Senate Fiscal Agency
P. O. Box 30036
Lansing, Michigan 48909-7536

SFA BILL ANALYSIS

Telephone: (517) 373-5383
Fax: (517) 373-1986
TDD: (517) 373-0543

Senate Bill 719 (as enrolled) **PUBLIC ACT 732 of 2002**
Sponsor: Senator Thaddeus G. McCotter
Senate Committee: Families, Mental Health and Human Services
House Committee: Criminal Justice

Date Completed: 1-14-03

RATIONALE

In 2000, Governor John Engler established the Domestic Homicide Prevention Task Force, chaired by Lieutenant Governor Dick Posthumus, to examine the factors leading to domestic violence and prevent domestic violence homicides. The Task Force's findings led to the passage in 2001 of a comprehensive legislative package addressing domestic violence issues. The bills addressed the enforcement of personal protection orders (PPOs) from other states; extended protections to people in "dating relationships"; established fingerprinting and record-keeping requirements for criminal contempt of PPO violations; increased the penalty for nonrelational assault and assault and battery to 93 days' imprisonment; required reimbursement of prosecution costs for PPO violations; and provided for the establishment of State and county domestic violence fatality review teams.

Public Act 192 of 2001 amended the domestic violence prevention and treatment Act to allow any State or local governmental unit to establish a domestic violence fatality review team to investigate a domestic violence-related homicide or suicide, and use that information to learn how to prevent domestic violence homicides and suicides by improving the response of individuals and agencies to domestic violence. Fatality review teams may review fatal or near-fatal incidents of domestic violence, including the events leading up to the killing, available community resources, current laws and policies, and actions taken by individuals and agencies in relation to the incident. A team may determine the number and type of incidents to review and make policy and other recommendations as to how domestic violence can be prevented. The information gathered by a fatality review team is generally confidential and exempt from the Freedom of Information Act, and no identifying information may be disclosed in any report available to the public. Anyone violating the confidentiality provisions is guilty of a misdemeanor. A fatality review team must submit an annual report of its findings and recommendations to the Michigan Domestic Violence Prevention and Treatment Board.

As counties around the State began putting together their fatality review teams, concerns about the confidentiality provisions of the law arose. It was suggested that those provisions should encompass all individuals providing information to a team or anyone else involved with the investigation, in addition to the team itself, and that the law should ensure immunity from all civil liability for anyone involved with a team's investigation.

CONTENT

The bill amended the domestic violence prevention and treatment Act to do the following:

-- Eliminate a requirement that one of the members serving on a State or county domestic violence fatality review team be trained in forensic pathology.
-- Require all members of a fatality review team to sign a confidentiality agreement.
-- Provide for immunity from all civil liability for a fatality review team, any member of a team, any individual providing information to a team, and any other person or agency acting under the scope of the Act.

The bill eliminated a requirement that one of the members serving on a domestic violence fatality review team be trained in forensic pathology. The bill retained provisions that a fatality review team must be made up of a health care professional with training and experience in responding to domestic violence, a medical examiner, a prosecuting attorney or a designated assistant prosecuting attorney, a representative of a domestic violence shelter that receives funding from the Michigan Domestic Violence Prevention and Treatment Board, and a law enforcement officer.

The bill retained the confidentiality provisions regarding information obtained or created by a domestic violence fatality review team, and extended these provisions to information obtained or created *for* a team. This information is not subject to discovery or the Freedom of Information Act, and documents created by or for a fatality review team are not subject to subpoena or discovery. A team may disclose information relevant to the investigation of a crime only to the prosecuting attorney or a law enforcement agency. Information required to be reported under the Child Protection Law must be disclosed by a fatality review team to the Family Independence Agency (FIA). The bill also specifies that individuals and organizations represented by individuals who participate as members of a fatality review team must sign a confidentiality agreement acknowledging the law's confidentiality provisions.

Previously, the law required any individual who appeared before or participated in a fatality review team to sign a confidentiality agreement acknowledging that any information provided to a team is confidential, but is subject to possible disclosure to the prosecuting attorney, a law enforcement agency, or the FIA. The bill specifies instead that any individual who provides information to a fatality review team must sign a confidentiality notice, acknowledging that any information he or she provides to the fatality review team will be kept confidential by the team, but is subject to possible disclosure to the prosecuting attorney, a law enforcement agency, or the FIA.

