COMMITTEE ON HEALTH AND HUMAN SERVICES
SENATE AMENDMENTS TO S.B. 1316
(Reference to printed bill)

Amendment instruction key:
[GREEN UNDERLINING IN BRACKETS] indicates text added to statute or previously enacted session law.
[Green underlining in brackets] indicates text added to new session law or text restoring existing law.
[~~GREEN STRIKEOUT IN BRACKETS~~] indicates new text removed from statute or previously enacted session law.
[~~Green strikeout in brackets~~] indicates text removed from existing statute, previously enacted session law or new session law.
<<Green carets>> indicate a section added to the bill.
<<~~Green strikeout in carets~~>> indicates a section removed from the bill.

The bill as proposed to be amended is reprinted as follows:

Section 1. Heading change

A. The chapter heading of title 36, chapter 35, Arizona Revised Statutes, is changed from "CHILD FATALITIES" to "CHILD AND MATERNAL DEATHS".

B. The article heading of title 36, chapter 35, article 1, Arizona Revised Statutes, is changed from "GENERAL PROVISIONS" to "CHILD FATALITIES AND MATERNAL MORTALITY".

Sec. 2. Section 36-3501, Arizona Revised Statutes, is amended to read:

36-3501. State child fatality review team; membership; duties; reporting requirements

A. The state child fatality review team is established in the department of health services. The state team is composed of the head of the following entities or that person's designee:

1. Attorney general.
2. Office of women's and children's health in the department of health services.
3. Arizona health care cost containment system.
4. Division of developmental disabilities in the department of economic security.
5. Department of child safety.
6. Governor's office ~~for~~ OF youth, faith and family.
7. Administrative office of the courts' parent assistance program.
8. Department of juvenile corrections.
9. Arizona chapter of a national pediatric society.

B. The director of the department of health services shall appoint the following members to serve on the state team:

1. A medical examiner who is a forensic pathologist.
2. A maternal and child health specialist who is involved with the treatment of Native Americans.
3. A representative of a private nonprofit organization of tribal governments in this state.
4. A representative of the Navajo tribe.
5. A representative of the United States military family advocacy program.
6. A representative of a statewide prosecuting attorneys advisory council.
7. A representative of a statewide law enforcement officers advisory council who is experienced in child homicide investigations.
8. A representative of an association of county health officers.
9. A child advocate who is not employed by or an officer of this state or a political subdivision of this state.
10. A local child fatality review team member.

C. The state team shall:

1. Develop a child fatalities data collection system.
2. Provide training to cooperating agencies, individuals and local child fatality review teams on the use of the child fatalities data system.
3. Conduct an annual statistical report on the incidence and causes of child fatalities in this state during the past year and submit a copy of this report, including its recommendations for action, to the governor, the president of the senate and the speaker of the house of representatives on or before November 15 of each year. The report shall include available information regarding plans for or progress toward implementation of recommendations. Recommendations made to a state agency, board or commission shall require a written response indicating whether the agency is capable of implementing the recommendations within its existing authority and resources, including any applicable implementation plan, to the governor, the president of the senate, the speaker of the house of representatives and the state child fatality review team within sixty days after the report is submitted.
4. Encourage and assist in the development of local child fatality review teams.
5. Develop standards and protocols for local child fatality review teams and provide training and technical assistance to these teams.
6. Develop protocols for child fatality investigations, including protocols for law enforcement agencies, prosecutors, medical examiners, health care facilities and social service agencies.
7. Study the adequacy of statutes, ordinances, rules, training and services to determine what changes are needed to decrease the incidence of preventable child fatalities and, as appropriate, take steps to implement these changes.
8. Provide case consultation on individual cases to local teams if requested.

9. Educate the public regarding the incidence and causes of child fatalities as well as the public's role in preventing these deaths.

10. Designate a state team chairperson.

11. Develop and distribute an informational brochure that describes the purpose, function and authority of the state team. The brochure shall be available at the offices of the department of health services.

