

First Regular Session of the 121st General Assembly (2019)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2018 Regular and Special Session of the General Assembly.

## SENATE ENROLLED ACT No. 278

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AN ACT to amend the Indiana Code concerning health.

*Be it enacted by the General Assembly of the State of Indiana:*

SECTION 1. IC 16-18-2-128.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 128.4. "Fetal death", for purposes of IC 16-49-6, has the meaning set forth in IC 16-49-6-1.**

SECTION 2. IC 16-18-2-188.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 188.8. "Infant death", for purposes of IC 16-49-6, has the meaning set forth in IC 16-49-6-2.**

SECTION 3. IC 16-18-2-210.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 210.5. "Local fetal-infant mortality review team", for purposes of IC 16-49-6, has the meaning set forth in IC 16-49-6-3.**

SECTION 4. IC 16-18-2-341 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 341. "Stillbirth", for purposes of IC 16-37 and IC 16-49-6, means a birth after twenty (20) weeks of gestation that is not a live birth.**

SECTION 5. IC 16-49-6 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

### **Chapter 6. Fetal-Infant Mortality Review Teams**

**Sec. 1. As used in this chapter, "fetal death" refers to a**

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stillbirth.

**Sec. 2.** As used in this chapter, "infant death" refers to the death of a child who is less than one (1) year of age.

**Sec. 3.** As used in this chapter, "local fetal-infant mortality review team" or "review team" refers to:

- (1) a county fetal-infant mortality review team; or
- (2) a regional fetal-infant mortality review team formed by multiple counties through a written agreement.

**Sec. 4. (a) A:**

- (1) local health department;
- (2) hospital licensed under IC 16-21; or
- (3) person or entity approved by the state department;

may establish a local fetal-infant mortality review team to review fetal deaths and infant deaths for the purpose of gathering information concerning fetal deaths and infant deaths and to use the information gathered to improve community resources and systems of care to reduce fetal deaths and infant deaths.

(b) Upon the establishment of a local fetal-infant mortality review team under this section, the review team shall notify the statewide fetal-infant mortality review coordinator of the establishment of the review team.

(c) A local fetal-infant mortality review team:

- (1) shall review the fetal death or infant death of a resident of; and
- (2) may review the fetal death or infant death that occurred in;

the county or area for which the review team is established.

(d) A local fetal-infant mortality review team shall do the following:

- (1) Identify similarities, trends, and factual patterns concerning fetal deaths and infant deaths in the area served by the review team.
- (2) Identify reasons for any higher minority fetal or infant mortality rate in the area served by the review team.
- (3) Create strategies and make recommendations for the prevention and reduction of fetal deaths and infant deaths, including minority fetal and infant deaths, in the area served by the review team.

(e) A local fetal-infant mortality review team may do any of the following:

- (1) Determine factors contributing to fetal deaths and infant deaths.



**(2) Identify public health and clinical interventions to improve systems of care and enhance coordination.**

**(3) Develop strategies for the prevention of fetal deaths and infant deaths.**

**Sec. 5. (a) A local fetal-infant mortality review team shall be multidisciplinary and culturally diverse. The review team should include professionals and representatives of agencies that provide services or community resources for families in the community.**

**(b) Members may include representatives from the following disciplines:**

- (1) Obstetrics.**
- (2) Mental health.**
- (3) Pediatrics.**
- (4) Family medicine.**
- (5) Public health nursing.**
- (6) Maternal fetal medicine.**
- (7) Emergency medical services.**
- (8) Social work.**
- (9) Addiction medicine.**

**(c) Members may also include any of the following:**

- (1) A coroner or deputy coroner.**
- (2) An epidemiologist.**
- (3) A pathologist.**
- (4) A law enforcement representative.**
- (5) A representative of the Indiana Minority Health Coalition.**

