

Requested by Senator GELSER BLOUIN

**PROPOSED AMENDMENTS TO
SENATE BILL 135**

1 On page 1 of the printed bill, line 2, after “ORS” delete the rest of the
2 line and delete line 3 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
6 the local public safety coordinating council or by the governing body of the
7 county may establish a multidisciplinary domestic violence fatality review
8 team to assist local organizations and agencies in identifying and reviewing
9 domestic violence fatalities. When no local domestic violence coordinating
10 council exists, a similar interdisciplinary group may establish the fatality
11 review team.

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

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

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

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

21 “(d) Providing accurate information about domestic violence to the com-

1 munity; and

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

4 “(3) A fatality review team shall include but is not limited to the fol-
5 lowing members, if available:

6 “(a) Domestic violence program service staff or other advocates for bat-
7 tered women;

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

9 “(c) Local health department staff;

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

11 “(e) Law enforcement personnel;

12 “(f) Civil legal services attorneys;

13 “(g) Protective services workers;

14 “(h) Community corrections professionals;

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

16 “(j) Perpetrator treatment providers;

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

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

20 **“(m) A representative of a local CASA Volunteer Program, as de-
21 fined in ORS 419A.004.**

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

26 “(5) Upon formation and before reviewing its first case, a fatality review
27 team shall adopt a written protocol for review of domestic violence fatalities.
28 The protocol must be designed to facilitate communication among organiza-
29 tions and agencies involved in domestic violence cases so that incidents of
30 domestic violence and domestic violence fatalities are identified and pre-

1 vented. The protocol shall define procedures for case review and preservation
2 of confidentiality, and shall identify team members.

3 “(6) Consistent with recommendations provided by the statewide interdis-
4 ciplinary team under ORS 418.718, a local fatality review team shall provide
5 the statewide team with information regarding domestic violence fatalities.

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

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

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

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

28 “(11) Information, documents and records otherwise available from other
29 sources are not immune from discovery or introduction into evidence solely
30 because the information, documents or records were presented to or reviewed

1 by a fatality review team.

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

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

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

10 “418.747. (1) The district attorney in each county shall be responsible for
11 developing county child abuse multidisciplinary teams to consist of but not
12 be limited to law enforcement personnel, Department of Human Services
13 child protective service workers, school officials, local health department
14 personnel, county mental health department personnel who have experience
15 with children and family mental health issues, child abuse intervention cen-
16 ter workers, if available, **staff of a local CASA Volunteer Program, as**
17 **defined in ORS 419A.004,** and juvenile department representatives, as well
18 as others specially trained in child abuse, child sexual abuse and rape of
19 children investigation.

20 “(2) The teams shall develop a written protocol for immediate investi-
21 gation of and notification procedures for child abuse cases, including child
22 sexual abuse, and for interviewing child abuse victims. Each team also shall
23 develop written agreements signed by member agencies that are represented
24 on the team that specify:

25 “(a) The role of each agency;

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

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

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

29 “(e) That upon clear disclosure that the alleged child abuse occurred in
30 a child care facility as defined in ORS 329A.250, immediate notification of

1 parents or guardians of children attending the child care facility is required
2 regarding any abuse allegation and pending investigation; and

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

5 “(3) Each team member and the personnel conducting child abuse inves-
6 tigations and interviews of child abuse victims shall be trained in risk as-
7 sessment, the dynamics of child abuse, child sexual abuse and rape of
8 children, and forensic interviewing.

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

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

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

28 “(7)(a) Each team shall develop and implement procedures for evaluating
29 and reporting compliance of member agencies with the protocols and proce-
30 dures required under this section. Each team shall submit to the adminis-

1 trator of the Child Abuse Multidisciplinary Intervention Program copies of
2 the protocols and procedures required under this section and the results of
3 the evaluation as requested.

4 “(b) The administrator may:

5 “(A) Consider the evaluation results when making eligibility determi-
6 nations under ORS 418.746 (3);

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

10 “(C) Ask a team to evaluate the team’s compliance with the protocols and
11 procedures in a particular case.

12 “(c) The information and records compiled under this subsection are ex-
13 empt from ORS 192.311 to 192.478.

