

Child Death and Fatality Review Teams: Multi-disciplinary Responses to Child Abuse

Updated (Feb. 2012)

Child death review teams bring together community agencies in a formal process to systematically share information on child death events and to identify risk factors in those deaths.¹ Child death review programs exist in all 50 states and the District of Columbia. Child death review leads to greater collaboration and, hopefully, prevention and better intervention responses. Some teams are established by executive order. Many states have legislation enabling child death review teams and establishing protocols for these teams. The attached compilation reflects statutory frameworks for child death and fatality review teams. This compilation is up-to-date as of February, 2012, but we recommend checking case law and current legislation for any possible modifications.

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¹ See Nat'l Cent. for the Review and Prevention of Child Deaths, <http://childdeathreview.org>.

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ALABAMA

ALA. CODE § 26-16-90 (2011). Legislative findings.

The Legislature finds and declares that: Every child is entitled to live in safety and in health and to survive into adulthood; there are concerns about the adequacy of efforts in this state to identify deaths; and recognizing that no single agency or person is responsible, that multidisciplinary, multiagency child death review teams are methods of achieving the state policy.

ALA. CODE § 26-16-91 (2011). Definitions.

The following words and phrases have the following meanings unless the context clearly indicates otherwise:

(1) Autopsy. An external and internal examination, medical history, and record review.

(2) Child. A person who has not yet reached his or her eighteenth birthday.

(3) Child deaths to be reviewed. Those deaths which are unexpected or unexplained.

(4) Community. The people and area within the local team jurisdiction.

(5) County. The county in which a deceased child resided prior to his or her death.

(6) Investigation. In the context of child death, includes all of the following:

a. A postmortem examination which may be limited to an external examination or may include an autopsy.

b. An inquiry by law enforcement agencies having jurisdiction into the circumstances of the death, including a scene investigation and interview with the child's parents, guardians, or caretakers and the person who reported the child's death.

c. A review of information regarding the child from relevant agencies, professionals, and providers of medical care.

(7) Local team. A multidisciplinary, multiagency child death review team established for a county or judicial circuit pursuant to Section 26-16-96.

(8) Meeting. In-person meetings and conferences as well as those through telephone and other live electronic means. Individual participation in meetings through electronic conferencing may be authorized through the state team chairperson or designee. Local teams may not meet by electronic means.

(9) Person acting in a professional capacity. A health practitioner, law enforcement officer, employee of a local department of social services, undertaker, funeral home director or employee of a funeral home, or firefighter, who is acting in the course of his or her professional duties.

(10) Provider of medical care. Any health practitioner who personally provides, or a facility through which is provided, any medical evaluation or treatment, including dental and mental health evaluation or treatment.

(11) State team. The State Child Death Review Team.

(12) Unexpected/Unexplained. In referring to a child's death, includes all deaths which, prior to investigation, appear possibly to have been caused by trauma, suspicious or obscure circumstances, child abuse or neglect, or other agents or Sudden Infant Death Syndrome.

ALA. CODE § 26-16-92 (2011). State policy.

It is the policy of this state that responding to unexpected/unexplained child deaths is a state and a community responsibility and must include an accurate and complete determination of the cause of death.

ALA. CODE § 26-16-93 (2011).. State Child Death Review Team -- Created.

(a) There is hereby created the State Child Death Review Team, referred to in this article as the state team.

(b) The state team shall be situated within the Alabama Department of Public Health for administrative and budgetary purposes.

(c) The state team shall be a multidisciplinary, multiagency review team, composed of 28 members, the first 7 of whom are ex officio. The ex officio members may designate representatives from their particular departments or offices to represent them on the state team who may vote and exercise all other prerogatives of the appointment. The members of the state team shall include all of the following:

(1) The Jefferson County Coroner, Medical Examiner.

(2) The State Health Officer who shall serve as chair.

(3) One member appointed by the Alabama Sheriff's Association.

(4) The Director of the Alabama Department of Forensic Sciences.

(5) The Commissioner of the Alabama Department of Human Resources.

(6) The Commissioner of the Alabama Department of Mental Health.