~~12. Evaluate the incidence and causes of maternal fatalities associated with pregnancy in this state. For the purposes of this paragraph, "maternal fatalities associated with pregnancy" means the death of a woman while she is pregnant or within one year after the end of her pregnancy.~~

~~13.~~ 12. Beginning January 1, 2025, conduct an annual statistical report on the incidence and causes of child fatalities and near fatalities identified by the department of child safety pursuant to section 8-807.01 for the past year and submit a copy of this report, including its recommendations for action, to the governor, the president of the senate and the speaker of the house of representatives on or before November 15 of each year. The report shall include available information regarding plans for or progress toward implementation of recommendations. Recommendations made to a state agency, board or commission shall require a written response indicating whether the agency is capable of implementing the recommendations within its existing authority and resources, including any applicable implementation plan, to the governor, the president of the senate, the speaker of the house of representatives and the state child fatality review team within sixty days after the report is submitted.

~~14.~~ 13. Inform the governor and the legislature of the need for specific recommendations regarding sudden unexpected infant death.

~~15.~~ 14. Periodically review the infant death investigation checklist developed by the department of health services pursuant to section 36-3506. In reviewing the checklist, the state team shall consider guidelines endorsed by national infant death organizations.

D. State team members are not eligible to receive compensation, but members appointed pursuant to subsection B of this section are eligible for reimbursement of expenses pursuant to title 38, chapter 4, article 2.

E. The department of health services shall provide professional and administrative support to the state team.

F. Notwithstanding subsections C and D of this section, this section does not require expenditures above the revenue available from the child fatality review fund.

Sec. 3. Title 36, chapter 35, article 1, Arizona Revised Statutes, is amended by adding section 36-3501.01, to read:

36-3501.01. Maternal mortality review program; committee; members; reports; compensation; definition

A. THE MATERNAL MORTALITY REVIEW PROGRAM IS ESTABLISHED TO EVALUATE THE INCIDENCE, CAUSES AND PREVENTABILITY OF PREGNANCY-ASSOCIATED DEATHS. THE PROGRAM SHALL COORDINATE AND FACILITATE CASE REVIEWS BY THE MATERNAL

MORTALITY REVIEW COMMITTEE. IN COLLABORATION WITH THE MATERNAL MORTALITY REVIEW PROGRAM, THE MATERNAL MORTALITY REVIEW COMMITTEE SHALL PRODUCE PREVENTION RECOMMENDATIONS THAT AIM TO ADDRESS THE CONTRIBUTING FACTORS THAT LEAD TO PREVENTABLE PREGNANCY-ASSOCIATED DEATHS.

B. THE MATERNAL MORTALITY REVIEW PROGRAM IS COMPOSED OF THE MATERNAL MORTALITY REVIEW COMMITTEE AND THE COMMITTEE'S STAFF. THE DIRECTOR OF THE DEPARTMENT OF HEALTH SERVICES SHALL APPOINT THE MEMBERS OF THE COMMITTEE. THE DIRECTOR OR THE DIRECTOR'S DESIGNEE SHALL SERVE AS COCHAIRPERSON OF THE COMMITTEE. THE COMMITTEE SHALL ELECT A SECOND COCHAIRPERSON FROM THE COMMITTEE'S MEMBERSHIP.

C. THE DIRECTOR OF THE DEPARTMENT OF HEALTH SERVICES SHALL APPOINT AT LEAST THE FOLLOWING MEMBERS OF THE MATERNAL MORTALITY REVIEW COMMITTEE, ONE OF WHOM IS FROM A COUNTY WITH A POPULATION OF LESS THAN FIVE HUNDRED THOUSAND PERSONS:

1. TWO OBSTETRICIANS WHO ARE LICENSED PURSUANT TO TITLE 32, CHAPTER 13 OR 17, AT LEAST ONE OF WHOM IS A MATERNAL FETAL MEDICINE SPECIALIST.

