SENATE JUDICIARY COMMITTEE
Senator Thomas Umberg, Chair
2021-2022 Regular Session

SB 863 (Min)
Version: April 18, 2022
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Fiscal: Yes
Urgency: No
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SUBJECT

Domestic violence: death review teams

DIGEST

This bill authorizes interagency domestic violence death review teams to assist local agencies in identifying and reviewing domestic violence near-death cases, as defined.

EXECUTIVE SUMMARY

Each county in California is authorized to establish an interagency domestic violence death review team (DVDRT) to assist local agencies in identifying and reviewing domestic violence deaths, including homicides and suicides, and facilitating communication among the various agencies involved in domestic violence cases. DVDRTs have been used successfully to ensure that incidents of domestic violence and abuse are recognized and that agency involvement is reviewed to develop recommendations for policies and protocols for community prevention and intervention initiatives to reduce and eradicate the incidence of domestic violence. These teams include medical professionals, prosecutors, domestic violence shelter staff and advocates, law enforcement, and criminologists.

Seeking to join over a dozen other states, this bill expands the role of these teams by authorizing "near-death" case examinations. The bill places guardrails around these teams, including restricting such reviews until after any relevant prosecution has concluded. An individual's informed consent is required before sharing confidential information regarding them, and the bill protects statements made by survivors from disclosure. The bill also provides qualified, civil immunity for members of the team.

This bill is author sponsored. It is supported by the California Partnership to End Domestic Violence, the Little Hoover Commission, Neighborhood Legal Services of Los Angeles County, and Tides Advocacy. It is opposed by California Attorneys for

Criminal Justice. This bill passed out of the Senate Public Safety Committee on a 5 to 0 vote.

PROPOSED CHANGES TO THE LAW

Existing law:

1) Authorizes a county to establish a DVDRT to assist local agencies in identifying and reviewing domestic violence deaths, including homicides and suicides, and facilitating communication among the various agencies involved in domestic violence cases. These teams are to be comprised of, but not limited to, the following:
   a) forensic pathology experts;
   b) medical personnel with expertise in domestic violence abuse;
   c) coroners and medical examiners;
   d) criminologists;
   e) district attorneys and city attorneys;
   f) domestic violence shelter service staff and battered women's advocates;
   g) law enforcement personnel;
   h) representatives of local agencies that are involved with domestic violence abuse reporting;
   i) county health department staff who deal with domestic violence victims' health issues;
   j) representatives of local child abuse agencies; and
   k) local professional associations of such individuals. (Pen. Code § 11163.3.)

2) Deems an oral or written communication or document shared within or produced by a DVDRT related to a domestic violence death review or provided by a third party to a team is confidential and not subject to disclosure or discoverable by a third party. Notwithstanding the foregoing, recommendations of a team upon the completion of a review may be disclosed at the discretion of a majority of the team. (Pen. Code § 11163.3(e).)

3) Authorizes each organization represented on a DVDRT to share with other members of the team information in its possession concerning the victim who is the subject of the review or any person who was in contact with the victim and any other information deemed by the organization to be pertinent to the review. Any information so shared is confidential. This authorization includes disclosure to the DVDRT of any information deemed confidential, privileged, or prohibited from disclosure by any other statute. (Pen. Code § 11163.3(f).)

4) Permits written and oral information to be disclosed to a DVDRT. The team may make a request in writing for information and an individual or agency in possession of such information are authorized, but not required, to provide such

information. The disclosure of this information is authorized notwithstanding applicable privilege laws. The information that may be shared includes:

a) medical and mental health information;
b) specified information from child abuse reports and investigations; and
c) criminal history information and information from a juvenile court proceeding.

This bill:

1) Authorizes DVDRTs to assist local agencies in identifying and reviewing domestic violence near deaths. "Near death" is defined as the victim suffered a substantial risk of serious bodily injury or death from domestic violence, or the circumstances of the domestic violence event indicate that the perpetrator more likely than not intended to kill or seriously injure the victim.

2) Replaces "domestic violence shelter service staff and battered women's advocates" with "representatives of domestic violence victim service organizations," as defined.

3) Requires representatives of domestic violence victim service organizations in near-death cases to obtain an individual's informed consent in accordance with all applicable state and federal confidentiality laws before disclosing confidential information about that individual to another team member. In death review cases, representatives of domestic violence victim service organizations shall only provide client-specific information in accordance with both state and federal confidentiality requirements.

