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## Bill Analysis

**Version:** As Introduced

**Primary Sponsors:** Reps. Boggs and Abrams

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### SUMMARY

- Authorizes the establishment of county or regional domestic violence fatality review boards.
- Requires each review board to submit to the Ohio Department of Health (ODH) an annual report containing specified information related to the domestic violence fatalities reviewed by the board.
- Requires ODH to adopt rules establishing a procedure for county or regional domestic violence fatality review boards to follow in conducting a review of a death by domestic violence.

### DETAILED ANALYSIS

#### Domestic violence fatality review boards

The bill authorizes the board of county commissioners of a single county or the boards of county commissioners of two or more counties jointly to establish a county or regional board to review deaths by domestic violence of individuals over 18 years of age. To establish a domestic violence fatality review board, the board of a single county must appoint a health commissioner of a board of health located in the county to establish the review board, and the boards of two or more counties must adopt a joint resolution passed by majority of the members of each participating board of county commissioners to establish a regional review board.<sup>1</sup> The joint resolution must appoint, for each participating county, one health commissioner from that county. The health commissioners must select one of their number to

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<sup>1</sup> R.C. 307.631.

establish the regional review board. A county that already has a review board performing these functions in place may appoint that body as its domestic violence fatality review board.

## **Purpose**

The purpose of a domestic violence fatality review board is to decrease the incidence of deaths occurring because of domestic violence by doing all of the following:

- Promoting cooperation, collaboration, and communication between all groups, professions, agencies, or entities engaged in the prevention of, and education about, domestic violence;
- Maintaining a comprehensive database of all deaths by domestic violence that occur in the county or region served by the review board in order to develop an understanding of the causes and incidence of those deaths;
- Recommending and developing plans for implementing local service and program changes and changes to the groups, professions, agencies, or entities that serve local residents that might prevent deaths by domestic violence; and
- Providing the Ohio Department of Health (ODH) with aggregate data, trends, and patterns concerning deaths by domestic violence.<sup>2</sup>

## **Membership, chairperson, and meetings**

If established, a review board must consist of the following 11 members, selected by the health commissioner:<sup>3</sup>

1. The county coroner or the coroner's designee;
2. The chief of police or sheriff or the chief or sheriff's designee;
3. A public health official or a public health official's designee;
4. The county prosecutor or the prosecutor's designee;
5. The executive director of a public children services agency or the executive director's designee;
6. An Ohio-licensed physician with expertise in domestic violence;
7. An individual representing a domestic violence shelter or with experience advocating for domestic violence victims;
8. An individual representing a domestic violence perpetrator treatment program;
9. A county corrections official or an official's designee;

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<sup>2</sup> R.C. 307.634.

<sup>3</sup> R.C. 307.632(A).

10. An individual representing school teachers, guidance counselors, or student health services staff; and
11. An individual representing judges or court administrators.

In the case of a review board serving two or more counties, the members described in (1), (2), (3), (4), (9), and (11) must be representatives from the most populous county.<sup>4</sup> A majority of the members may invite additional members to serve on the board. Each additional member serves for the period of time determined by the majority and has the same authority, duties, and responsibilities as an original member.

The review board selects a chairperson by majority vote; the chairperson is responsible for convening meetings, notifying members of meetings, providing members with a list of fatalities to be reviewed, and ensuring that the board complies with review procedures.<sup>5</sup> Board meetings are not subject to Ohio's Open Meetings Law.<sup>6</sup> Any vacancy on the board must be filled in the same manner as original appointments. Members are neither compensated for serving on the board nor reimbursed for expenses incurred, unless compensation or reimbursement is received as part of the member's regular employment.<sup>7</sup>

### **Information to be collected**

For each death occurring because of domestic violence reviewed by a board, the board must collect all of the following:<sup>8</sup>

1. Demographic information of the deceased and the perpetrator, including age, sex, race, and ethnicity;
2. The year in which the death occurred;
3. The geographic location of the death;
4. The cause of death;
5. Any factors contributing to the death; and
6. Any other information the board considers relevant.

On the request of a review board, any individual, law enforcement agency, or other public or private entity that provided services to the deceased, to a child of the deceased, or to the perpetrator must submit to the board a summary sheet of information. In the case of a request made to a health care entity, the summary sheet must contain only information available and reasonably drawn from a medical record created by the entity. With respect to a

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<sup>4</sup> R.C. 307.632(A)(2).