2. A CERTIFIED NURSE MIDWIFE WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 15.

3. A REPRESENTATIVE OF A NONPROFIT ORGANIZATION THAT PROVIDES EDUCATION, SERVICES OR RESEARCH RELATED TO MATERNAL AND CHILD HEALTH.

4. A REPRESENTATIVE OF AN ORGANIZATION THAT REPRESENTS HOSPITALS IN THIS STATE.

5. A BEHAVIORAL HEALTH PROFESSIONAL.

6. A DOMESTIC OR INTERPERSONAL VIOLENCE SPECIALIST.

7. A FORENSIC PATHOLOGIST AND TOXICOLOGIST.

8. AN INDIVIDUAL WITH PERSONAL OR COMMUNITY-LEVEL EXPERIENCE IN MATERNAL HEALTH ISSUES.

9. A REPRESENTATIVE FROM THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

10. A REPRESENTATIVE FROM THE DEPARTMENT OF CHILD SAFETY.

11. A REPRESENTATIVE FROM THE ARIZONA PERINATAL TRUST.

12. A REPRESENTATIVE OF INDIAN HEALTH SERVICES.

D. THE MATERNAL MORALITY REVIEW PROGRAM SHALL:

1. DEVELOP A DATA COLLECTION SYSTEM FOR MATERNAL FATALITIES.

2. PROVIDE TRAINING TO COOPERATING AGENCIES AND INDIVIDUALS ON IDENTIFICATION, REVIEW AND DISSEMINATION PROCESSES.

3. ON OR BEFORE MAY 15 OF EACH EVEN-NUMBERED YEAR, PRODUCE A STATISTICAL REPORT ON THE INCIDENCE AND CAUSES OF PREGNANCY-RELATED DEATHS IN THIS STATE AND SUBMIT A COPY OF THIS REPORT, INCLUDING THE COMMITTEE'S RECOMMENDATIONS FOR PREVENTING MATERNAL FATALITIES, TO THE GOVERNOR, THE PRESIDENT OF THE SENATE, THE SPEAKER OF THE HOUSE OF REPRESENTATIVES AND THE CHAIRPERSONS OF THE HEALTH AND HUMAN SERVICES COMMITTEES OF THE HOUSE OF REPRESENTATIVES AND THE SENATE, OR THEIR SUCCESSOR COMMITTEES.

4. STUDY THE ADEQUACY OF STATUTES, ORDINANCES, RULES, TRAINING AND SERVICES TO DETERMINE THE CHANGES THAT ARE NEEDED TO DECREASE THE INCIDENCE OF PREVENTABLE MATERNAL FATALITIES.

E. COMMITTEE MEMBERS ARE NOT ELIGIBLE TO RECEIVE COMPENSATION, BUT MEMBERS APPOINTED PURSUANT TO SUBSECTION C OF THIS SECTION ARE ELIGIBLE FOR REIMBURSEMENT OF EXPENSES PURSUANT TO TITLE 38, CHAPTER 4, ARTICLE 2.

F. FOR THE PURPOSES OF THIS SECTION, "PREGNANCY-ASSOCIATED DEATH" MEANS A DEATH THAT OCCURRED DURING PREGNANCY OR WITHIN ONE YEAR AFTER THE END OF PREGNANCY.

Sec. 4. Section 36-3502, Arizona Revised Statutes, is amended to read:

36-3502. Local child fatality review teams; members; duties

A. Local child fatality review teams shall abide by the standards and protocol for local child fatality review teams developed by the state team and must have prior authorization from the state team to conduct reviews. Local teams shall be composed of the head of the following departments, agencies or associations, or that person's designee:

1. County medical examiner.

2. Department of child safety.

3. County health department.

B. The chairperson of the state child fatality review team shall appoint the following members of the local team:

1. A domestic violence specialist.

2. A mental health specialist.

3. A pediatrician who is certified by the American board of pediatrics or a family physician who is certified by the American board of family medicine. The pediatrician or family physician shall also be licensed in this state.