(7) The Director of the Alabama Department of Public Safety.

(8) A pediatrician with expertise in SIDS appointed by the Alabama Chapter, American Academy of Pediatrics.

(9) A health professional with expertise in child abuse and neglect appointed by the Alabama Department of Public Health.

(10) A family practice physician appointed by the Alabama Academy of Family Physicians.

(11) A pediatric pathologist appointed by the Alabama Department of Forensic Sciences.

(12) Eight private citizens appointed by the Governor.

(13) A member of the clergy appointed by the Governor.

(14) A representative of the Alabama Coroner's Association.

(15) A representative of the Alabama Network of Children's Advocacy Centers.

(16) A representative of the Alabama Sheriff's Association.

(17) A representative of the Alabama District Attorney's Association.

(18) A specialist in pediatric emergency medicine appointed by the Alabama Medical Association.

(19) A representative of the Alabama Association of Chiefs of Police.

(20) Chair of the Senate Health Committee or his or her designee and the Chair of the House Health Committee or his or her designee.

(d) Members who are not ex officio shall serve for a three-year term and shall not serve more than two consecutive terms. Terms for these members shall be staggered.

(e) Staffing for the state team shall be provided through the Alabama Department of Public Health using funds appropriated for this article.

(f) The initial meeting of the state team shall be held within 60 days of September 11, 1997. Meetings shall be held at least quarterly thereafter.

(g) Fifteen members shall constitute a quorum for conducting all activities of the state team which may require a vote among the members. A simple majority of members present constituting a quorum shall be required for any affirmative vote.

ALA. CODE § 26-16-94 (2011). State Child Death Review Team -- Purpose; duties.

The purpose of the state team is to decrease the risk and incidence of unexpected/unexplained child injury and death by undertaking all of the following duties:

- (1) Identifying factors which make a child at risk for injury or death.
- (2) Collecting and sharing information among state team members and agencies which provide services to children and families or investigate child deaths.
- (3) Making suggestions and recommendations to appropriate participating agencies regarding improving coordination of services and investigations.
- (4) Identifying trends relevant to unexpected/unexplained child injury and death.
- (5) Reviewing reports from local child death teams and, upon request of a local team, individual cases of child deaths.
- (6) Providing training and written materials to the local teams to assist them in carrying out their duties. Such written materials shall include model protocols for the operation of the local teams.
- (7) Developing a protocol for child death investigations, and revising the protocol as needed. The protocol for child death investigations shall not include any activity that causes public scrutiny of the family circumstances surrounding the subject death.
- (8) Undertaking a study of the operations of local teams considering training needs and service gaps. If the state team determines that changes to any statute, regulation, or policy

is needed to decrease the risk and incidence of child injury and death, it shall propose and recommend changes to such statute, regulation, or policy in its annual report.

(9) Educating the public in Alabama regarding the incidence and causes of child injury and death and the public role in aiding in reducing the risk of such injuries and deaths. The state team shall enlist the support of civil, philanthropic, and public service organizations in its performance of its education duties.

(10) Developing and implementing such procedures and policies as are necessary for its own operation.

(11) Providing the Governor and the Legislature with an annual written report which shall include, but not be limited to, the state team's findings and recommendations for each of its duties; and providing copies of such report to the public.

(12) Determining, by consent of state team members, what protocols should be followed by team members for providing data and/or information to the state team as a whole.

(13) Examining confidentiality and access to information laws, regulations, and policies for agencies with responsibilities for children, including health, public welfare, education, social services, mental health, and law enforcement agencies, and determining whether those laws, regulations, or policies impede the exchange of information necessary to reduce the risk of injury and death. If the state team determines that such laws, regulations, or policies do impede the necessary exchange of information, it shall take prompt steps to propose and recommend changes to the appropriate state agencies.

ALA. CODE § 26-16-95 (2011). Liability of team members.

State and local team members shall be immune from any and all civil and criminal liability in connection with their good faith participation on the state or local team and all activities associated therewith, provided however, this immunity shall not be available in the event any state or local team member violates the provisions of confidentiality enumerated in this article.