14 “(8) Each team shall develop policies that provide for an independent re-
15 view of investigation procedures of sensitive cases after completion of court
16 actions on particular cases. The policies shall include independent citizen
17 input. Parents of child abuse victims shall be notified of the review proce-
18 dure.

19 “(9) Each team shall designate at least one physician, physician associate
20 or nurse practitioner who has been trained to conduct child abuse assess-
21 ments, as defined in ORS 418.782, and who is, or who may designate another
22 physician, physician associate or nurse practitioner who is, regularly avail-
23 able to conduct the medical assessment described in ORS 419B.023.

24 “(10) If photographs are taken pursuant to ORS 419B.028, and if the team
25 meets to discuss the case, the photographs shall be made available to each
26 member of the team at the first meeting regarding the child’s case following
27 the taking of the photographs.

28 “(11) No later than September 1, 2008, each team shall submit to the De-
29 partment of Justice a written summary identifying the designated medical
30 professional described in subsection (9) of this section. After that date, this

1 information shall be included in each regular report to the Department of
2 Justice.

3 “(12) If, after reasonable effort, the team is not able to identify a desig-
4 nated medical professional described in subsection (9) of this section, the
5 team shall develop a written plan outlining the necessary steps, recruitment
6 and training needed to make such a medical professional available to the
7 children of the county. The team shall also develop a written strategy to
8 ensure that each child in the county who is a suspected victim of child abuse
9 will receive a medical assessment in compliance with ORS 419B.023. This
10 strategy, and the estimated fiscal impact of any necessary recruitment and
11 training, shall be submitted to the Department of Justice no later than Sep-
12 tember 1, 2008. This information shall be included in each regular report to
13 the Department of Justice for each reporting period in which a team is not
14 able to identify a designated medical professional described in subsection (9)
15 of this section.

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

17 “418.811. (1) When the Department of Human Services becomes aware of
18 a critical incident, the department shall assign a Critical Incident Review
19 Team.

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

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

24 “(b) Seven days after the department causes an investigation under ORS
25 419B.020 to be made into the nature and cause of a fatality when the de-
26 partment reasonably believes the fatality is the result of child abuse.

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

28 “(A) The Director of Human Services or a deputy director of the depart-
29 ment;

30 “(B) The lead department personnel responsible for the administration and

1 oversight of the child welfare system within the department or the lead
2 personnel's deputy; [and]

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

5 **“(D) If available, a representative of a local CASA Volunteer Pro-**
6 **gram, as defined in ORS 419A.004.**

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

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

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

11 “(C) A member of a local citizen review board established under ORS
12 419A.090 whose service area does not include the location where the critical
13 incident occurred; or

14 “(D) If the director determines it is appropriate to include one or more
15 legislators as members of the team, up to one state Senator appointed by the
16 President of the Senate and one state Representative appointed by the
17 Speaker of the House of Representatives. A person is ineligible for appoint-
18 ment to a team under this subparagraph if the critical incident occurred in
19 the person's district, the person had prior contact with or knowledge of the
20 deceased child or the deceased child's family, or the person is a family
21 member of any person associated with the case.

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

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

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

8 “(b) Information and records provided to team members are confidential
9 and may be disclosed only as necessary to carry out the purposes of the
10 team’s case review.

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

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

17 “(b) Document and make a part of the record of the case review all team
18 conclusions and decisions.

19 “(c) Complete the case review even if:

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

23 “(B) The department’s investigation into the critical incident results in
24 a finding that the report of child abuse is unfounded or cannot be deter-
25 mined, as described in ORS 419B.026.

26 “(d) Prepare and submit the final report required under ORS 418.813.

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

30 “(8) The team may meet, upon conclusion of a criminal investigation or

1 prosecution arising out of a child fatality to which the team was assigned
2 for review, with members of law enforcement that investigated the child
3 fatality or with the prosecuting attorneys who prosecuted the case for the
4 purpose of reviewing the conclusions and recommendations of the team and
5 the reports prepared and submitted by the team.

6 “(9) The department shall adopt rules necessary to carry out the pro-
7 visions of ORS 418.806 to 418.816. The rules adopted by the department shall
8 substantially conform with the department’s child welfare protocol regarding
9 Notification and Review of Critical Incidents.”.

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