4. A person from a local law enforcement agency.

5. A person from a local prosecutor's office.

6. A parent.

C. Local child fatality review teams shall:

1. Designate a team chairperson who shall review the death certificates of all children ~~and women~~ who die within the team's jurisdiction and call meetings of the local team when necessary.

2. Assist the state team in collecting relevant data.

3. Submit written reports to the state team as directed by that team. These reports shall include nonidentifying information on individual cases and steps taken by the local team to implement necessary changes and improve the coordination of services and investigations.

Sec. 5. Section 36-3503, Arizona Revised Statutes, is amended to read:

36-3503. Access to information; confidentiality; violation; classification

A. On request of the chairperson of the state or a local child fatality review team OR THE MATERNAL MORTALITY REVIEW PROGRAM and as necessary to carry out the team's OR PROGRAM'S duties, the chairperson shall be provided within five days excluding weekends and holidays with access to all information and records regarding a child whose fatality or near fatality is being reviewed by the team~~,~~ or information and records

regarding the child's family and records of a maternal fatality associated with pregnancy pursuant to section ~~36-3501, subsection C~~ 36-3501.01 [~~A~~]:

1. From a person or institution providing medical, dental, nursing or mental health care.

2. From this state or a political subdivision of this state that might assist a team OR PROGRAM to review a child fatality or near fatality OR A CASE OF MATERNAL MORTALITY.

B. A law enforcement agency with the approval of the prosecuting attorney may withhold from release pursuant to subsection A of this section any investigative records that might interfere with a pending criminal investigation or prosecution.

C. The director of the department of health services or the director's designee may apply to the superior court for a subpoena as necessary to compel the production of books, records, documents and other evidence related to a team investigation. Subpoenas issued shall be served and, on application to the court by the director or the director's designee, enforced in the manner provided by law for the service and enforcement of subpoenas. A law enforcement agency is not required to produce the information requested under the subpoena if the subpoenaed evidence relates to a pending criminal investigation or prosecution. All records shall be returned to the agency or organization on completion of the review. Written reports or records containing identifying information shall not be kept by the team.

D. All information and records acquired by the state team, any local team or a program are confidential and are not subject to subpoena, discovery or introduction into evidence in any civil or criminal proceedings, except that information, documents and records otherwise available from other sources are not immune from subpoena, discovery or introduction into evidence through those sources solely because they were presented to or reviewed by a team or program.

E. Members of a team OR PROGRAM, persons attending a team OR PROGRAM meeting and persons who present information to a team OR PROGRAM may not be questioned in any civil or criminal proceedings regarding information presented in or opinions formed as a result of a meeting. This subsection does not prevent a person from testifying to information that is obtained independently of the team OR PROGRAM or that is public information.

F. Pursuant to policies adopted by the state child fatality review team or ~~a~~ THE maternal mortality review program, a member of the state or a local child fatality review team or ~~a~~ THE maternal mortality review program, or the member's designee, may contact, interview or obtain information from a close contact or family member of a child or woman who dies within the team's or program's jurisdiction. The state child fatality review team and maternal mortality review program shall establish a process for approving any contact, interview or request before any team or program member or designee contacts, interviews or obtains information from the close contact or family member of a child or woman who dies

within the team's or program's jurisdiction. Policies adopted pursuant to this subsection must require that any individual who engages with a family member be trained in trauma informed interview techniques and educated on support services available to the close contact or family member.

G. State and local team and program meetings are closed to the public and are not subject to title 38, chapter 3, article 3.1 if the team or program is reviewing individual child fatality cases or cases of maternal fatalities associated with pregnancy. All other team and program meetings are open to the public.

H. A person who violates the confidentiality requirements of this section is guilty of a class 2 misdemeanor.

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Amend title to conform

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