ALA. CODE § 26-16-96 (2011). Local child death review teams.

(a) There are hereby created local child death review teams.

(b) Each county of the state shall be included in a local multidisciplinary, multiagency child death review team's jurisdiction. The district attorney shall initiate the establishment of local teams by convening a meeting of potential team members within 60 days of September 11, 1997. In the absence of the initiation of a child death review team by the district attorney within 60 days of September 11, 1997, the local public health representative will initiate the first team meeting. During this meeting, participants shall recommend whether to establish a team for that county alone or to establish a team with and for the counties within that judicial circuit.

(c) The local team shall include, but not be limited to, all of the following members, the first five of whom are ex officio. The ex officio members may designate representatives from their particular departments or offices to represent them on the local team who may vote and exercise all other prerogatives of the appointment. The members of the local team include the following:

(1) The county health officer.

(2) The director of the county department of human resources.

(3) The county district attorney.

(4) The medical examiner.

(5) The local coroner.

(6) An investigator with a local sheriff's department who is familiar with homicide investigation.

(7) An investigator with a local police department who is familiar with homicide investigation.

(8) A pediatrician, or if no pediatrician is available a primary care physician, appointed by the county medical society.

(9) A representative from a local child advocacy center, if one exists.

(d) The local team shall select a chair from among its members. The chair shall serve a term of three years and may serve more than one consecutive term.

(e) Members who are not ex officio shall serve for a three-year term and may succeed themselves but shall not serve more than two consecutive terms. Terms for these members shall be staggered.

(f) The initial meeting of the local team shall be held within 60 days of September 11, 1997.

(g) A quorum for conducting all activities shall be determined by the local team. A simple majority of members present constituting a quorum shall be required for any affirmative vote.

(h) The purpose of the local team is to decrease the incidence of unexpected/unexplained child injury and death by the following means:

(1) Identifying factors which make a child at risk of injury or death.

(2) Sharing information among the agencies which provide services to children and families or which investigate child deaths or provide services.

(3) Improving local investigations of unexpected/unexplained child deaths by participating agencies.

(4) Improving existing services and systems and assisting in the establishment of additional services and systems to fill in gaps in the community.

(5) Identifying trends relevant to unexpected/unexplained child injury and death.

(6) Educating the local public regarding the incidence and causes of child injury and death and the public role in aiding and reducing the risk of such injuries and deaths.

(i) To achieve its purpose, the local team shall perform all the following duties and functions:

(1) Establish and implement a protocol for the local team within two months of receipt of the model protocols from the state team as required by Section 26-16-93.

(2) Respond by recording all child deaths and reviewing individual unexpected/unexplained child deaths in accordance with protocols from the state team.

(3) Meet as deemed necessary by the local chair, but not less than annually, to review the status of unexpected/unexplained child death cases, propose recommendations for improving coordination of services and investigations between member agencies, and propose changes within the member agencies which shall reduce the risk and incidence of unexpected/unexplained child injury and death.

(4) Collect data as required for submittal to the state team.

(5) Provide reports to the state team following each team meeting which shall include data on child deaths, steps taken to improve coordination of services and investigations, steps taken to implement changes within member agencies, and advice on needed changes to law, policy, and practice which shall aid in reducing the risk and incidence of child injury and death.

(j) At a local team meeting to review unexpected/unexplained child deaths, information shall be provided as specified below, except where otherwise protected by statute, to carry out each of the following of the local team's purpose and duties:

(1) The providers of medical care, the physician representative, or the medical examiner, shall provide pertinent health and medical information regarding a child whose death is being reviewed by the local team.

(2) State, county, or local government agencies shall provide all of the following data on forms developed by the state team for reporting to local child death review teams:

- a. Birth information for children who died at less than one year of age including confidential information collected for medical and health use.
- b. Death information for children who have not reached their eighteenth birthday.
- c. Law enforcement investigative data, medical examiner investigative data, parole and probation information, and records.
- d. Medical care, including dental, mental, and prenatal health care.
- e. Pertinent information from any social services agency that provided services to the child or family.