**(d) The local fetal-infant mortality review team shall select a member to serve as chairperson of the review team.**

**(e) The local fetal-infant mortality review team shall meet at least quarterly.**

**Sec. 6. (a) In conducting a review under this chapter, the local fetal-infant mortality review team may review all applicable records and information related to the death, including the following:**

- (1) Records held by any of the following:**
  - (A) The state department.**
  - (B) A local health department, including certificates of death or certificates of stillbirths.**
  - (C) The department of child services.**
- (2) Medical records.**
- (3) Law enforcement records.**
- (4) Coroner records, including autopsy reports.**
- (5) Mental health records.**



(6) Emergency medical services and fire department run reports.

(7) Qualitative results of a family or maternal interview.

(b) The following shall provide to the local fetal-infant mortality review team, in good faith, access to records concerning a case under review under this chapter:

(1) A health care provider.

(2) A health care facility.

(3) An individual.

(4) An entity.

(c) A person described in subsection (b) that provides access to records in good faith under this section is not subject to liability in:

(1) a civil;

(2) an administrative;

(3) a disciplinary; or

(4) a criminal;

action that might otherwise be imposed as a result of the disclosure.

(d) Except as otherwise provided under this chapter, information and records acquired and interviews conducted by the local fetal-infant mortality review team in the exercise of the review team's duties under this chapter are confidential and exempted from disclosure.

(e) Records, information, documents, and reports acquired or produced by the local fetal-infant mortality review team are not:

(1) subject to subpoena or discovery; or

(2) admissible as evidence;

in any judicial or administrative proceeding. Information that is otherwise discoverable or admissible from original sources is not immune from discovery or use in any proceeding merely because the information was presented during proceedings before the review team.

(f) The local fetal-infant mortality review team members and individuals who attend a local fetal-infant mortality review team meeting at the invitation of the chairperson shall maintain the confidentiality of records and information discussed and disseminated during the meeting.

Sec. 7. The state department shall employ a statewide fetal-infant mortality review coordinator to assist local fetal-infant mortality review teams and do the following:

(1) Establish local fetal-infant mortality review teams statewide.



- (2) Act as a liaison between the statewide child fatality review committee and local fetal-infant mortality review teams.**
- (3) Create and provide forms, including a data collection form for the data described in section 8(d) of this chapter.**
- (4) Develop protocols for meetings of and case reviews conducted by local fetal-infant mortality review teams.**
- (5) Provide data collection tools that include collecting and storing the following information:**
  - (A) Identifying and nonidentifying information.**
  - (B) Information concerning the circumstances surrounding a fetal death or an infant death.**
  - (C) Information concerning factors that contributed to a fetal death or an infant death.**
  - (D) Information concerning findings and recommendations concerning a fetal death or infant death by the review team.**
- (6) Provide information on the prevention of fetal deaths and infant deaths.**
- (7) Obtain certificates of death and certificates of stillbirths for the review teams.**
- (8) Coordinate local or statewide training concerning a fetal death or infant death review under this chapter.**

**Sec. 8. (a) Before July 1 of each year, a local fetal-infant mortality review team shall submit a report to the state department that includes the following information:**

- (1) A summary of the data collected concerning the reviews conducted by the local fetal-infant mortality review team for the previous calendar year.**
- (2) Actions recommended by the local fetal-infant mortality review team to improve systems of care and community resources to reduce fetal deaths and infant deaths in the area served by the review team.**
- (3) Solutions proposed for any system inadequacies.**

**(b) The report described in subsection (a) may not contain identifying information relating to the deaths reviewed by the local fetal-infant mortality review team.**

**(c) Review data concerning a fetal death or an infant death is confidential and may not be released.**

**(d) The local fetal-infant mortality review team may provide the state department with data concerning the reviews of a death under this chapter.**

**Sec. 9. (a) Except as provided under subsection (b), a local**



**fetal-infant mortality review team meeting is open to the public.**

**(b) A local fetal-infant mortality review team meeting that involves confidential records or identifying information concerning a fetal death or an infant death that is confidential under state or federal law must be held as a executive session.**

