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LEGISLATURE OF NEBRASKA

ONE HUNDRED EIGHTH LEGISLATURE

FIRST SESSION

LEGISLATIVE BILL 75

Introduced by Vargas, 7; DeBoer, 10; Jacobson, 42.

Read first time January 05, 2023

Committee: Health and Human Services

A BILL FOR AN ACT relating to the Child and Maternal Death Review Act; to amend sections 71-3404, 71-3405, 71-3407, 71-3408, 71-3409, and 71-3410, Revised Statutes Cumulative Supplement, 2022; to provide for the review of incidents of severe maternal morbidity; to define a term; to harmonize provisions; and to repeal the original sections.

Be it enacted by the people of the State of Nebraska,

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Section 1. Section 71-3404, Revised Statutes Cumulative Supplement, 2022, is amended to read:

71-3404 (1) Sections 71-3404 to 71-3411 shall be known and may be cited as the Child and Maternal Death Review Act.

(2) The Legislature finds and declares that it is in the best interests of the state, its residents, and especially the children of this state that the number and causes of death of children, including stillbirths, in this state be examined. There is a need for a comprehensive integrated review of all child deaths and stillbirths in Nebraska and a system for statewide retrospective review of existing records relating to each child death and stillbirth.

(3) The Legislature further finds and declares that it is in the best interests of the state and its residents that the number and causes of maternal death and severe maternal morbidity in this state be examined. There is a need for a comprehensive integrated review of all maternal deaths and incidents of severe maternal morbidity in Nebraska and a system for statewide retrospective review of existing records relating to each maternal death and incident of severe maternal morbidity.

(4) It is the intent of the Legislature, by creation of the Child and Maternal Death Review Act, to:

(a) Identify trends from the review of past records to prevent future child deaths, stillbirths, ~~and~~ maternal deaths, and incidents of severe maternal morbidity from similar causes when applicable;

(b) Recommend systematic changes for the creation of a cohesive method for responding to certain child deaths, stillbirths, ~~and~~ maternal deaths, and incidents of severe maternal morbidity; and

(c) When appropriate, cause referral to be made to those agencies as required in section 28-711 or as otherwise required by state law.

Sec. 2. Section 71-3405, Revised Statutes Cumulative Supplement, 2022, is amended to read:

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71-3405 For purposes of the Child and Maternal Death Review Act:

(1) Child means a person from birth to eighteen years of age;

(2) Investigation of child death means a review of existing records and other information regarding the child or stillbirth from relevant agencies, professionals, and providers of medical, dental, prenatal, and mental health care. The records to be reviewed may include, but not be limited to, medical records, coroner's reports, autopsy reports, social services records, records of alternative response cases under alternative response implemented in accordance with sections 28-710.01, 28-712, and 28-712.01, educational records, emergency and paramedic records, and law enforcement reports;

(3) Investigation of maternal death means a review of existing records and other information regarding the woman from relevant agencies, professionals, and providers of medical, dental, prenatal, and mental health care. The records to be reviewed may include, but not be limited to, medical records, coroner's reports, autopsy reports, social services records, educational records, emergency and paramedic records, and law enforcement reports;

(4) Maternal death means the death of a woman during pregnancy or the death of a postpartum woman;

(5) Postpartum woman means a woman during the period of time beginning when the woman ceases to be pregnant and ending one year after the woman ceases to be pregnant;

(6) Preventable child death means the death of any child or stillbirth which reasonable medical, social, legal, psychological, or educational intervention may have prevented. Preventable child death includes, but is not limited to, the death of a child or stillbirth resulting from (a) intentional and unintentional injuries, (b) medical misadventures, including untoward results, malpractice, and foreseeable complications, (c) lack of access to medical care, (d) neglect and reckless conduct, including failure to supervise and failure to seek

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medical care for various reasons, and (e) preventable premature birth;

(7) Preventable maternal death means the death of a pregnant or postpartum woman when there was at least some chance of the death being averted by one or more reasonable changes to (a) the patient, (b) the patient's family, (c) the health care provider, facility, or system, or (d) community factors;

(8) Reasonable means taking into consideration the condition, circumstances, and resources available; ~~and~~

(9) Severe maternal morbidity means the unexpected outcomes of labor and delivery resulting in significant short- or long-term consequences to a woman's health;

(10) ~~(9)~~ Stillbirth means a spontaneous fetal death which resulted in a fetal death certificate pursuant to section 71-606; and

(11) ~~(10)~~ Teams means the State Child Death Review Team and the State Maternal Death Review Team.