ALA. CODE § 26-16-97 (2011). Meetings; disclosure of information; violation; penalties.

- (a) Meetings of the state team and of local teams shall be closed to the public and not subject to the State Sunshine Law when the state team or local team is discussing a specific child death.
- (b) Information identifying a deceased child, a family member, guardian or caretaker of a deceased child, or an alleged or suspected perpetrator of abuse or neglect upon a child, may not be disclosed during a meeting which is open to the public.
- (c) Information regarding the involvement of any agency with the deceased child or family may not be disclosed during a public meeting.

(d) Nothing in this section shall be construed as preventing the state team or a local team from requesting the attendance at a team meeting of a person who has information relevant to the team's exercise of its purpose and duties.

(e) Any person who intentionally violates any portion of this section commits a Class C misdemeanor and shall be punished as prescribed by law.

Any person who violates the provisions of confidentiality in any proceedings conducted by either a local team or the state team shall be removed from the team in addition to any other penalty.

ALA. CODE § 26-16-91 (2011). § 26-16-98. Confidentiality of information and records.

(a) All information and records acquired by the state team or by a local team, in the exercise of its purpose and duties pursuant to this article, are confidential, exempt from disclosure under Section 41-13-1, and may only be disclosed as necessary to carry out the team's duties and purposes.

(b) Reports of the state team and of a local team which do not contain any information that would permit the identification of any person to be ascertained shall be public information.

(c) Except as necessary to carry out a team's purpose and duties, members of a team and persons attending a team meeting may not disclose what transpired at a meeting which is not public under Section 26-16-97, nor shall they disclose any information the disclosure of which is prohibited by this section.

(d) Members of a team, persons attending a team meeting, and persons who present information to a team may release information to such government agencies as is necessary for the purpose of carrying out assigned team duties.

(e) Information, documents, and records of the state team or of a local team are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal

proceeding, 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 during proceedings of the team or are maintained by a team.

(f) Moreover, notwithstanding subsections (a) and (b), those criminal records, court records, and other records that have been open to public inspection before September 11, 1997, shall remain open.

ALA. CODE § 26-16-99 (2011). Duties of coroner/medical examiner.

The duties of the coroner/medical examiner shall include the following:

(1) Except in locations where a county medical examiner has jurisdiction, the coroner or a person acting in a professional capacity shall report the death of a child by telecommunications to the medical examiner or his or her representative as soon as possible upon discovery.

(2) Upon receipt of a report of a child death, the county medical examiner or state medical examiner shall determine whether the death appears to be unexpected/unexplained. If the death appears to be unexpected/unexplained, the county medical examiner or state medical examiner shall commence an investigation of the death consisting of a postmortem examination conducted by a state or county medical examiner. Upon the recommendation of the state medical examiner, with authorization from a district attorney, an autopsy may be conducted. A county medical examiner may conduct an autopsy at his or her discretion as authorized by existing statutes. This section should not be interpreted as mandating an autopsy. In a case where an autopsy is not performed, the postmortem examination shall consist of an external examination.

ALASKA

Alaska Stat. § 12.65.120 (2011). STATE CHILD FATALITY REVIEW TEAM

(a) The state child fatality review team is established in the Department of Health and Social Services to assist the state medical examiner. The team is composed of

(1) the following persons, or that person's designee:

(A) the state medical examiner;

(B) a state prosecutor with experience in homicide prosecutions, appointed by the attorney general;

(C) an investigator with the state troopers who has experience in conducting investigations of homicide, child abuse, or child neglect, appointed by the commissioner of public safety;

(D) a social worker with the Department of Health and Social Services who has experience in conducting investigations of child abuse and neglect, appointed by the commissioner of health and social services;

(2) the following persons, or that person's designee, appointed by the commissioner of health and social services:

(A) a physician licensed under AS 08.64 who

(i) specializes in neonatology or perinatology; or

(ii) is certified by the American Board of Pediatrics;

(B) a municipal law enforcement officer with experience in conducting investigations of homicide, child abuse, or child neglect;

(C) other persons, including educators, whose experience and expertise would, as determined by the commissioner of health and social services, contribute to the effectiveness of the team.