**Sec. 10. (a) Local fetal-infant mortality review team members and individuals who attend a local fetal-infant mortality review team meeting at the invitation of the chairperson shall maintain the confidentiality of records and information discussed and disseminated during a local fetal-infant mortality review team meeting.**

**(b) The local fetal-infant mortality review team members and individuals who attend a review team meeting at the invitation of the chairperson:**

**(1) may discuss among themselves confidential matters that are before the local fetal-infant mortality review team; and**

**(2) are, except when acting:**

**(A) with malice;**

**(B) in bad faith; or**

**(C) with negligence;**

**immune from any civil or criminal liability that might otherwise be imposed as a result of sharing among themselves those matters.**

**(c) The discussions, determinations, conclusions, and recommendations of the local fetal-infant mortality review team or its members concerning a review of a fatality at a review team meeting:**

**(1) are privileged; and**

**(2) are not:**

**(A) subject to subpoena or discovery; or**

**(B) admissible as evidence;**

**in any judicial or administrative proceeding.**

**Sec. 11. Nothing in this chapter shall preclude any death, illness, or injury investigation or review to the extent authorized by other laws.**

SECTION 6. IC 31-33-18-2, AS AMENDED BY P.L.48-2018, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 2. The reports and other material described in section 1(a) of this chapter and the unredacted reports and other material described in section 1(b) of this chapter shall be made available only to the following:

**(1) Persons authorized by this article.**

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- (2) A legally mandated public or private child protective agency investigating a report of child abuse or neglect or treating a child or family that is the subject of a report or record.
- (3) Any of the following who are investigating a report of a child who may be a victim of child abuse or neglect:
  - (A) A police officer or other law enforcement agency.
  - (B) A prosecuting attorney.
  - (C) A coroner, in the case of the death of a child.
- (4) A physician who has before the physician a child whom the physician reasonably suspects may be a victim of child abuse or neglect.
- (5) An individual legally authorized to place a child in protective custody if:
  - (A) the individual has before the individual a child whom the individual reasonably suspects may be a victim of abuse or neglect; and
  - (B) the individual requires the information in the report or record to determine whether to place the child in protective custody.
- (6) An agency having the legal responsibility or authorization to care for, treat, or supervise a child who is the subject of a report or record or a parent, guardian, custodian, or other person who is responsible for the child's welfare.
- (7) An individual named in the report or record who is alleged to be abused or neglected or, if the individual named in the report is a child or is otherwise incompetent, the individual's guardian ad litem or the individual's court appointed special advocate, or both.
- (8) Each parent, guardian, custodian, or other person responsible for the welfare of a child named in a report or record and an attorney of the person described under this subdivision, with protection for the identity of reporters and other appropriate individuals.
- (9) A court, for redaction of the record in accordance with section 1.5 of this chapter, or upon the court's finding that access to the records may be necessary for determination of an issue before the court. However, except for disclosure of a redacted record in accordance with section 1.5 of this chapter, access is limited to in camera inspection unless the court determines that public disclosure of the information contained in the records is necessary for the resolution of an issue then pending before the court.
- (10) A grand jury upon the grand jury's determination that access to the records is necessary in the conduct of the grand jury's



official business.

(11) An appropriate state or local official responsible for child protection services or legislation carrying out the official's official functions.

(12) The community child protection team appointed under IC 31-33-3 (or IC 31-6-11-14 before its repeal), upon request, to enable the team to carry out the team's purpose under IC 31-33-3.

(13) A person about whom a report has been made, with protection for the identity of:

(A) any person reporting known or suspected child abuse or neglect; and

(B) any other person if the person or agency making the information available finds that disclosure of the information would be likely to endanger the life or safety of the person.

