SENATE COMMITTEE ON PUBLIC SAFETY

Senator Aisha Wahab, Chair
2023 - 2024 Regular

Bill No:	AB 271	**Hearing Date:**	June 13, 2023
Author:	Quirk-Silva		
Version:	February 16, 2023		
Urgency:	No	**Fiscal:**	No
Consultant:	MK		

Subject: ***Homeless death review committees***

HISTORY

Source: Orange County Sheriff's Department

Prior Legislation: AB 2654 (Lackey) held Assembly Approps. 2022
AB 2660 (Maienschein) Vetoed 2022
SB 187 (Budget), Chapter 50, Stats. 2022
SB 863 (Min), Chapter 986, Stats. 2022

Support: Aids Healthcare Foundation; CalOptima Health; California Long-term Care Ombudsman Association; California State Sheriffs' Association; Illumination Foundation; Tustin Police Department

Opposition: None known

Assembly Floor Vote: 79-0

PURPOSE

The purpose of this bill is to permit counties to establish homeless death review teams.

Existing law defines "homeless" as any of the following:

a) An individual or family who lacks a fixed, regular, and adequate nighttime residence;
b) An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including, but not limited to, a car, park, abandoned building, bus station, train station, airport, or camping ground;
c) An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements, including hotels or motels paid for by federal, state, or local government programs for low-income individuals or by charitable organizations, congregate shelters, or transitional housing;
d) An individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where the individual temporarily resided;
e) An individual or family who will imminently lose their housing, including, but not limited to, housing they own, rent, or live in without paying rent, are sharing with others, or rooms in hotels or motels not paid for by federal, state, or local government programs

for low-income individuals or by charitable organizations, if any of the following criteria are met:

i. The primary nighttime residence will be lost within 14 days, as evidenced by any of the following:
   1) A court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days;

   2) The individual or family having a primary nighttime residence that is a room in a hotel or motel and where they lack the resources necessary to reside there for more than 14 days; and,
   3) Credible evidence indicating that the owner or renter of the housing will not allow the individual or family to stay for more than 14 days, and any oral statement from an individual or family seeking homeless assistance that is found to be credible shall be considered credible evidence for purposes of this clause.

ii. The individual or family has no subsequent residence identified; and,
iii. The individual or family lacks the resources or support networks needed to obtain other permanent housing.

f) Unaccompanied youth and homeless families with children and youth defined as homeless under any other federal statute, as of the effective date of this program, who meet all of the following:

   i. Have experienced a long-term period without living independently in permanent housing;
   ii. Have experienced persistent instability as measured by frequent moves over that long-term period; and,
   iii. Can be expected to continue in that status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or multiple barriers to employment. (Welfare & Institutions Code § 16523 (d).)

Existing law states that "homelessness" means the status of being homeless, as defined (Welfare & Institutions Code § 16523 (e).)

Existing law allows each county to establish an interagency child death review team to assist local agencies in identifying and reviewing suspicious child deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in child abuse or neglect cases. (Penal Code § 11174.32(a).)

Existing law allows each county to develop an autopsy protocol that may be used as a guideline to assist coroners and other persons who perform autopsies in the identification of child abuse or neglect in the determination of whether child abuse or neglect contributed to death or whether child abuse or neglect had occurred prior to but was not the actual cause of death, and in the proper reporting procedures for child abuse or neglect, including the designation of the cause and mode of death. (Penal Code § 11174.32 (b).) Permits the following information to be disclosed to a child death review team:

a) Medical information, unless disclosure is prohibited by federal law;
b) Mental health information;
c) Information from child abuse reports and investigations, except the identity of the person making the report, which shall not be disclosed;
d) State summary criminal history information, criminal offender record information, and local summary criminal history information, as specified;
e) Information pertaining to reports by health practitioners of persons suffering from physical injuries inflicted by means of a firearm or of persons suffering physical injury where the injury is a result of assaultive or abusive conduct; and,
f) Records of in-home supportive services, unless disclosure is prohibited by federal law. (Penal Code § 11174.32 (e)(2).)

Existing law allows each county to establish an interagency elder and dependent adult death review team to assist local agencies in identifying and reviewing suspicious elder and dependent adult deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in elder and dependent adult abuse or neglect cases. (Penal Code § 11174.5 (a).)

This bill allows each county to establish a homeless death review committee to assist local agencies in identifying the root causes of death of homeless individuals.

This bill allows each county to develop an autopsy protocol that may be used as a guideline to assist coroners and other persons who perform autopsies on homeless individuals in the identification of the cause and mode of death for the individual.

This bill provides that written or oral communication, or, a document shared within or produced by a homeless death review committee information is confidential and not subject to third party discovery or disclosure;

This bill permits the homeless death review committee to share recommendations upon the completion of a review at the discretion of a majority of the members on the committee.

This bill allows an organization represented on the homeless death review committee to share with other members of the committee information that may be pertinent to review. Any information shared is confidential.

This bill states that an individual or agency that has information governed by these provisions is not required to disclose information; the intent is to allow the voluntary disclosure of information by the individual or agency that has the information.

This bill allows an individual or agency that has information requested by the homeless death review committee to reply on the committee's request as a basis for disclosing the information.