(b) A team member is not eligible to receive compensation from the state for service on the team. A member appointed under (a)(2) of this section

(1) is eligible for travel expenses and per diem from the Department of Health and Social Services under AS 39.20.180; and

(2) serves at the pleasure of the commissioner of health and social services.

(c) In addition to the persons specified in (a) of this section, the team may invite a person to participate as a member of the team if the person has expertise that would be helpful to the team in a review of a specific death. A person participating under this subsection is eligible only for travel expenses and per diem from the Department of Health and Social Services under AS 39.20.180.

(d) The state medical examiner serves as chair of the team.

ALASKA STAT. § 12.65.130 (2011). State child fatality review team duties

(a) The state child fatality review team shall

(1) assist the state medical examiner in determining the cause and manner of the deaths in this state of children under 18 years of age;

(2) unless the child's death is currently being investigated by a law enforcement agency, review a report of a death of a child within 48 hours of the report being received by the medical examiner if

(A) the death is of a child under 10 years of age;

(B) the deceased child, a sibling, or a member of the deceased child's household

(i) is in the legal or physical custody of the state under AS 47 or under similar custody of another state or political subdivision of a state; or

(ii) has been the subject of a report of harm under AS 47.17 or a child abuse or neglect investigation by the Department of Health and Social Services or by a similar child protective service in this or another state;

(C) a protective order under AS 18.66.100 or 18.66.110 has been in effect during the previous year in which the petitioner or respondent was a member of the deceased child's immediate family or household; or

(D) the child's death occurred in a mental health institution, mental health treatment facility, foster home, or other residential or child care facility, including a day care facility;

(3) review records concerning

(A) abuse or neglect of the deceased child or another child in the deceased child's household;

(B) the criminal history or juvenile delinquency of a person who may have caused the death of the child and of persons in the deceased child's household; and

(C) a history of domestic violence involving a person who may have caused the death of the child or involving persons in the deceased child's household, including records in the central registry of protective orders under AS 18.65.540;

(4) if insufficient information exists to adequately determine the cause and manner of death, recommend to the state medical examiner that additional information be obtained under AS 12.65.020; and

(5) if a local, regional, or district child fatality review team has not been appointed under AS 12.65.015 or is not available, be available to provide recommendations, suggestions, and advice to state or municipal law enforcement or social service agencies in the investigation of deaths of children.

(b) The state child fatality review team may

(1) collect data and analyze and interpret information regarding deaths of children in this state;

(2) develop state and local data bases on deaths of children in this state;

(3) develop a model protocol for the investigation of deaths of children; and

(4) periodically issue reports to the public containing statistical data and other information that does not violate federal or state law concerning confidentiality of the children and their families involved in the reviews; these reports may include

(A) identification of trends, patterns, and risk factors in deaths of the children;

(B) analyses of the incidence and causes of deaths of children in this state;

(C) recommendations for improving the coordination of government services and investigations; and

(D) recommendations for prevention of future deaths of children.

ALASKA STAT. § 12.65.140 (2011). Records; information; meetings; confidentiality; immunity

(a) The state child fatality review team and its members shall have access to all information and records to which the state medical examiner has access under this chapter. The state child fatality review team and its members shall maintain the confidentiality of information and records concerning deaths under review, except when disclosures may be necessary to enable the team to carry out its duties under this chapter. However, the team and its members may not disclose a record that is confidential under federal or state law.

(b) Except for public reports issued by the team, records and other information collected by the team or a member of the team related to duties under this chapter are confidential and not subject to public disclosure under AS 40.25.100--40.25.295.

(c) Meetings of the state child fatality review team are closed to the public and are not subject to the provisions of AS 44.62.310 - 44.62.319 (Open Meetings Act).

(d) The determinations, conclusions, and recommendations of the state child fatality review team, or its members, are not admissible in a civil or criminal proceeding. Members may not be compelled to disclose their determinations, conclusions, recommendations, discussions, or thought processes through discovery or testimony in any civil or criminal proceeding. Records and information collected by the state child fatality review team are not subject to discovery or subpoena in connection with a civil or criminal proceeding.

