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SFA BILL ANALYSIS

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Senate Bill 504 (as introduced 5-14-97)
Sponsor: Senator Loren Bennett
Committee: Families, Mental Health and Human Services

Date Completed: 5-15-97

**CONTENT**

**The bill would amend the Child Protection Law (CPL) to do all of the following:**

- **Require information from an incomplete investigation to be included in the central registry maintained under the CPL.**
- **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 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 established under the bill or the advisory committee required to be established by the FIA 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.**

Central Registry

The CPL requires that the FIA maintain a central registry to carry out the intent of the Law. A written report, document, or photograph filed with the FIA under the Law is a confidential record available only to specified people or entities. The bill specifies that the FIA would have to place in the central registry a written report, document, or photograph filed with or obtained by the FIA as part of an investigation conducted under the CPL that was not completed. The information placed in the central registry would continue to be a confidential record available only to a specific list of people or entities.

One of the entities to which information in the central registry 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.

Child Fatality Review Teams

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.

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. 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 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

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 in the report the name of an individual who was responsible for the health and welfare of a deceased child. 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. Legislative Analyst: P. Affholter

**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 Institute, $2,200.

Fiscal Analyst: C. Cole

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