

SENATE AMENDMENTS TO SENATE BILL 135

By COMMITTEE ON HUMAN SERVICES

March 31

1 On page 1 of the printed bill, line 2, after “ORS” delete the rest of the line and delete line 3
2 and insert “418.714, 418.747 and 418.811.”.

3 Delete lines 5 through 28 and delete pages 2 through 10 and insert:

4 “**SECTION 1.** ORS 418.714 is amended to read:

5 “418.714. (1) A local domestic violence coordinating council recognized by the local public safety
6 coordinating council or by the governing body of the county may establish a multidisciplinary do-
7 mestic violence fatality review team to assist local organizations and agencies in identifying and
8 reviewing domestic violence fatalities. When no local domestic violence coordinating council exists,
9 a similar interdisciplinary group may establish the fatality review team.

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

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

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

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

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

17 “(e) Generating recommendations for improving community response to and prevention of do-
18 mestic violence.

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

20 “(a) Domestic violence program service staff or other advocates for battered women;

21 “(b) Medical personnel with expertise in the field of domestic violence;

22 “(c) Local health department staff;

23 “(d) The local district attorney or the district attorney’s designees;

24 “(e) Law enforcement personnel;

25 “(f) Civil legal services attorneys;

26 “(g) Protective services workers;

27 “(h) Community corrections professionals;

28 “(i) Judges, court administrators or their representatives;

29 “(j) Perpetrator treatment providers;

30 “(k) A survivor of domestic violence; *[and]*

31 “(L) Medical examiners or other experts in the field of forensic pathology[.]; and

32 “**(m) A representative of a local CASA Volunteer Program, as defined in ORS 419A.004.**

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

1 “(5) Upon formation and before reviewing its first case, a fatality review team shall adopt a
2 written protocol for review of domestic violence fatalities. The protocol must be designed to facili-
3 tate communication among organizations and agencies involved in domestic violence cases so that
4 incidents of domestic violence and domestic violence fatalities are identified and prevented. The
5 protocol shall define procedures for case review and preservation of confidentiality, and shall iden-
6 tify team members.

7 “(6) Consistent with recommendations provided by the statewide interdisciplinary team under
8 ORS 418.718, a local fatality review team shall provide the statewide team with information re-
9 garding domestic violence fatalities.

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

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

15 “(9) An individual who is a member of an organization or agency that is represented on a
16 fatality review team is not required to disclose information. The intent of this section and ORS
17 418.718 is to allow the voluntary disclosure of information.

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

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

29 “(12) ORS 192.610 to 192.705 do not apply to meetings of a fatality review team.

30 “(13) Each fatality review team shall develop written agreements signed by member organiza-
31 tions and agencies that specify the organizations’ and agencies’ understanding of and agreement
32 with the principles outlined in this section.

33 “**SECTION 2.** ORS 418.747, as amended by section 62, chapter 73, Oregon Laws 2024, is
34 amended to read:

35 “418.747. (1) The district attorney in each county shall be responsible for developing county
36 child abuse multidisciplinary teams to consist of but not be limited to law enforcement personnel,
37 Department of Human Services child protective service workers, school officials, local health de-
38 partment personnel, county mental health department personnel who have experience with children
39 and family mental health issues, child abuse intervention center workers, if available, **staff of a**
40 **local CASA Volunteer Program, as defined in ORS 419A.004**, and juvenile department represen-
41 tatives, as well as others specially trained in child abuse, child sexual abuse and rape of children
42 investigation.

43 “(2) The teams shall develop a written protocol for immediate investigation of and notification
44 procedures for child abuse cases, including child sexual abuse, and for interviewing child abuse
45 victims. Each team also shall develop written agreements signed by member agencies that are re-

1 presented on the team that specify:

2 “(a) The role of each agency;

3 “(b) Procedures to be followed to assess risks to the child;

4 “(c) Guidelines for timely communication between member agencies;

5 “(d) Guidelines for completion of responsibilities by member agencies;

6 “(e) That upon clear disclosure that the alleged child abuse occurred in a child care facility as
7 defined in ORS 329A.250, immediate notification of parents or guardians of children attending the
8 child care facility is required regarding any abuse allegation and pending investigation; and

9 “(f) Criteria and procedures to be followed when removal of the child is necessary for the child’s
10 safety.

11 “(3) Each team member and the personnel conducting child abuse investigations and interviews
12 of child abuse victims shall be trained in risk assessment, the dynamics of child abuse, child sexual
13 abuse and rape of children, and forensic interviewing.

14 “(4) All investigations of child abuse and interviews of child abuse victims shall be carried out
15 by appropriate personnel using the protocols and procedures called for in this section. If trained
16 personnel are not available in a timely fashion and, in the judgment of a law enforcement officer
17 or child protective services worker, there is reasonable cause to believe a delay in investigation or
18 interview of the child abuse victim could place the child in jeopardy of physical harm, the investi-
19 gation may proceed without full participation of all personnel. This authority applies only for as
20 long as reasonable danger to the child exists. A law enforcement officer or child protective services
21 worker shall make a reasonable effort to find and provide a trained investigator or interviewer.

22 “(5) To ensure the protection and safe placement of a child, the Department of Human Services
23 may request that team members obtain criminal history information on any person who is part of
24 the household where the department may place or has placed a child who is in the department’s
25 custody. All information obtained by the team members and the department in the exercise of their
26 duties is confidential and may be disclosed only when necessary to ensure the safe placement of a
27 child.

28 “(6) Each team shall classify, assess and review cases under investigation.