(14) An employee of the department, a caseworker, or a juvenile probation officer conducting a criminal history check under IC 31-26-5, IC 31-34, or IC 31-37 to determine the appropriateness of an out-of-home placement for a:

(A) child at imminent risk of placement;

(B) child in need of services; or

(C) delinquent child.

The results of a criminal history check conducted under this subdivision must be disclosed to a court determining the placement of a child described in clauses (A) through (C).

(15) A local child fatality review team established under IC 16-49-2.

(16) The statewide child fatality review committee established by IC 16-49-4.

(17) The department.

(18) The division of family resources, if the investigation report:

(A) is classified as substantiated; and

(B) concerns:

(i) an applicant for a license to operate;

(ii) a person licensed to operate;

(iii) an employee of; or

(iv) a volunteer providing services at;

a child care center licensed under IC 12-17.2-4 or a child care home licensed under IC 12-17.2-5.

(19) A citizen review panel established under IC 31-25-2-20.4.

(20) The department of child services ombudsman established by IC 4-13-19-3.

(21) The state superintendent of public instruction with protection





for the identity of:

- (A) any person reporting known or suspected child abuse or neglect; and
  - (B) any other person if the person or agency making the information available finds that disclosure of the information would be likely to endanger the life or safety of the person.
- (22) The state child fatality review coordinator employed by the state department of health under IC 16-49-5-1.
- (23) A person who operates a child caring institution, group home, or secure private facility if all the following apply:
- (A) The child caring institution, group home, or secure private facility is licensed under IC 31-27.
  - (B) The report or other materials concern:
    - (i) an employee of;
    - (ii) a volunteer providing services at; or
    - (iii) a child placed at;
 the child caring institution, group home, or secure private facility.
  - (C) The allegation in the report occurred at the child caring institution, group home, or secure private facility.
- (24) A person who operates a child placing agency if all the following apply:
- (A) The child placing agency is licensed under IC 31-27.
  - (B) The report or other materials concern:
    - (i) a child placed in a foster home licensed by the child placing agency;
    - (ii) a person licensed by the child placing agency to operate a foster family home;
    - (iii) an employee of the child placing agency or a foster family home licensed by the child placing agency; or
    - (iv) a volunteer providing services at the child placing agency or a foster family home licensed by the child placing agency.
  - (C) The allegations in the report occurred in the foster family home or in the course of employment or volunteering at the child placing agency or foster family home.
- (25) The National Center for Missing and Exploited Children.
- (26) A local domestic violence fatality review team established under IC 12-18-8, as determined by the department to be relevant to the death or near fatality that the local domestic violence fatality review team is reviewing.
- (27) The statewide domestic violence fatality review committee



established under IC 12-18-9-3, as determined by the department to be relevant to the death or near fatality that the statewide domestic violence fatality review committee is reviewing.

(28) The statewide maternal mortality review committee established under IC 16-50-1-3, as determined by the department to be relevant to the case of maternal morbidity or maternal mortality that the statewide maternal mortality review committee is reviewing.

**(29) A local fetal-infant mortality review team established under IC 16-49-6, as determined by the department to be relevant to the case of fetal or infant fatality that the local fetal-infant mortality review team is reviewing.**

SECTION 7. IC 34-30-2-84.2, AS ADDED BY P.L.119-2013, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 84.2. (a) IC 16-49-3-5 (Concerning hospitals, physicians, coroners, law enforcement officers, and mental health providers who provide certain records to local child fatality review teams).

**(b) IC 16-49-6-6 (Concerning health care providers, health care facilities, individuals, and entities that provide certain records to the local fetal-infant mortality review team).**

SECTION 8. IC 34-30-2-84.3, AS ADDED BY P.L.119-2013, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 84.3. (a) IC 16-49-3-9 (Concerning a member of a local child fatality review team or an individual who attends a meeting of a local child fatality review team as an invitee of the chairperson).

