services

House Bill 4782 as enrolled
Public Act 220 of 1995
Sponsor: Rep. Michelle McManus
House Committee: Human Services

Senate Committee: Families, Mental Health and Human Services

Second Analysis (1-5-96)

THE APPARENT PROBLEM:

It has been estimated that prevention of child abuse has almost a 20:1 cost advantage over the expenses that the state will incur for treatment of abused children when they grow up. However, statistics also indicate that incidents involving child abuse and neglect increased by more than 13 percent during the 1980s. Recognizing this, the Governor's Task Force on Children's Justice stated in its June, 1992, recommendations for improving Michigan's response to child abuse and neglect that, among other things, one of the key problems in the state's investigative handling of child abuse cases was the need for coordinated investigations. The task force included the following among its June, 1992, policy recommendations:

"To further enhance the investigative response, we recommend the formation of coordinated investigative teams to investigate child abuse/neglect and child sexual abuse cases. These teams would typically include police, protective services, prosecutors, and medical personnel."

The Department of Social Services (DSS) has implemented many of the task force's suggestions. For instance, it has formed "child fatality review teams" under the task force's guidance. These teams are charged with reviewing the deaths of children in the community, with the aim of protecting children and eliminating preventable fatalities. Following the task force's recommendations, the department has incorporated the most successful provisions of model teams employed in other states. The program is being implemented, first, in pilot counties, and eventually will be implemented in all counties. Each pilot team consists of a medical examiner, a local law enforcement agency representative, a DSS representative, the county prosecutor, and the Department of Public Health (DPH) representative. In addition, the local community may choose to include an emergency medical services technician, a physician (preferably a pediatrician), a mental health professional, a school representative, a representative of the juvenile division of the Probate Court, a member of the clergy, or a funeral home representative, and other members who may be brought in on a case-by-case basis because of their knowledge of a child's death.

According to the department, it is important that all members of child fatality review teams have access to its confidential central registry, which contains information of reports relating to child abuse and neglect, in order to properly analyze the causes of children's deaths. (For further information on the DSS central registry, see **BACKGROUND INFORMATION**.) In fact, some feel that it is especially important that access be granted to medical examiners, not only in their capacity as members of child fatality review teams, but also in their daily practice, since, in determining the cause of deaths, they are the ones most likely to discover patterns of abuse or neglect. Some members of child fatality review teams -- members of law enforcement agencies, for example --

currently have access to the information contained in the central registry under the Child Protection Law, and legislation has been proposed that would grant access to all members.

THE CONTENT OF THE BILLS:

Currently, under the Child Protection Law, the Department of Social Services (DSS) is required to maintain a central registry of confidential information on reports and investigations of suspected incidents of child abuse. The bills would amend the law to include medical examiners and DSS child fatality review teams among those with access to the registry information. House Bills 4731 and 4782 would specify that members of a child fatality review team, authorized by the DSS to investigate and review children's deaths, would have access to the registry information, and that a child fatality review team would consist, at a minimum, of the following members:

a) A county medical examiner or deputy county medical examiner;

b) A representative of a local law enforcement agency;

c) A representative of the DSS;

d) The county prosecuting attorney or his or her designee; and

e) A representative of the Department of Public Health or of a local health department.

In addition, House Bill 4731 would specify that county medical examiners would have access to the registry information when investigating the death of a child in the performance of their duties.

MCL 722.627

BACKGROUND INFORMATION:

Various people, such as physicians and teachers, whose professions bring them into close contact with children, are required under the Child Protection Law to report known or suspected child abuse or neglect to the Department of Social Services (DSS). The department investigates and maintains substantiated reports of abuse and neglect in a confidential central registry. While the act explicitly allows a number of entities (such as juvenile court staff investigating prospective foster homes, legal counsel, and law enforcement and child placement agencies) access to central registry information, there are other entities with an interest in episodes of child abuse and neglect that do not have access to the registry. Among these are county medical examiners, who must investigate all deaths in which the circumstances are unusual, and the deaths of children under two years of age whose deaths are sudden or from unknown causes.

Others involved in investigating cases of child abuse and neglect are "child fatality review teams." These are teams that the DSS is organizing in pilot communities to review child deaths. According to the department, each team includes the county medical examiner, a local law enforcement agency representative, representatives of the DSS and the Department of Public Health, and the county prosecuting attorney. In addition, a local community may include emergency medical services, a clinical physician (preferably a pediatrician), a mental health professional, a school representative, a representative of the juvenile division of the Probate Court, a member of the clergy, a funeral home director, or, on a case by case basis, other members of the community that have specific information regarding a child's death.

FISCAL IMPLICATIONS:

According to the Department of Social Services, the bills have no fiscal impact. (1-5-96)

ARGUMENTS:

For:

It is vitally important that the Department of Social Services (DSS) intervene as early as possible to avert problems with dysfunctional families. To do this, the department and those responsible for reporting suspected cases of child abuse and neglect to the department must have the tools to determine the causes of the deaths of children. By granting medical examiners and members of the child fatality review teams access to the department's confidential registry, the bills would provide the tools to aid the Department of Social Services (DSS) in the discovery and investigation of this abuse.

Against:

House Bill 4782 would allow members of a child fatality review team access to the central registry of confidential information on reports of suspected child abuse. The bill also specifies that the membership of such teams would include county medical examiners. Therefore, House Bill 4731 seems unnecessary and redundant.

Against:

The bills would allow access to the DSS central registry of confidential information on child abuse reports to a number of people who do not have access under current law. Specifically, information in the central registry would be available to members of child fatality review teams which have been authorized to investigate child deaths by the department, but which are not established in statute. However, since the only persons with the statutory authority to investigate deaths are medical examiners, some would question the legal status of these teams.

Response:

The DSS acknowledges these concerns. However, its policy is that child fatality review teams should not be established under statute until the performance of the pilot teams are evaluated and final plans for their successful operations worked out.

Against:

Concerns have been raised that some communities could, conceivably, decide to form child fatality review teams that were independent of the department's authority. It is also possible that these groups would also seek access to the DSS central registry, thus broadening access to confidential information on suspected child abuse or neglect. This could have serious liability consequences for the state in cases where the central registry information proved to be inaccurate. It would make sense to establish child fatality review teams in statute to assure that the confidentiality of the registry information is protected.

Response:

The bills specify that only those teams authorized by the department may have access to the central registry. In any case, under the provisions of Public Act 393 of 1994, those alleged to have committed child abuse or neglect are extended a measure of due process before their names are maintained on the central registry. Specifically, the DSS must notify each individual named as a perpetrator of child abuse or neglect in the central registry. The person notified has the right to request that the records be expunged, and the right to a hearing if the department refuses that request.

Against:

According to the Michigan Federation of Private Child and Family Agencies, there are more than 60 nonprofit child care organizations in Michigan that supervise nearly 10,000 children in foster and group homes. The federation has long argued that these organizations, too, should have access to the DSS central registry for the purpose of potential employees. In fact, in testimony before the House Human Services Committee, a representative of the federation pointed out that the Governor's Task Force on Children's Justice referred to this issue, as follows, in its June, 1992, recommendations:

". . . Once a fair hearing system is in place, the central child abuse and neglect registry should be available for screening applicants for sensitive jobs in the child care field, including foster care, residential treatment settings, day care centers, nursery schools, summer camps, and the like."

In view of recent controversy concerning allegations of child abuse by some child care workers, it would make sense to allow child care organizations to screen potential applicants by allowing them access to the central registry.

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.