

Enrolled
Senate Bill 1047

Sponsored by COMMITTEE ON RULES

CHAPTER

AN ACT

Relating to establishment of multidisciplinary teams to study domestic violence fatalities.

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

SECTION 1. As used in sections 2 and 3 of this 2005 Act, “domestic violence fatality” means a fatality in which:

(1) The deceased was the victim of a homicide committed by a current or former spouse, fiance, fiancée or dating partner;

(2) The deceased was the victim of a suicide and there is evidence that the suicide is related to previous domestic violence;

(3) The deceased was the perpetrator of the homicide of a current or former spouse, fiance, fiancée or dating partner and the perpetrator also died in the course of the domestic violence incident;

(4) The deceased was a child who died in the course of a domestic violence incident in which either a parent of the child or the perpetrator also died;

(5) The deceased was a current or former spouse, fiance, fiancée or dating partner of the current or former spouse, fiance, fiancée or dating partner of the perpetrator; or

(6) The deceased was a person 18 years of age or older not otherwise described in this section and was the victim of a homicide related to domestic violence.

SECTION 2. (1) A local domestic violence coordinating council recognized by the local public safety coordinating council or by the governing body of the county may establish a multidisciplinary domestic violence fatality review team to assist local organizations and agencies in identifying and reviewing domestic violence fatalities. When no local domestic violence coordinating council exists, a similar interdisciplinary group may establish the fatality review team.

(2) The purpose of a fatality review team is to review domestic violence fatalities and make recommendations to prevent domestic violence fatalities by:

(a) Improving communication between public and private organizations and agencies;

(b) Determining the number of domestic violence fatalities occurring in the team’s county and the factors associated with those fatalities;

(c) Identifying ways in which community response might have intervened to prevent a fatality;

(d) Providing accurate information about domestic violence to the community; and

(e) Generating recommendations for improving community response to and prevention of domestic violence.

(3) A fatality review team shall include but is not limited to the following members, if available:

- (a) Domestic violence program service staff or other advocates for battered women;**
- (b) Medical personnel with expertise in the field of domestic violence;**
- (c) Local health department staff;**
- (d) The local district attorney or the district attorney's designees;**
- (e) Law enforcement personnel;**
- (f) Civil legal services attorneys;**
- (g) Protective services workers;**
- (h) Community corrections professionals;**
- (i) Judges, court administrators or their representatives;**
- (j) Perpetrator treatment providers;**
- (k) A survivor of domestic violence; and**
- (L) Medical examiners or other experts in the field of forensic pathology.**

(4) Other individuals may, with the unanimous consent of the team, be included in a fatality review team on an ad hoc basis. The team, by unanimous consent, may decide the extent to which the individual may participate as a full member of the team for a particular review.

(5) Upon formation and before reviewing its first case, a fatality review team shall adopt a written protocol for review of domestic violence fatalities. The protocol must be designed to facilitate communication among organizations and agencies involved in domestic violence cases so that incidents of domestic violence and domestic violence fatalities are identified and prevented. The protocol shall define procedures for case review and preservation of confidentiality, and shall identify team members.

(6) Consistent with recommendations provided by the statewide interdisciplinary team under section 3 of this 2005 Act, a local fatality review team shall provide the statewide team with information regarding domestic violence fatalities.

(7) To ensure consistent and uniform results, fatality review teams may collect and summarize data to show the statistical occurrence of domestic violence fatalities in the team's county.

(8) Each organization or agency represented on a fatality review team may share with other members of the team information concerning the victim who is the subject of the review. Any information shared between team members is confidential.

(9) An individual who is a member of an organization or agency that is represented on a fatality review team is not required to disclose information. The intent of this section and section 3 of this 2005 Act is to allow the voluntary disclosure of information.

(10) An oral or written communication or a document related to a domestic violence fatality review that is shared within or produced by a fatality review team is confidential, not subject to disclosure and not discoverable by a third party. An oral or written communication or a document provided by a third party to a fatality review team is confidential, not subject to disclosure and not discoverable by a third party. All information and records acquired by a team in the exercise of its duties are confidential and may be disclosed only as necessary to carry out the purposes of the fatality review. However, recommendations of a team upon the completion of a review may be disclosed without personal identifiers at the discretion of two-thirds of the members of the team.

(11) Information, documents and records otherwise available from other sources are not immune from discovery or introduction into evidence solely because the information, documents or records were presented to or reviewed by a fatality review team.

(12) ORS 192.610 to 192.690 do not apply to meetings of a fatality review team.

(13) Each fatality review team shall develop written agreements signed by member organizations and agencies that specify the organizations' and agencies' understanding of and agreement with the principles outlined in this section.

SECTION 3. (1) The Department of Human Services may form a statewide interdisciplinary team to meet twice a year to review domestic violence fatality cases, identify domestic violence trends, make recommendations and take actions involving statewide issues.

(2) The statewide interdisciplinary team may recommend specific cases to a local multidisciplinary domestic violence fatality review team for review under section 2 of this 2005 Act.

(3) The statewide interdisciplinary team shall provide recommendations to local fatality review teams in the development of protocols. The recommendations must be designed to facilitate communication among organizations and agencies involved in domestic violence fatality cases so that incidents of domestic violence and fatalities related to domestic violence are identified and prevented. The recommendations must include procedures relevant for both urban and rural counties.

Passed by Senate June 17, 2005

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Secretary of Senate

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President of Senate

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Speaker of House

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.....M.,....., 2005

Approved:

.....M.,....., 2005

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Governor

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