(e) Notwithstanding (d) of this section, the state medical examiner may testify in a civil or criminal proceeding even though the death was reviewed by the state child fatality review team under AS 12.65.130 and information received from the review formed a basis of the state medical examiner's testimony.

(f) A person who is a member or an employee of, or who furnishes services to or advises, the state child fatality review team is not liable for damages or other relief in an action brought by reason of the performance of a duty, a function, or an activity of the review team.

Current through the 2011 of the First Regular Session and First Special Session of the 27th Legislature

ARIZONA

ARIZ. REV. STAT. § 36-3501 (2011). Child fatality review team; membership; duties

A. The child fatality review team is established in the department of health services. The team is composed of the head of the following departments, agencies, councils or associations, or that person's designee:

1. Attorney general.
2. Office of women's and children's health in the department of health services.

3. Office of planning and health status monitoring in the department of health services.
4. Division of behavioral health in the department of health services.
5. Division of developmental disabilities in the department of economic security.
6. Division of children and family services in the department of economic security.
7. Governor's office for children.
8. Administrative office of the courts.
9. Parent assistance office of the supreme court.
10. Department of juvenile corrections.
11. Arizona chapter of a national pediatric society.

B. The director of the department of health services shall appoint the following members to serve staggered three year terms:

1. A medical examiner who is a forensic pathologist.
2. A maternal and child health specialist 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 the Arizona sudden infant death advisory council.
7. A representative of a statewide prosecuting attorneys advisory council.
8. A representative of a statewide law enforcement officers advisory council who is experienced in child homicide investigations.
9. A representative of an association of county health officers.
10. A child advocate who is not employed by or an officer of this state or a political subdivision of this state.

11. A public member. If local teams are formed pursuant to this article, the director of the department of health services shall select this member from one of those local teams.

C. The 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 fiscal 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.
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 team chairperson.
11. Develop and distribute an informational brochure which describes the purpose, function and authority of a 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.

D. Team members are not eligible to receive compensation, but members appointed pursuant to subsection B are eligible for reimbursement of expenses pursuant to title 38, chapter 4, article 2. [FN1]

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

F. Notwithstanding subsections C and D, this section shall not be construed to require expenditures above the revenue available from the child fatality review fund.

ARIZ. REV. STAT. § 36-3502 (2011). Local teams; membership; duties

A. If local child fatality teams are organized, they 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 fatality 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. Child protective services office of the department of economic security.
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 psychiatrist or psychologist licensed in this state.
3. A pediatrician certified by the American board of pediatrics or a family practice physician certified by the American board of family practice. The pediatrician or family practice physician shall also be licensed in this state.
4. A person from a local law enforcement agency.
5. A person from a local prosecutors office.
6. A parent.

C. If local child fatality teams are authorized, they shall:

1. Designate a team chairperson who shall review the death certificates of all children who die within the team's jurisdiction and call meetings of the team when necessary.
2. Assist the state team in collecting data on child fatalities.
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.

ARIZ. REV. STAT. § 36-3503 (2011). Access to information; confidentiality; violation; classification

A. On request of the chairperson of a state or local team and as necessary to carry out the team's duties, the chairperson shall be provided within five days excluding weekends and holidays with access to information and records regarding a child whose death 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 § 36-3501, subsection C:

1. From a provider of medical, dental or mental health care.
2. From this state or a political subdivision of this state that might assist a team to review a child fatality.

B. A law enforcement agency with the approval of the prosecuting attorney may withhold 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 child fatality or a maternal fatality associated with pregnancy 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 or any local team 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.

E. Members of a team, persons attending a team meeting and persons who present information to a team 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 that is public information.

F. A member of the state or a local child fatality review team shall not contact, interview or obtain information by request or subpoena from a member of a deceased child's family, except that a member of the state or a local child fatality review team who is otherwise a public officer or employee may contact, interview or obtain information from a family member, if necessary, as part of the public officer's or employee's other official duties.

