

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:

1 A BILL FOR AN ACT relating to the Child and Maternal Death Review Act; to
2 amend sections 71-3404, 71-3405, 71-3407, 71-3408, 71-3409, and
3 71-3410, Revised Statutes Cumulative Supplement, 2022; to provide
4 for the review of incidents of severe maternal morbidity; to define
5 a term; to harmonize provisions; and to repeal the original
6 sections.

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

1 Section 1. Section 71-3404, Revised Statutes Cumulative Supplement,
2 2022, is amended to read:

3 71-3404 (1) Sections 71-3404 to 71-3411 shall be known and may be
4 cited as the Child and Maternal Death Review Act.

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

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

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

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

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

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

30 Sec. 2. Section 71-3405, Revised Statutes Cumulative Supplement,
31 2022, is amended to read:

1 71-3405 For purposes of the Child and Maternal Death Review Act:

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

3 (2) Investigation of child death means a review of existing records
4 and other information regarding the child or stillbirth from relevant
5 agencies, professionals, and providers of medical, dental, prenatal, and
6 mental health care. The records to be reviewed may include, but not be
7 limited to, medical records, coroner's reports, autopsy reports, social
8 services records, records of alternative response cases under alternative
9 response implemented in accordance with sections 28-710.01, 28-712, and
10 28-712.01, educational records, emergency and paramedic records, and law
11 enforcement reports;

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

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

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

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

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

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

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

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

12 (10) (9) Stillbirth means a spontaneous fetal death which resulted
13 in a fetal death certificate pursuant to section 71-606; and

14 (11) (10) Teams means the State Child Death Review Team and the
15 State Maternal Death Review Team.

16 Sec. 3. Section 71-3407, Revised Statutes Cumulative Supplement,
17 2022, is amended to read:

18 71-3407 (1) The purpose of the teams shall be to (a) develop an
19 understanding of the causes and incidence of child deaths, stillbirths,
20 ~~or~~ maternal deaths, and severe maternal morbidity in this state, (b)
21 develop recommendations for changes within relevant agencies and
22 organizations which may serve to prevent child deaths, stillbirths, ~~or~~
23 maternal deaths, and incidents of severe maternal morbidity and (c)
24 advise the Governor, the Legislature, and the public on changes to law,
25 policy, and practice which will prevent child deaths, stillbirths, ~~or~~
26 maternal deaths, and incidents of severe maternal morbidity.

27 (2) The teams shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 Sec. 4. Section 71-3408, Revised Statutes Cumulative Supplement,
16 2022, is amended to read:

17 71-3408 (1) The chairperson of each team shall:

18 (a) Chair meetings of the teams; and

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

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

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

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

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

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

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

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

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

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

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

17 (d) Summarize findings in a case summary; and

18 (e) Report all findings to the team coordinators.

19 Sec. 5. Section 71-3409, Revised Statutes Cumulative Supplement,
20 2022, is amended to read:

21 71-3409 (1)(a) The State Child Death Review Team shall review child
22 deaths in the manner provided in this subsection.

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

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

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

4 (2)(a) The team may review stillbirths ~~occurring on or after January~~
5 ~~1, 2023,~~ in the manner provided in this subsection.

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

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

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

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

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

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

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

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

1 review of any incident of severe maternal morbidity.

2 Sec. 6. Section 71-3410, Revised Statutes Cumulative Supplement,
3 2022, is amended to read:

4 71-3410 (1) Upon request, the teams shall be immediately provided:

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

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

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

25 Sec. 7. Original sections 71-3404, 71-3405, 71-3407, 71-3408,
26 71-3409, and 71-3410, Revised Statutes Cumulative Supplement, 2022, are
27 repealed.