29 “(7)(a) Each team shall develop and implement procedures for evaluating and reporting compli-
30 ance of member agencies with the protocols and procedures required under this section. Each team
31 shall submit to the administrator of the Child Abuse Multidisciplinary Intervention Program copies
32 of the protocols and procedures required under this section and the results of the evaluation as re-
33 quested.

34 “(b) The administrator may:

35 “(A) Consider the evaluation results when making eligibility determinations under ORS 418.746
36 (3);

37 “(B) If requested by the Advisory Council on Child Abuse Assessment, ask a team to revise the
38 protocols and procedures being used by the team based on the evaluation results; or

39 “(C) Ask a team to evaluate the team’s compliance with the protocols and procedures in a par-
40 ticular case.

41 “(c) The information and records compiled under this subsection are exempt from ORS 192.311
42 to 192.478.

43 “(8) Each team shall develop policies that provide for an independent review of investigation
44 procedures of sensitive cases after completion of court actions on particular cases. The policies shall
45 include independent citizen input. Parents of child abuse victims shall be notified of the review

1 procedure.

2 “(9) Each team shall designate at least one physician, physician associate or nurse practitioner
3 who has been trained to conduct child abuse assessments, as defined in ORS 418.782, and who is,
4 or who may designate another physician, physician associate or nurse practitioner who is, regularly
5 available to conduct the medical assessment described in ORS 419B.023.

6 “(10) If photographs are taken pursuant to ORS 419B.028, and if the team meets to discuss the
7 case, the photographs shall be made available to each member of the team at the first meeting re-
8 garding the child’s case following the taking of the photographs.

9 “(11) No later than September 1, 2008, each team shall submit to the Department of Justice a
10 written summary identifying the designated medical professional described in subsection (9) of this
11 section. After that date, this information shall be included in each regular report to the Department
12 of Justice.

13 “(12) If, after reasonable effort, the team is not able to identify a designated medical professional
14 described in subsection (9) of this section, the team shall develop a written plan outlining the nec-
15 essary steps, recruitment and training needed to make such a medical professional available to the
16 children of the county. The team shall also develop a written strategy to ensure that each child in
17 the county who is a suspected victim of child abuse will receive a medical assessment in compliance
18 with ORS 419B.023. This strategy, and the estimated fiscal impact of any necessary recruitment and
19 training, shall be submitted to the Department of Justice no later than September 1, 2008. This in-
20 formation shall be included in each regular report to the Department of Justice for each reporting
21 period in which a team is not able to identify a designated medical professional described in sub-
22 section (9) of this section.

23 “**SECTION 3.** ORS 418.811 is amended to read:

24 “418.811. (1) When the Department of Human Services becomes aware of a critical incident, the
25 department shall assign a Critical Incident Review Team.

26 “(2) The department shall assign the team required under subsection (1) of this section no later
27 than the earlier of:

28 “(a) Ten days after the department becomes aware of a fatality that the department reasonably
29 believes is the result of child abuse; or

30 “(b) Seven days after the department causes an investigation under ORS 419B.020 to be made
31 into the nature and cause of a fatality when the department reasonably believes the fatality is the
32 result of child abuse.

33 “(3)(a) Members of the team shall include, at a minimum, the following:

34 “(A) The Director of Human Services or a deputy director of the department;

35 “(B) The lead department personnel responsible for the administration and oversight of the child
36 welfare system within the department or the lead personnel’s deputy; *[and]*

37 “(C) The department personnel responsible for media and communications; **and**

38 “**(D) If available, a representative of a local CASA Volunteer Program, as defined in ORS**
39 **419A.004.**

40 “(b) Members of the team may include:

41 “(A) Members of the public, appointed by the director, as appropriate;

42 “(B) A juvenile court judge appointed by the Chief Justice of the Supreme Court;

43 “(C) A member of a local citizen review board established under ORS 419A.090 whose service
44 area does not include the location where the critical incident occurred; or

45 “(D) If the director determines it is appropriate to include one or more legislators as members

1 of the team, up to one state Senator appointed by the President of the Senate and one state Representative appointed by the Speaker of the House of Representatives. A person is ineligible for appointment to a team under this subparagraph if the critical incident occurred in the person's district, the person had prior contact with or knowledge of the deceased child or the deceased child's family, or the person is a family member of any person associated with the case.

6 "(4)(a) During the course of its review of the case, the team may include or consult with the district attorney from the county in which the critical incident occurred.

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

13 "(5)(a) All information and records available to the department regarding the critical incident shall be provided to team members. Information and records under this subsection include, but are not limited to, medical records, hospital records, records maintained by any state, county or local agency, police investigative data, coroner or medical examiner investigative data and social services records, as necessary to complete a case review under this section.

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

20 "(6) In reviewing the case to which the team has been assigned, the team shall, with the assistance and cooperation of the department:

22 "(a) Review the case with the primary focus on the history of the safety and well-being of the child who was involved in the critical incident and any other children who may be impacted by the circumstances surrounding the critical incident.

25 "(b) Document and make a part of the record of the case review all team conclusions and decisions.

27 "(c) Complete the case review even if:

28 "(A) The team concludes that the critical incident was the result of the actions of one or more department employees or staff and that such actions were inconsistent with department policy or administrative rule; or

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

33 "(d) Prepare and submit the final report required under ORS 418.813.

34 "(7) If the team concludes that the critical incident involves personnel matters relevant to the department, the department shall refer the matters to the human resources or personnel divisions of the department.

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

42 "(9) The department shall adopt rules necessary to carry out the provisions of ORS 418.806 to 418.816. The rules adopted by the department shall substantially conform with the department's child welfare protocol regarding Notification and Review of Critical Incidents."