Sec. 3. Section 71-3407, Revised Statutes Cumulative Supplement, 2022, is amended to read:

71-3407 (1) The purpose of the teams shall be to (a) develop an understanding of the causes and incidence of child deaths, stillbirths, ~~or~~ maternal deaths, and severe maternal morbidity in this state, (b) develop recommendations for changes within relevant agencies and organizations which may serve to prevent child deaths, stillbirths, ~~or~~ maternal deaths, and incidents of severe maternal morbidity and (c) advise the Governor, the Legislature, and the public on changes to law, policy, and practice which will prevent child deaths, stillbirths, ~~or~~ maternal deaths, and incidents of severe maternal morbidity.

(2) The teams shall:

(a) Undertake annual statistical studies of the causes and incidence of child or maternal deaths in this state. The studies shall include, but not be limited to, an analysis of the records of community, public, and private agency involvement with the children, the pregnant or postpartum

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women, and their families prior to and subsequent to the child or maternal deaths;

(b) Develop a protocol for retrospective investigation of child or maternal deaths by the teams;

(c) Develop a protocol for collection of data regarding child or maternal deaths by the teams;

(d) Consider training needs, including cross-agency training, and service gaps;

(e) Include in its annual report recommended changes to any law, rule, regulation, or policy needed to decrease the incidence of preventable child or maternal deaths;

(f) Educate the public regarding the incidence and causes of child or maternal deaths, the public role in preventing child or maternal deaths, and specific steps the public can undertake to prevent child or maternal deaths. The teams may enlist the support of civic, philanthropic, and public service organizations in the performance of educational duties;

(g) Provide the Governor, the Legislature, and the public with annual reports which shall include the teams' findings and recommendations for each of their duties. Each team shall submit an annual report on or before each December 31 to the Legislature electronically; and

(h) When appropriate, make referrals to those agencies as required in section 28-711 or as otherwise required by state law.

(3) The teams may enter into consultation agreements with relevant experts to evaluate the information and records collected. All of the confidentiality provisions of section 71-3411 shall apply to the activities of a consulting expert.

(4) The teams may enter into written agreements with entities to provide for the secure storage of electronic data, including data that contains personal or incident identifiers. Such agreements shall provide

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for the protection of the security and confidentiality of the content of the information, including access limitations, storage of the information, and destruction of the information. All of the confidentiality provisions of section 71-3411 shall apply to the activities of the data storage entity.

(5) The teams may enter into agreements with a local public health department as defined in section 71-1626 to act as the agent of the teams in conducting all information gathering and investigation necessary for the purposes of the Child and Maternal Death Review Act. All of the confidentiality provisions of section 71-3411 shall apply to the activities of the agent.

(6) For purposes of this section, entity means an organization which provides collection and storage of data from multiple agencies but is not solely controlled by the agencies providing the data.

Sec. 4. Section 71-3408, Revised Statutes Cumulative Supplement, 2022, is amended to read:

71-3408 (1) The chairperson of each team shall:

(a) Chair meetings of the teams; and

(b) Ensure identification of strategies to prevent child or maternal deaths.

(2) The team coordinator of each team provided under subsection (5) of section 71-3406 shall:

(a) Have the necessary information from investigative reports, medical records, coroner's reports, autopsy reports, educational records, and other relevant items made available to the team;

(b) Ensure timely notification of the team members of an upcoming meeting;

(c) Ensure that all team reporting and data-collection requirements are met;

(d) Oversee adherence to the review process established by the Child and Maternal Death Review Act; and

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(e) Perform such other duties as the team deems appropriate.