G. State and local team meetings are closed to the public and are not subject to title 38, chapter 3, article 3.1 [FN1] if the team is reviewing individual child fatality cases or cases of maternal fatalities associated with pregnancy. All other team meetings are open to the public.

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

ARIZ. REV. STAT. § 36-3504 (2011). Child fatality review fund

A. The child fatality review fund is established consisting of appropriations, monies received pursuant to § 36-342, subsection E and gifts, grants and donations made to the department of health services to implement subsection B of this section. The department of health services shall administer the fund. The department shall deposit, pursuant to §§ 35-146 and 35-147, all monies it receives in the fund.

B. The department of health services shall use fund monies to staff the state child fatality review team and to train and support local child fatality review teams.

C. Monies spent for the purposes specified in subsection B of this section are subject to legislative appropriation. Any fee revenue collected in excess of one hundred thousand dollars in any fiscal year is appropriated from the child fatality review fund to the child abuse prevention fund established pursuant to § 8-550.01, subsection A, to be used for healthy start programs.

ARKANSAS

ARK. CODE ANN. § 20-47-501 (2011). Purpose

The General Assembly finds that services to children are provided by various departments and agencies at both the state and local level, often without appropriate collaboration. The General Assembly declares that the purpose of this subchapter is to establish a structure for coordinated policy development, comprehensive planning, collaborative budgeting, and resource allocation for services to children with emotional disturbance and their families. It is further the intention of this subchapter to build on existing resources and to design and implement a coordinated service system for children with emotional disturbances that is child-centered, family-centered, and community-based.

ARK. CODE ANN. § 20-47-501 (2011). Definitions

As used in this subchapter:

(1)(A) “Case management” means those efforts that ensure that necessary services for the child and family are obtained and monitored.

(B) Such efforts shall include coordination across agencies for evaluations, the provision of services based on assessments and evaluations that result in the development of an interagency service plan, the review for adequacy of services through client progress, and maintaining cooperation among agencies;

(2)(A) “Case review” means a multiagency effort to design and provide a service delivery plan for difficult-to-serve children who may require unusual services or service configurations.

(B) When utilizing a group process for reaching service delivery decisions, the group shall be composed of those who carry sufficient authority to ensure timely provision of services;

(3) “CASSP” means the Child and Adolescent Service System Program;

(4) “Child with emotional disturbance” means an individual who has been diagnosed with a mental, behavioral, or emotional disorder of a long-term nature under the age of eighteen (18) or under the age of twenty-one (21) if program services began before the age of eighteen (18):

- (A) Who is exhibiting inappropriate emotional, interpersonal, or behavioral problems within the home, preschool program, school, or community given his or her age, intellectual level, and cultural background;
- (B) Whose degree of dysfunction is at least disruptive and often disabling;
- (C) Whose problems persist after efforts to deal with the problems have been made by significant others in the child's social environment;
- (D) Who meets specific criteria established by the Child and Adolescent Service System Program Coordinating Council; and
- (E) Who has multiagency needs exhibited by one (1) or more of the following characteristics:
 - (i) The behavior occurs with a sufficient frequency to be considered a pattern of response or to be so intense that the consequences lead to a severe measure of control, including, but not limited to:
 - (a) Seclusion;
 - (b) Restraint;
 - (c) Hospitalization; or
 - (d) Chemical intervention;
 - (ii) The behavior, although provoked, is judged to be extreme or inappropriate for the age, including, but not limited to:
 - (a) Very aggressive; or
 - (b) Self-withdrawn;
 - (iii) The behavior is sufficiently disruptive as to lead to exclusion from school, home, therapeutic, or recreational settings; or
 - (iv) The behavior is sufficiently intense or severe to be considered seriously detrimental to the child's growth, development, or welfare or seriously detrimental to the safety or welfare of others.
- (5) "Comprehensive Children's Behavioral Health System of Care Plan" means a plan to assist the Division of Behavioral Health of the Department of Human Services in providing oversight for the Child and Adolescent Service System Program;

(6)(A) “Flexible funds” means a specific fiscal allocation designated for atypical expenditures to meet extraordinary needs of a child and family identified in the multiagency plan of services.