The bill also provides immunity from all civil liability for a fatality review team, any member of a fatality review team, any individual providing information to a fatality review team, or any other person or agency acting within the scope of this law, resulting from an act or omission arising out of and in the course of the team's, member's, individual's, person's, or agency's performance of that activity, unless the act or omission was the result of gross negligence or willful misconduct. The bill specifies that this law does not limit the immunity conferred by the governmental immunity Act or any other immunity provided by statute or common law.

(Previously, the domestic violence prevention and treatment Act specified that a member of a domestic violence fatality review team or any person providing information to a team was not liable for personal injury or property damage sustained by any person as a result of an act or proceeding undertaken or performed within the scope of this section of the law. The Act also stated that a person acting as a team member or anyone providing information to a team was not liable in a civil action for damages resulting from an act or omission arising out of and in the course of the person's good faith performance of that activity, unless the person's act or omission was the result of his or her gross negligence or willful misconduct. In addition, the Act provided that the State, a political subdivision, or, except in cases of willful misconduct, gross negligence, or bad faith, an employee, agent, or representative of the State or a political subdivision, or a fatality review team, complying with or reasonably attempting to comply with the Act, was not liable for personal injury or property damage as a result of any act or proceeding undertaken or performed within the scope of this section.)

MCL 400.1511

BACKGROUND

According to a representative of the Michigan Domestic Violence Prevention and Treatment Board, Wayne County presently has the only domestic violence fatality review team in the State. Several other counties are in the planning stages and were waiting to assemble their teams until this legislation was passed. Once established, the Wayne County team spent over a year crafting its protocol for selecting cases to review. Since the Wayne County team does not have the funds to review every death resulting from domestic

violence, it focuses on high-profile cases and those that are likely to provide a greater understanding of all domestic violence homicides.

Many other states have implemented domestic violence fatality review teams that vary widely in the scope of cases they review and their methodology. California, Delaware, Nevada, New Mexico, Ohio, Pennsylvania, and West Virginia all have teams at either the city, county, or state level. Washington and Florida received Violence Against Women grants through the Office of Justice Programs of the United States Department of Justice to establish their teams. The teams have a great deal of autonomy in their practices, ranging from the Philadelphia Women's Death Review Team, which reviews hundreds of cases every year to identify patterns, to the San Francisco Task Force, which relies on an extremely detailed analysis of one case to identify system failures. The teams examine such factors as the gender, race, ethnicity, sexual orientation, socioeconomic status, geo-cultural background (urban/suburban/rural), and familial relationships of the victim and perpetrator, as well as a prior history of domestic violence, the presence of personal protection orders, pending divorce or other relationship breakdown, calls to police, drug or alcohol abuse, emotional problems, mental illness, a history of weapon use or access to firearms, death threats, the method used to kill the victim, the location of the homicide, and the involvement of professionals and community agencies prior to the incident.

Other states with domestic violence fatality review teams have included confidentiality provisions similar to Michigan's, requiring team members and people providing information to the team to sign confidentiality agreements and exempting certain information from the Freedom of Information Act, subpoena, and discovery. Team members or other people involved with the investigation generally are granted immunity from criminal and civil liability, provided they are acting in good faith and without malice.

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

The bill clarifies confidentiality and immunity provisions of the fatality review team law. In particular, the bill makes it clear that a fatality review team must maintain the confidentiality of information provided to it. In addition, the bill provides for immunity from all civil liability, rather than just immunity from liability for personal injury or property damage, or civil immunity for activity performed in good faith. The bill also extends immunity to anyone acting within the scope of this law, in addition to fatality review team members, people providing information to a team, the State and local units, and governmental employees. These provisions are necessary to allow a fatality review team effectively to investigate homicides resulting from domestic violence while maintaining the victim's dignity and minimizing further trauma to the victim's family.

Legislative Analyst: Julie Koval

FISCAL IMPACT

As the language regarding the establishment of these review teams is permissive, the State and counties would not experience any costs unless they established teams. If they did, then most of the costs would be associated team expenses, such as per diem or per meeting stipends. (For example, in the Department of Community Health budget, members of the community health advising council are limited to a $50 per diem.) Other costs could include regular office supplies and the printing of forms and reports. While the amount of these costs is unknown, the costs associated with a similar concept, the Fetal Infant Mortality Review teams, were $56,000 for FY 2000-01. A total of 1,100 infant deaths occurred during 2000, though only a subset of these deaths are reviewed. The estimated total number of deaths for the age cohort of women who might be victims of domestic violence was 132. About 30% or 40 women may have died at the hand of their spouse or ex-spouse.

Fiscal Analyst: John Walker

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