4) Immunizes members of DVDRTs, as well as their agents and employees, from civil liability for any act or omission made in connection with participation in a domestic violence death review, unless that act or omission was the result of gross negligence or willful misconduct.

5) Immunizes any organization, institution, or person furnishing information, data, testimony, reports, or records to DVDRTs, as part of the review, from civil liability for any act or omission in furnishing that information, unless that act or omission was the result of gross negligence or willful misconduct.

6) Provides that statements provided by a survivor in a near-death case review is confidential and not subject to disclosure or discoverable by a third party.

7) Provides that near-death case reviews shall only occur after any prosecution has concluded.

8) Provides that participation by near-death survivors is voluntary. In cases of death, the victim's family members may be invited to participate.

9) Requires members of DVDRTs to be prepared to provide referrals for services to address the unmet needs of survivors and their families when appropriate.

COMMENTS

1. Domestic Violence Death Review Teams

Domestic violence death review teams were inspired by similar teams focused on child deaths and share the same general goals. As explained by the United States Department of Justice:

> The concept of the DVDRT is an outgrowth of the collaborative efforts between legal, health, criminal justice, advocacy and judicial groups that have been developing across the nation for several years. The DVDRT model is based on the original Los Angeles County Child Death Review Team (CDRT) begun in 1978. A major role of CDRTs is to function as a case investigating agency, providing in-depth analysis by many agencies on the possible causes of infant and child deaths in specific cases.
>
> However, despite the many successes experienced by CDRTs, several public agencies were reluctant to participate in the review of domestic violence-related deaths via a DVDRT without statutory authority, which prompted action by the California Legislature.[1]

That action came in the form of SB 1320 (Solis, Ch. 710, Stats. 1995). It specifically authorized counties to establish interagency teams to assist local agencies in identifying and reviewing domestic violence deaths, including homicides and suicides, and facilitating communication among the various agencies involved in domestic violence cases. The DVDRTs are to be comprised of, but not limited to, the following:

- experts in the field of forensic pathology;
- medical personnel with expertise in domestic violence abuse;
- coroners and medical examiners;
- criminologists;
- district attorneys and city attorneys;
- domestic violence shelter service staff and battered women's advocates;
- law enforcement personnel;

[1] *California's Domestic Violence Death Review Team Protocol* (2001) California Attorney General's Office, https://www.ojp.gov/pdffiles1/Photocopy/191667NCJRS.pdf. All internet citations are current as of April 7, 2022.

- representatives of local agencies that are involved with domestic violence abuse reporting;
- county health department staff who deal with domestic violence victims' health issues;
- representatives of local child abuse agencies; and
- local professional associations of persons described above.

The Legislature found that such teams were successful in ensuring that incidents of domestic violence and abuse are recognized and that agency involvement is reviewed to develop recommendations for policies and protocols for community prevention and intervention initiatives to reduce and eradicate the incidence of domestic violence.

The Orange County DVDRT defines itself and its mission:

> The Orange County DVDRT is an interagency team that collects and assesses data regarding domestic violence fatalities across Orange County, California. The team consists of leadership from the Orange County Chiefs of Police and Sheriff's Association, Orange County Coroner's Office, Orange County District Attorney's Office, Orange County Probation Department, Human Options (domestic violence service agency), University California Irvine School of Law's Domestic Violence Clinic, Wel-Mor Psychology Group, Inc., and courts, along with researchers, psychologists, and scholars. The Orange County DVDRT assists local agencies in identifying and reviewing domestic violence deaths, including homicides and suicides, and facilitating communication among various agencies involved in domestic violence cases. Through examining county coroner case files once prosecutions conclude, the Orange County DVDRT analyzes trends in domestic violence fatalities in order to develop recommendations for community prevention and intervention initiatives to reduce and eradicate domestic violence.
>
> Domestic violence fatality review can also be described as the "deliberative process for identification of deaths, both homicide and suicide, caused by domestic violence, for examination of the systemic interventions into known incidents of domestic violence occurring in the family of the deceased prior to the death, for consideration of altered systemic response to avert future [intimate partner] violence deaths, or for development of recommendations for coordinated community prevention and intervention initiatives to eradicate domestic violence."[2]

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[2] *Domestic Violence Fatality Review: An Analysis of Over a Decade of Domestic Violence Fatalities in Orange County, CA: 2006-2017* (February 2022) Orange County Domestic Violence Death Review Team, https://www.law.uci.edu/academics/real-life-learning/clinics/pdfs/DVDRT-2006-2017-FullReport.pdf.