**(b) IC 16-49-6-10 (Concerning a member of the local fetal-infant mortality review team or an individual who attends a meeting of the local fetal-infant mortality review team as an invitee of the chairperson).**

SECTION 9. IC 34-46-2-11.6 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 11.6. IC 16-49-6-10 (Concerning discussions, determinations, conclusions, and recommendations of the local fetal-infant mortality review team).**

SECTION 10. IC 36-2-14-18, AS AMENDED BY P.L.48-2018, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 18. (a) Notwithstanding IC 5-14-3-4(b)(1), when a coroner investigates a death, the office of the coroner is required to make available for public inspection and copying the following:

(1) The name, age, address, sex, and race of the deceased.



(2) The address where the dead body was found, or if there is no address the location where the dead body was found and, if different, the address where the death occurred, or if there is no address the location where the death occurred.

(3) The name of the agency to which the death was reported and the name of the person reporting the death.

(4) The name of any public official or governmental employee present at the scene of the death and the name of the person certifying or pronouncing the death.

(5) Information regarding an autopsy (requested or performed) limited to the date, the person who performed the autopsy, where the autopsy was performed, and a conclusion as to:

(A) the probable cause of death;

(B) the probable manner of death; and

(C) the probable mechanism of death.

(6) The location to which the body was removed, the person determining the location to which the body was removed, and the authority under which the decision to remove the body was made.

(7) The records required to be filed by a coroner under section 6 of this chapter and the verdict and the written report required under section 10 of this chapter.

(b) A county coroner or a coroner's deputy who receives an investigatory record from a law enforcement agency shall treat the investigatory record with the same confidentiality as the law enforcement agency would treat the investigatory record.

(c) Notwithstanding any other provision of this section, a coroner shall make available a full copy of an autopsy report, other than a photograph, a video recording, or an audio recording of the autopsy, upon the written request of a parent of the decedent, an adult child of the decedent, a next of kin of the decedent, or an insurance company investigating a claim arising from the death of the individual upon whom the autopsy was performed. A parent of the decedent, an adult child of the decedent, a next of kin of the decedent, and an insurance company are prohibited from publicly disclosing any information contained in the report beyond that information that may otherwise be disclosed by a coroner under this section. This prohibition does not apply to information disclosed in communications in conjunction with the investigation, settlement, or payment of the claim.

(d) Notwithstanding any other provision of this section, a coroner shall make available a full copy of an autopsy report, other than a photograph, a video recording, or an audio recording of the autopsy, upon the written request of:

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- (1) the director of the division of disability and rehabilitative services established by IC 12-9-1-1;
- (2) the director of the division of mental health and addiction established by IC 12-21-1-1; or
- (3) the director of the division of aging established by IC 12-9.1-1-1;

in connection with a division's review of the circumstances surrounding the death of an individual who received services from a division or through a division at the time of the individual's death.

(e) Notwithstanding any other provision of this section, a coroner shall make available, upon written request, a full copy of an autopsy report, including a photograph, a video recording, or an audio recording of the autopsy, to:

- (1) the department of child services established by IC 31-25-1-1, including an office of the department located in the county where the death occurred;
- (2) the statewide child fatality review committee established by IC 16-49-4; or
- (3) a county child fatality review team or regional child fatality review team established under IC 16-49-2 for the area where the death occurred;

for purposes of an entity described in subdivisions (1) through (3) conducting a review or an investigation of the circumstances surrounding the death of a child (as defined in IC 16-49-1-2) and making a determination as to whether the death of the child was a result of abuse, abandonment, or neglect. An autopsy report made available under this subsection is confidential and shall not be disclosed to another individual or agency, unless otherwise authorized or required by law.