(3) The team data abstractor provided under subsection (5) of section 71-3406 shall:

(a) Possess qualifying ~~nursing~~ experience, a demonstrated understanding of child and maternal outcomes, strong professional communication skills, data entry and relevant computer skills, experience in medical record review, flexibility and ability to accomplish tasks in short time frames, appreciation of the community, knowledge of confidentiality laws, the ability to serve as an objective unbiased storyteller, and a demonstrated understanding of social determinants of health;

(b) Request records for identified cases from sources described in section 71-3410;

(c) Upon receipt of such records, review all pertinent records to complete fields in child, stillbirth, ~~and~~ maternal death, and severe maternal morbidity databases;

(d) Summarize findings in a case summary; and

(e) Report all findings to the team coordinators.

Sec. 5. Section 71-3409, Revised Statutes Cumulative Supplement, 2022, is amended to read:

71-3409 (1)(a) The State Child Death Review Team shall review child deaths in the manner provided in this subsection.

(b) The members shall review the death certificate, birth certificate, coroner's report or autopsy report if done, and indicators of child or family involvement with the department. The members shall classify the nature of the death, whether accidental, homicide, suicide, undetermined, or natural causes, determine the completeness of the death certificate, and identify discrepancies and inconsistencies.

(c) A review shall not be conducted on any child death under active investigation by a law enforcement agency or under criminal prosecution. The members may seek records described in section 71-3410. The members

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shall identify the preventability of death, the possibility of child abuse or neglect, the medical care issues of access and adequacy, and the nature and extent of interagency communication.

(2)(a) The team may review stillbirths ~~occurring on or after January 1, 2023,~~ in the manner provided in this subsection.

(b) The members may review the death certificates and other documentation which will allow the team to identify preventable causes of stillbirths.

(c) Nothing in this subsection shall be interpreted to require review of any stillbirth death.

(3)(a) The State Maternal Death Review Team shall review all maternal deaths in the manner provided in this subsection.

(b) The members shall review the maternal death records in accordance with evidence-based best practices in order to determine: (i) If the death is pregnancy-related; (ii) the cause of death; (iii) if the death was preventable; (iv) the factors that contributed to the death; (v) recommendations and actions that address those contributing factors; and (vi) the anticipated impact of those actions if implemented.

(c) A review shall not be conducted on any maternal death under active investigation by a law enforcement agency or under criminal prosecution. The members may seek records described in section 71-3410. The members shall identify the preventability of death, the possibility of domestic abuse, the medical care issues of access and adequacy, and the nature and extent of interagency communication.

(4)(a) The team may review incidents of severe maternal morbidity in the manner provided in this subsection and additionally, may use guidelines published by the Centers for Disease Control or develop its own guidelines for such review.

(b) The members may review any records or documents which will allow the team to identify preventable causes of severe maternal morbidity.

(c) Nothing in this subsection shall be interpreted to require the

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review of any incident of severe maternal morbidity.

Sec. 6. Section 71-3410, Revised Statutes Cumulative Supplement, 2022, is amended to read:

71-3410 (1) Upon request, the teams shall be immediately provided:

(a) Information and records maintained by a provider of medical, dental, prenatal, and mental health care, including medical reports, autopsy reports, and emergency and paramedic records; and

(b) All information and records maintained by any agency of state, county, or local government, any other political subdivision, any school district, or any public or private educational institution, including, but not limited to, birth and death certificates, law enforcement investigative data and reports, coroner investigative data and reports, educational records, parole and probation information and records, and information and records of any social services agency that provided services to the child, the pregnant or postpartum woman, or the family of the child or woman.

(2) The Department of Health and Human Services shall have the authority to issue subpoenas to compel production of any of the records and information specified in subdivisions (1)(a) and (b) of this section, except records and information on any child death, stillbirth, ~~or~~ maternal death, or incident of severe maternal morbidity under active investigation by a law enforcement agency or which is at the time the subject of a criminal prosecution, and shall provide such records and information to the teams.

Sec. 7. Original sections 71-3404, 71-3405, 71-3407, 71-3408, 71-3409, and 71-3410, Revised Statutes Cumulative Supplement, 2022, are repealed.