<sup>5</sup> R.C. 307.633.

<sup>6</sup> R.C. 121.22(D)(18).

<sup>7</sup> R.C. 307.632(B) through (D).

<sup>8</sup> R.C. 307.636(B).

request made to any other individual or entity, the sheet must contain only information available and reasonably drawn from any record involving the person to which the individual or entity has access. On the request of the review board, an individual or entity has the option to make any additional information, documents, or reports available to the review board.<sup>9</sup>

### **Security of information collected**

Each review board must establish a system for collecting and maintaining information necessary for the review of deaths by domestic violence in the county or region. In an effort to ensure confidentiality, each board must maintain all records in a secure location, develop security measures to prevent unauthorized access to records containing information that could reasonably identify any person, and develop a system for storing, processing, indexing, retrieving, and destroying information obtained in the course of reviewing a death.<sup>10</sup>

### **Annual reports**

By April 1 of each year, a board's chairperson must prepare and submit to ODH a report that includes the following information for the previous calendar year:

1. The total number of deaths by domestic violence in the county or region;
2. The total number of deaths by domestic violence reviewed by the board and the total number of deaths by domestic violence that were not reviewed by the board;
3. A summary of demographic information for the deaths reviewed, including age, sex, race, and ethnicity of both deceased and perpetrators; and
4. A summary of any trends or patterns identified by the board.

The report also must include recommendations for actions that might prevent other deaths and may include any other information the review board determines should be included. The report is a public record for the purposes of Ohio's Public Records Law.<sup>11</sup>

### **Confidentiality**

Any information, document, or report presented to a review board, all statements made by board members during meetings, all work products of the board, and all data submitted to ODH other than the annual report, are confidential, exempt from the Public Records Law, and may be used by the review board, its members, and ODH only in the exercise of proper board or departmental functions.<sup>12</sup> All review board members must sign a statement acknowledging these conditions before serving.<sup>13</sup>

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<sup>9</sup> R.C. 307.637(A); conforming changes in R.C. 4731.22(B)(4).

<sup>10</sup> R.C. 307.636(A).

<sup>11</sup> R.C. 307.636(C) and (D).

<sup>12</sup> R.C. 149.43(A)(1)(nn) and 307.639.

<sup>13</sup> R.C. 307.632(E) and 307.99(F).

## Pending investigations or prosecutions

A review board may not conduct a review of a death while an investigation of the death or prosecution of a person for causing the death is pending, unless the prosecuting attorney agrees to allow the review. On the conclusion of an investigation or prosecution, the law enforcement agency conducting the criminal investigation, or the prosecuting attorney prosecuting the case, must notify the board's chairperson that the investigation or prosecution is complete.<sup>14</sup>

## Immunity

Any individual or entity providing information to a review board is immune from civil liability for injury, death, or loss to person or property that otherwise might be incurred or imposed as a result of providing the information. Each member of a review board is also immune from civil liability as a result of the member's participation on the board. This immunity does not extend to disclosure of confidential information, or failure to sign a statement acknowledging confidentiality obligations.<sup>15</sup>

## Rulemaking

The bill requires ODH to adopt rules establishing a procedure for county or regional domestic violence fatality review boards to follow in conducting a review of a death by domestic violence. The rules must do all of the following:

1. Establish a format for annual reports to be submitted to the Department by domestic violence fatality review boards;
2. Establish guidelines for a county or regional review board to follow in compiling statistics for annual reports so that the reports do not contain any information that would permit any person's identity to be ascertained from a report;
3. Establish guidelines for a county or regional review board to follow in creating and maintaining the comprehensive database of deaths by domestic violence, including provisions establishing uniform record-keeping procedures;
4. Establish guidelines for reporting domestic violence fatality review data to ODH, which must maintain the confidentiality of information that would permit a person's identity to be ascertained; and
5. Establish guidelines, materials, and training to help educate members of county or regional review boards about the purpose of the review process and the confidentiality of the information.<sup>16</sup>

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<sup>14</sup> R.C. 307.635.

<sup>15</sup> R.C. 307.638.

<sup>16</sup> R.C. 3701.0410.

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## HISTORY

Action	Date
Introduced	04-13-21

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