**(f) Notwithstanding any other provision of this section, a coroner shall make available, upon written request, a full copy of an autopsy report, including a photograph, a video recording, or an audio recording of the autopsy, to the local fetal-infant mortality review team established under IC 16-49-6 for purposes of the local fetal-infant mortality review team conducting a review or an investigation of the circumstances surrounding a fetal death or an infant death (as defined in IC 16-49-6). An autopsy report made available under this subsection is confidential and shall not be disclosed to another individual or agency, unless otherwise authorized or required by law.**

**(g)** Notwithstanding any other provision of this section, a coroner shall make available, upon written request, a full copy of an autopsy



report, including a photograph, a video recording, or an audio recording of the autopsy, to the statewide maternity mortality review committee established under IC 16-50-1.

~~(g)~~ **(h)** Notwithstanding any other provision of this section, and except as otherwise provided in this subsection, a coroner may make available, upon written request, a full copy of an autopsy report to the peer review committee (as defined in IC 34-6-2-99) of a hospital at which the decedent was treated immediately before death for purposes of the hospital's peer review activities. An autopsy report made available under this subsection:

(1) may not include:

- (A) a photograph;
- (B) a video recording; or
- (C) an audio recording;

of the autopsy; and

(2) is confidential and may not be disclosed to another individual or agency, unless otherwise authorized or required by law.

However, if immediately making available an autopsy report under this subsection will interfere with the coroner's investigation or other legal proceedings related to the decedent's death, the coroner may delay making available the requested autopsy related information until the investigation or other legal proceedings are concluded.

~~(h)~~ **(i)** Except as provided in subsection ~~(i)~~; **(j)**, the information required to be available under subsection (a) must be completed not later than fourteen (14) days after the completion of:

- (1) the autopsy report; or
- (2) if applicable, any other report, including a toxicology report, requested by the coroner as part of the coroner's investigation;

whichever is completed last.

~~(i)~~ **(j)** The prosecuting attorney may petition a circuit or superior court for an order prohibiting the coroner from publicly disclosing the information required in subsection (a). The prosecuting attorney shall serve a copy of the petition on the coroner.

~~(j)~~ **(k)** Upon receipt of a copy of the petition described in subsection ~~(j)~~; **(j)**, the coroner shall keep the information confidential until the court rules on the petition.

~~(k)~~ **(l)** The court shall grant a petition filed under subsection ~~(j)~~ **(j)** if the prosecuting attorney proves by a preponderance of the evidence that public access or dissemination of the information specified in subsection (a) would create a significant risk of harm to the criminal investigation of the death. The court shall state in the order the reasons for granting or denying the petition. An order issued under this



subsection must use the least restrictive means and duration possible when restricting access to the information. Information to which access is restricted under this subsection is confidential.

~~(h)~~ **(m)** Any person may petition the court to modify or terminate an order issued under subsection ~~(k)~~: **(l)**. The petition for modification or termination must allege facts demonstrating that:

- (1) the public interest will be served by allowing access; and
- (2) access to the information specified in subsection (a) would not create a significant risk to the criminal investigation of the death.

The person petitioning the court for modification or termination shall serve a copy of the petition on the prosecuting attorney and the coroner.

~~(m)~~ **(n)** Upon receipt of a petition for modification or termination filed under subsection ~~(h)~~: **(m)**, the court may:

- (1) summarily grant, modify, or dismiss the petition; or
- (2) set the matter for hearing.

If the court sets the matter for hearing, upon the motion of any party or upon the court's own motion, the court may close the hearing to the public.

~~(n)~~ **(o)** If the person filing the petition for modification or termination proves by a preponderance of the evidence that:

- (1) the public interest will be served by allowing access; and
- (2) access to the information specified in subsection (a) would not create a significant risk to the criminal investigation of the death;

the court shall modify or terminate its order restricting access to the information. In ruling on a request under this subsection, the court shall state the court's reasons for granting or denying the request.



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President of the Senate

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President Pro Tempore

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Speaker of the House of Representatives

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Governor of the State of Indiana

Date: \_\_\_\_\_ Time: \_\_\_\_\_

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