SUBJECT: Authorizing teams to review unexpected adult deaths

COMMITTEE: Criminal Jurisprudence — favorable, with amendment

VOTE: 7 ayes — Hinojosa, Dunnam, Garcia, Green, Kitchen, Martinez Fischer, Shields

0 nays

2 absent — Keel, Talton

SENATE VOTE: On final passage, March 7 — voice vote

WITNESSES: For — Joe E. Thornton, San Antonio Safe Family Coalition; Erik T. Dahler, University Health System; Bree Buchanan, Texas Council on Family Violence; *Registered but did not testify:* Evelyn Swenson-Britt, San Antonio Safe Family Coalition; Elizabeth Murray-Kolb

Against — None

On — *Registered but did not testify:* Michael R. Ramsey, Texas Trial Lawyers Association

DIGEST: SB 515, as amended, would authorize a county to establish a review team to conduct reviews of unexpected deaths that occur in the county. Review teams for counties with populations below 50,000 could join with adjacent counties to establish combined teams.

A commissioners court could oversee the team; commissioners could designate a county department as overseer; or commissioners could designate a nonprofit agency or political subdivision of the state involved in family violence, abuse, or suicide treatment to oversee the team, if the agency or political subdivision agreed.

The purpose of the teams would include developing an understanding of the causes and incidences of unexpected deaths in the county and advising the Legislature, state agencies, and local law enforcement agencies about

changes to law, policy, or practice to reduce the number of unexpected deaths. To achieve their purpose, teams would have to meet to review fatality cases suspected to have resulted from suicide, family violence, or abuse and recommend methods to improve coordination of services and investigations among agencies represented on the team.

Reporting unexpected deaths. A person, including a health-care provider, who knew of an adult death indicating suicide, family violence, or abuse would have to report it to the medical examiner in the county where the death occurred, or if the county had no medical examiner, to a justice of the peace. Medical examiners and justices of the peace could hold inquests to determine whether a death was caused by suicide, family violence, or abuse. Medical examiners and justices of the peace would have to notify the entity overseeing the review team of each notice of an unexpected death, each death found to be caused by suicide, family violence, or abuse, or each death that could have been caused by suicide, family violence, or abuse.

Information and records. The review team could request information and records about deaths, including medical, dental, and mental health-care information and information maintained by state or local governmental agencies, including birth certificates, law enforcement investigation data, medical examiner investigative data, juvenile court records, parole and probation records, and adult protective services records. Custodians of this information would have to provide it to the team. Law enforcement agencies and medical examiners could decline to provide information until after the conclusion of their investigations.

SB 515 would not authorize the release of state or local government agency mental health or medical records of an deceased adult's family, guardian, or caretaker or of an alleged suspected perpetrator of family violence or abuse, unless this information was acquired as part of an investigation by a state or local government agency.

Information and records required by teams would be confidential and exempt from disclosure under the state's open records law. Reports of the team and statistical compilation of statistics would be public records subject to the open records law if the report or compilation did not identify individuals and was not otherwise confidential or privileged. Review team members could

not disclose confidential information. It would be a Class A misdemeanor (punishable by up to one year in jail and/or a maximum fine of $4,000) to disclose information made confidential by SB 515.

Team meetings would be closed to the public and not subject to the state's open meetings law.

Not later than December 15 of each even-numbered year, each review team would have to submit to the Department of Protective and Regulatory Services (DPRS) a report on the deaths reviewed. DPRS would have to make the reports available to the public.

Composition of the teams. Review teams could include prosecutors involved in family violence cases, peace officers, justices of the peace, medical examiners, public health professionals, a DPRS representative, mental health service providers, representatives of family violence shelters, victim and witness advocates from prosecutor's offices, representatives of the county's battering intervention and prevention program, and probation officers. Team members would choose the presiding officer and could select additional members as needed, but additional members would have to reflect the area's geographical, cultural, racial, ethnic, and gender diversity.

Liability. The review teams would be considered local governmental units for the purposes of governmental liability. Review teams, subject to the liability limits in the Texas Torts Claims Act (Civil Practice and Remedies Code, chapter 101) for units of local government, and team members would be civilly liable for damages caused by the disclosure of information in violation of SB 515.

The bill would take effect September 1, 2001.

SUPPORTERS SAY:

SB 515 would better enable counties to confront the problem of adult deaths by suicide, family violence, or abuse by authorizing the establishment of adult fatality review teams. These teams would mirror the child fatality review teams authorized by the Legislature in 1995.

While deaths of people not being treated by physicians most likely are investigated by law enforcement agencies or medical examiners, this occurs

on case-by-case basis and does not necessarily involve looking at the system of government and community services. SB 515 would provide an important framework for ensuring that no death due to suicide, family violence, or abuse goes unnoticed. The review teams would help ensure that further investigations could be conducted where appropriate and that service agencies would know if they were providing appropriate services. Team members could share information and ideas. The teams could identify gaps or breakdowns in government or community services and could work to revise services, procedures, and investigation protocols. The teams' efforts could lead to more accurate reporting of fatalities and development of needed prevention initiatives.

SB 515 would formalize and expand what already occurs in some parts of the state. In some areas, coordinated community response teams of prosecutors, law enforcement representatives, and community group representatives work together to help provide services for victims of abuse and family violence. However, in most cases, these teams do not examine each unexpected death systematically and do not look at the "big picture" of available services, as would the review teams created under SB 515.

Although review teams could be formed without legislation authorizing them, SB 515 is necessary to give the teams access to information, to ensure that the information is kept confidential, and to provide limits on the team's liability. The bill also would provide guidelines for these teams in their day-to-day operation and in the applicability of the state's open meetings and open records law.

Without the confidentiality requirements in SB 515, people or agencies could be reluctant to share information about unexpected deaths. The bill would ensure that information was kept confidential by imposing a criminal penalty and by allowing civil damages for disclosing confidential information. These provisions would be effective deterrents, and it is unlikely that either would be used.

SB 515 would subject the team to the appropriate liability limits in the Tort Claims Act for units of local government. Most team members would be employees of government agencies and would be covered by other liability limits under the Tort Claims Act. Other team members could be covered by

liability limits in Civil Practice and Remedies Code, chapter 84, which covers liability for some volunteers of charitable organizations.

OPPONENTS SAY:

SB 515 is unnecessary because local communities already are free to form teams to look at unexpected deaths without statewide legislation. In fact, many communities already do so with coordinated community response teams.

OTHER OPPONENTS SAY:

SB 515 would not provide enough liability protection for individual team members. Individual members could be sued and required to pay damages if information was disclosed through no fault of theirs. Team members who were not government employees might have no limits on their liability.

NOTES:

The committee amendment would add the provision that would make review teams and members civilly liable for disclosing information. The amendment would delete provisions from the Senate-passed bill that would make team members immune from civil or criminal liability, make review teams' records exempt from subpoena or discovery, and prohibit the records from being introduced into evidence in civil or criminal proceedings.