The Orange County DVDRT reports that between 2006 and 2017 there were 113 deaths that were flagged as domestic violence fatalities, although it acknowledges that this number is a significant undercounting of the true total.

2. Expanding the impact of DVDRTs

This bill authorizes DVDRTs to assist local agencies in identifying and reviewing domestic violence *near-death* cases. "Near death" is defined as the victim suffered a substantial risk of serious bodily injury or death from domestic violence, or the circumstances of the domestic violence event indicate that the perpetrator more likely than not intended to kill or seriously injure the victim.

By expanding the purview of these existing teams, the bill seeks to further effectuate its goal to ultimately reduce and eradicate domestic violence. Given that these additional reviews inherently involve a survivor of such violence, the bill provides that any information provided by the survivor is protected under the same extremely broad protective shield. Currently, communications or documents shared with or within DVDRTs are confidential and not subject to disclosure or discoverable by a third party. This bill extends these protections to statements provided by a survivor in a near-death case review.

In order to center survivors' interests, the bill makes clear that their participation is voluntary. Representatives of domestic violence victim service organizations are required to obtain an individual's informed consent in accordance with applicable confidentiality laws before disclosing confidential information about that individual to another team member. All near-death reviews are to be conducted after any relevant prosecution has concluded.

According to the author:

> Across the state, Domestic Violence Death Review Teams create awareness of domestic abuse and prevent tragic murders by working with local governments to research domestic abuse deaths. These teams produce uniquely valuable data and research, which can help service providers and law enforcement prevent future incidents. Unfortunately, these teams are only able to investigate abuse when it has resulted in a death, excluding the voices or survivors of near-fatal incidents.
>
> To support the role domestic violence death review teams play in promoting awareness of intimate partner violence, SB 863 will authorize teams to investigate near-death incidents. By bringing California in alignment with the 15 other states that have passed similar laws in recent years, the bill will both promote the crucial work of review teams and support their ongoing efforts to amplify the powerful voices of survivors.

3. Is qualified immunity for DVDRT members warranted?

The bill also grants qualified immunity to all members of DVDRTs, as well as their agents and employees, from civil liability for any act or omission made in connection with participation in a review, unless that act or omission was the result of gross negligence or willful misconduct. It further immunizes any organization, institution, or person furnishing information to DVDRTs from civil liability for any act or omission in furnishing that information, unless that act or omission was the result of gross negligence or willful misconduct.

As a general rule, California law provides that persons are responsible, not only for the result of their willful acts, but also for an injury occasioned to another by their want of ordinary care or skill in the management of their property or person, except so far as the latter has, willfully or by want of ordinary care, brought the injury upon themselves. (Civ. Code § 1714(a).) Liability has the primary effect of ensuring that some measure of recourse exists for those persons injured by the negligent or willful acts of others; the risk of that liability has the primary effect of ensuring parties act reasonably to avoid harm to those to whom they owe a duty.

Conversely, immunity from liability disincentivizes careful planning and acting on the part of individuals and entities. When one enjoys immunity from civil liability, it is relieved of the responsibility to act with due regard and an appropriate level of care in the conduct of its activities. Immunity provisions are also disfavored because they, by their nature, preclude parties from recovering when they are injured, and force injured parties to absorb losses for which they are not responsible. Liability acts not only to allow a victim to be made whole, but to encourage appropriate compliance with legal requirements.

