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 504 (Substitute S-1 as passed by the Senate)
Sponsor: Senator Loren Bennett
Committee: Families, Mental Health and Human Services

Date Completed: 5-21-97

RATIONALE

In early 1992, Governor Engler appointed the Governor's Task Force on Children's Justice with the express purpose of meeting the requirements of a state multidisciplinary task force under the Federal Children's Justice Act. The Task Force was charged with reviewing and evaluating Michigan's handling of child abuse, and making recommendations in certain areas. In its June 1992 report, the task force included among its recommendations the formation of coordinated teams to investigate child abuse and neglect cases. The Michigan Public Health Institute subsequently was selected to implement a child fatality review program. By June 1994, 17 counties had agreed to participate in a pilot project to review the deaths of children in their communities, and all of the teams were ready to begin reviews by January 1996. To enhance these efforts, Public Acts 220 and 225 of 1995 amended the Child Protection Law to allow county medical examiners and child fatality review teams to receive records from the central registry of child abuse and neglect reports maintained by the Family Independence Agency.

On December 30, 1996, the Michigan Public Health Institute reported on the first year of the program. According to the report, "The pilot project for Child Death Review shows great promise in helping the people of Michigan better understand how and why our children die and in taking action to prevent other deaths to children. It is recommended that the program be expanded and made available to all counties throughout the state." To implement this expansion, the report recommended several specific actions, such as increasing the number of local review teams, ensuring adequate training for all teams, establishing a State-level advisory team, and linking child fatality review to other State initiatives.

CONTENT

The bill would amend the Child Protection Law to do all of the following:

- **Require that each county establish a standing child fatality review team to investigate each child fatality occurring in the county or counties that established the team.**
- **Require the Family Independence Agency (FIA) to make training available to each review team.**
- **Require the FIA to establish an advisory committee to identify and make recommendations on policy and statutory changes pertaining to child fatalities and guide statewide prevention, education, and training efforts.**
- **Provide that an individual who was a member of a child fatality review team or the advisory committee would be immune from tort liability for injuries to persons or damage to property caused by the member while acting on behalf of the team or the advisory committee.**

Child Fatality Review Teams

With certain exceptions, information contained in the FIA's central registry is confidential. One of the entities to which information may be made available is a child fatality review team authorized by the FIA to investigate and review child deaths. The bill would change that to a child fatality review team established under the bill and authorized by the bill to investigate and review a child death. The bill would delete a provision prohibiting the FIA from authorizing a child fatality review team to investigate and review a child death unless the team's membership consists of at least a county medical examiner or deputy county medical examiner; a representative of a local law enforcement agency; a representative of the FIA; the county prosecuting attorney or his or her

designee; and a representative of the Department of Public Health or a local health department.

Under the bill, by January 1, 1999, each county would have to have in place a standing child fatality review team. Two or more counties could appoint a single child fatality review team for those counties. The membership of a child fatality review team would have to consist of at least all of the following:

-- A county medical examiner or deputy county medical examiner.
-- A representative of a local law enforcement agency.
-- A representative of the FIA.
-- The county prosecuting attorney, or his or her designee.
-- A representative of the Department of Community Health (DCH) or a local health department.
-- The Children's Ombudsman or his or her designee, subject to the Ombudsman's choice to be represented.

A child fatality review team established under the bill would have to investigate each child fatality occurring in the county or counties that established the team. Before a team began an investigation, the county or counties that appointed the team would have to notify the Children's Ombudsman's office of the pending investigation. The Children's Ombudsman could choose to be represented or not on the team for purposes of that investigation. If the team determined that a child fatality was caused by an act or omission of one or more individuals, the team would have to report that fact to the FIA and, if the Children's Ombudsman had chosen not to be represented, to the Children's Ombudsman.

The FIA would have to make available to each child fatality review team professional, interagency training and orientation on the review of child fatalities. The FIA would have to make available, as was necessary, training on specific types of child fatalities, investigation techniques, and prevention initiatives.

Information obtained by a child fatality review team established under the bill would be confidential and could be disclosed by the team only to the FIA, the Children's Ombudsman, the office of a team member, or another child fatality review team. The information would not be subject to the Freedom of Information Act.

Advisory Committee

By January 1, 1998, the FIA would have to establish a multiagency, multidisciplinary advisory committee to identify and make recommendations on policy and statutory changes pertaining to child fatalities and to guide statewide prevention, education, and training efforts. The advisory committee would have to consist of the following:

-- Two representatives of the FIA.
-- Two representatives of the DCH.
-- One county medical examiner.
-- One representative of law enforcement.
-- One county prosecuting attorney.
-- The Children's Ombudsman or his or her designee.

Using the annual compilation of child fatalities reported by the State Registrar under the Public Health Code, and data received from the child fatality review teams established under the bill, the advisory committee would have to publish an annual report on child fatalities. The committee would have to include in the report at least all of the following:

-- The total number of child fatalities and the type or cause of each child fatality.
-- The number of child fatalities that occurred while the child was in foster care.
-- The number of cases in which the child's death occurred within five years after family preservation or family reunification.
-- Trends in child fatalities.

The advisory committee would have to break down the information required to be included in the annual report by county or by groups of counties that formed child fatality review teams. The information contained in the advisory committee's annual report would be public information. The committee could not include identifying information of persons named in the report. The committee would have to transmit a copy of the annual report to the Governor and to the standing committees of the Legislature with jurisdiction over child protection matters.

MCL 722.627 et al.

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 would enact various recommendations of the Michigan Public Health Institute contained in its December 1996 report. Specifically, the Institute recommended increasing the number of child fatality review teams from 17 to 30 in 1997, and expanding the program Statewide in 1998. Under the bill, every county would have to have a review team in place by January 1, 1999. Also, as recommended, the FIA would have to make available to each team professional, interagency training and orientation on child death review, and the FIA would have to establish a multiagency, multidisciplinary advisory committee to guide Statewide prevention, education, and training efforts. In addition, the Institute recommended that child death review be linked to other State initiatives. The bill would ensure that the Children's Ombudsman had the opportunity to participate in an investigation, and received notice if a team determined that a child fatality was caused by one or more individuals. Further, the bill would ensure the confidentiality of information obtained by a review team, as recommended in the report.

As the report pointed out, "All children whose death could have been prevented deserve a full and thorough review of their death." The bill would enhance existing efforts to investigate the circumstances of children's deaths, and to save the lives of other children.

Legislative Analyst: S. Margules

FISCAL IMPACT

The bill would have an indeterminate fiscal impact on State government. The Family Independence Agency currently conducts child death reviews; therefore, the bill would codify this activity. The reviews began as a pilot project in January 1996 in 17 counties. The FIA plan is to expand to 30 communities during FY 1996-97, with full statewide implementation expected in FY 1997-98. The FY 1997-98 budget proposal includes an additional $500,000 Gross/GF to finance the expansion.

Various departments and agencies across State government are involved in the child death review activity. In the Michigan Public Health Institute's Second Quarter Report on Child Death Review Activity, the Institute outlined the various agencies' current-year expenditures. Total FY 1996-97 funding available is $262,200 and is divided among the agencies as follows: FIA, $180,000; Department of Community Health, $50,000; Michigan State Police, $15,000; Wayne County, $15,000; and the Michigan Public Health Institute, $2,200.

Fiscal Analyst: C. Cole

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