This bill permits the following information to be disclosed to a homeless death review committee:

a) Medical information, unless disclosure is prohibited by federal law;
b) Mental health information;
c) State summary criminal history information, criminal offender record information, and local summary criminal history information, as specified;

d) Information pertaining to reports by health practitioners of persons suffering from physical injuries inflicted by means of a firearm or of persons suffering physical injury where the injury is a result of assaultive or abusive conduct; and,
e) Information provided to probation officers in the course of the performance of their duties, including, but not limited to reports and the information on which these reports are based.

This bill states that written or oral information may disclosed, notwithstanding the following:

a) Willful, unauthorized violations of professional confidences which constitute unprofessional conduct;
b) Confidential communications between a psychologist and client;
c) Confidential communications between a licensed marriage and family therapists and client
d) Attorney-client privilege;
e) Lawyer-client privilege;
f) Physician-patient privilege; and,
g) Psychotherapist-patient privilege.

This bill requires any information and recommendations gathered by the homeless death review committee be used by the county to develop education and prevention strategies that will lead to improved coordination of services for the homeless population.

COMMENTS

1. Need for This Bill

According to the author:

> Last year in one month, there were approximately 45 homeless individuals that died in my district alone. That is 45 too many. AB 271 would allow counties to establish death review committees that will specifically focus on uncovering underlying causes of deaths from our homeless population, and determine how these factors can be preventable. We must be active in making changes to ensure preventable deaths concerning homeless individuals does not occur in California

2. Homelessness in California

According to background information provided by the author's office, "On average, approximately over 129,000 people experience homelessness throughout the state of California. According to the National Alliance on Homelessness, in Los Angeles alone, 49,995 people fall under the definition homeless on daily basis." (California - National Alliance to End Homelessness). Given the affordable housing shortage throughout the state, this number could be higher.

A recent study by the University of California San Francisco concluded that people who first became homeless at age 50 or later were about 60 percent more likely to die than those who had become homeless earlier in life. But homelessness was a risk for everyone, and those who remained homeless were about 80 percent more likely to die than those who were able to

return to housing. (https://www.ucsf.edu/news/2022/08/423551/older-homeless-people-are-great-risk-dying) Because this study was prospective it was able to identify and gather important information prior to people dying such as medical history or drug and substance abuse problems.

In an article by CalMatters, provided to the committee by the author's office, "Across the state, the U.S. Census shows about 6.5% of Californians identify as black or African American, but they account for nearly 40% of the state's homeless, according to a Department of Housing and Urban Development report to Congress. Nationally, black people account for 13.4% of the population but are 39.8% of the homeless population." In the same article, they point to deficiencies for those coming out of California Prisons. "Felony records, stagnant wages and a rising housing crisis combined with policies that exclude or punish marginalized groups can ensnare vulnerable black people in homelessness. Even without felony records, black people face more difficulties finding employment and housing than other races or ethnicities, the National Fair Housing Alliance (NFHA) demonstrated in a recent report." (Black people disproportionately homeless in California - CalMatters)

3. Death Review Team

This bill is modeled after child death review teams and elder & dependent adult death review teams. Both teams authorize counties to establish death review teams for suspicious child, elder and dependent adult deaths.

Local Child Death Review Teams have been functioning since the early 1980s, with Los Angeles County starting in 1978. Some California counties maintain child death review teams, however while they are formally authorized in statute, they are not mandated. (Penal Code §11174.32.)

Elder and dependent adult death review teams were authorized in statute in 2001 (Penal Code § 11174.5). According to the Sacramento District Attorney's Office "In July 1999, the District Attorney's Office partnered with Sacramento County Department of Health and Human Services to form the Elder Death Review Team (EDRT). EDRT is a multidisciplinary team with members representing law enforcement, social services, the coroner and community based organizations. Their purpose is to conduct in-depth reviews of elder and dependent adult abuse and neglect cases that resulted in death. They identify systemic needs, develop strategies, policies and procedures to improve communication between the organizations, and work toward preventing elder abuse and neglect. EDRT meets six times a year, and produces a report of findings for the Board of Supervisors." (https://www.sacda.org/victim-services/elder-abuse/elder-death-interdisciplinary-review-team/)This team has reports on its website dating back to 2004.

This bill would allow counties to establish homeless death review committees with specific protocols and guidelines.

4. Argument in Support

The sponsor, the Orange County Sheriff's Association states in support of this bill:

> Communities across our state have witnessed the troubling rise of deaths among homeless individuals. In response, Orange County established its Homeless Death Review Committee in January 2022, consisting of experts from the public and non-

profit sector to determine what, if any, factors contributing to deaths among homeless individuals were preventable. In the course of its work, it was determined that the complexity of in-depth data sharing to assess each homeless individual's death would not be possible without express authorization in state statute.

AB 271 provides a necessary means for counties to conduct more complete reviews of deaths among unhoused individuals, and implements best practices recommended by the National Health Care for the Homeless Council. The information sharing authorized by AB 271 will result in more data being available to counties and provide them with the tools to make data-driven decisions rooted in best practices to prevent deaths of more homeless individuals.

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