Given that the law authorizes the sharing of extremely sensitive information, including information that would otherwise be prohibited from being disclosed pursuant to statutory privileges such as lawyer-client or physician-patient, DVDRT members should be held to a high standard and negligence should not be countenanced. In fact, it may deter survivors and others from sharing crucial information if members were not incentivized to act reasonably in maintaining and protecting this information. In response, the author has agreed to remove the provisions regarding immunity:

Amendment

Delete Section 11163.3(g)(5)(A)

4. Stakeholder positions

The California Partnership to End Domestic Violence writes in support:

> Domestic violence death review teams are a collaborative effort between legal, health service, advocacy, and judicial groups to provide a confidential forum to systematically review domestic violence-related deaths. They provide crucial data to local law enforcement, service-providers, and advocates for survivors to help prevent future fatalities.
>
> California currently limits domestic violence death review teams to only explore fatalities, while other states are increasingly moving to expand their roles. Since 2004, 15 states have amended or passed statutes authorizing near-death case examinations. It is time for California to follow this pattern to ensure that domestic violence death review teams can provide crucial information about domestic abuse.
>
> To support the role domestic violence death review teams play in protecting survivors of domestic violence, SB 863 would permit teams to examine near-deaths and equip those teams to leverage the powerful voices of survivors against fatal domestic violence.

Writing in support, the Little Hoover Commission states:

> In its 2021 report, *Beyond the Crisis: A Long-Term Approach to Reduce, Prevent, and Recover from Intimate Partner Violence*, the Commission found that California needs more accurate data to successfully address intimate partner violence. Specifically, the Commission learned that California does not have a complete understanding of the full scope and impact of intimate partner violence on Californians. Nor does the state know the effectiveness of its main programs for intimate partner violence survivors. To facilitate evidence-based decision making, the Commission recommended that California create a framework for data collection and analysis to evaluate the effectiveness of the methods the state is using to combat intimate partner violence. Further, the Commission urged state leaders to not be afraid to change course if the evidence indicates current methods are not working.
>
> We believe SB 863 would implement part of our recommendation by helping the state find patterns in system failures, which would provide decision-makers valuable information on how to adapt state programs and policies to better serve survivors.

However, California Attorneys for Criminal Justice writes in opposition to the bill. They argue the bill "will invent an entire new class of 'near death cases' that are over-inclusive, ill-advised and incompatible with the fair administration of justice." They assert:

> SB 863 selectively gathers post-conviction survivor information; it concurrently ignores post-acquittal survivors and those who the authorities determine not to charge. In this fashion, and without a single representative from the defense bar being included in the "team", SB 863 inexorably leads to institutionalized ignorance about a significant number of "near-deaths" (and deaths) related to Battered Women's Syndrome or "BWS". . . .
>
> The goal of lowering the incidence of domestic violence near deaths is not advanced by ignoring the significant number of persons who have engaged in lawful self-defense. SB 863 ignores as a matter of law the views of an entire class of victims. Those who may claim factual or legal innocence and the attorneys who represent them.

SUPPORT

California Partnership to End Domestic Violence
Family Violence Appellate Project
Family Violence Law Center
Little Hoover Commission
Neighborhood Legal Services of Los Angeles County
Orange County Domestic Violence Death Review Team
Orange County Sheriff-Coroner
Prosecutors Alliance of California
Tides Advocacy

OPPOSITION

California Attorneys for Criminal Justice

RELATED LEGISLATION

Pending Legislation:

SB 1171 (Caballero, 2022) establishes a hearsay exception for evidence of a statement made by a domestic violence victim describing any act, or attempted act, of domestic violence if the statement was made for purposes of medical diagnosis or treatment, as specified. This bill is currently in this Committee.

AB 1977 (Lackey, 2022) requires local law enforcement agencies to include in required reports whether a child was present during a domestic violence incident. The bill requires courts and district attorneys' offices to provide specific data regarding domestic violence-related calls, including the total number of cases where a felony or misdemeanor was charged and the ultimate disposition of the cases. This bill is currently in the Assembly Appropriations Committee.

AB 2185 (Weber, 2022) requires that victims of domestic violence have access to medical evidentiary examinations, free of charge. It requires Local Sexual Assault Response Teams (SART), Sexual Assault Forensic Examiner (SAFE) teams, or other qualified medical evidentiary examiners to develop and implement written policies and procedures for maintaining the confidentiality of domestic violence forensic reports, subject to the confidentiality laws pertaining to the release of medical forensic examination records. This bill is currently in the Assembly Appropriations Committee.

Prior Legislation:

SB 218 (Solis, Ch. 662, Stats. 1999) established broad authorization for disclosures between and with DVDRT members.

SB 1320 (Solis, Ch. 710, Stats. 1995) *See* Comment 1.

PRIOR VOTES:

Senate Public Safety Committee (Ayes 5, Noes 0)

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