(B) Decisions for expenditure of flexible funds shall be made at the regional or local level and shall be approved by all involved service providers;

(7) “Multiagency plan of services” means the integrated, individualized plan of care that is developed through the collaboration of all agencies providing services for that child and based on evaluations shared by each involved agency with the Child and Adolescent Service System Program local service team;

(8)(A) “Regional plan” means a written strategy developed by regional program teams that specifies the kind, mix, and priority of services to be provided in each community mental health center catchment area.

(B) The regional plan shall:

(i) Address all components of the system of care;

(ii) Be based on the principles for the system of care provided in this section and on the service needs of the children with emotional disturbance in the region;

(iii) Include procedures for evaluating services provided to children with emotional disturbance and their families;

(iv) Be reviewed annually by the council; and

(v) Upon approval be incorporated into the statewide plan;

(9) “Screening and assessment” means an initial appraisal of a child identified or suspected of having emotional disturbance that provides sufficient information to make decisions about service needs;

(10) “Service array” means those services in the system of care that address the varying areas of needs of children with emotional disturbance and their families and shall include but not be limited to:

(A) Behavioral health services;

(B) Substance abuse services;

(C) Social services;

(D) Education services;

(E) Health services;

(F) Vocational services;

(G) Recreational services;

(H) Case management;

(I) Advocacy; and

(J) Other necessary services;

(11) “Single point of entry” means a unit, agency, or group designated as the gatekeeper for the Child and Adolescent Service System Program service system for children with emotional disturbance and their families;

(12) “Statewide plan” means a comprehensive strategy that identifies the procedures for developing and implementing the system of care that is prepared by the council incorporating all regional plans; and

(13) “System of care” means a comprehensive spectrum of behavioral health and other necessary services organized into a coordinated network to meet the multiple and changing needs of children with emotional disturbance, based on principles set forth in this subchapter.

ARK. CODE ANN. § 20-47-503 (2011). Guiding principles

The following guiding principles shall be incorporated into the system of care:

(1) Services shall be child-centered and family-centered and give priority to keeping children with their families;

(2) Services shall be community-based, with decision-making responsibility and management at the regional and local levels;

(3) Services shall be comprehensive, addressing the child's physical, educational, social, and emotional needs;

(4) Agency resources and services shall be shared and coordinated;

- (5) Services shall be provided in the least restrictive setting consistent with effective services and as close to home as appropriate;
- (6) Services shall be culturally and ethnically sensitive;
- (7) Services shall address the unique needs and potential of each child and shall be sufficiently flexible to meet highly individualized child and family needs;
- (8) Services shall promote early identification and intervention; and
- (9) Services shall be designed to protect the rights of children.

ARK. CODE ANN. § 20-47-504 (2011). Components of the system

The components of the system of care shall include, but not be limited to:

- (1) Single point of entry;
- (2) Screening and assessment;
- (3) Case management;
- (4) Case review;
- (5) Collaborative evaluation; and
- (6) Service array.

ARK. CODE ANN. § 20-47-505 (2011). Child and Adolescent Service System Program Coordinating Council

- (a)(1) There is created a Child and Adolescent Service System Program Coordinating Council that shall meet on a quarterly basis and at other times deemed necessary to perform its functions.
- (2) The coordinating council shall include the following persons to be selected and appointed by the Commissioner of Education and the Director of the Department of Human Services:
 - (A) At least three (3) parents, parent surrogates, or family members of a child or children with emotional disturbance;

(B) A member of an ethnic minority;

(C) A child advocate;

(D) Child and Adolescent Service System Program coordinators from each of the certified community mental health centers;

(E)(i) One (1) or more representatives from specific divisions or agencies in the Department of Human Services and the Department of Education.

(ii) Each representative shall have official duties related to the delivery of behavioral health services for children and adolescents with emotional disturbances.

(iii) Specific designations of membership of the coordinating council shall be determined through interdepartmental and intradepartmental agreements that will be renewed on an annual basis; and

(F)(i) At least seven (7) representatives from private or public agencies or organizations that are stakeholders in behavioral health services for children and adolescents with emotional disturbances.

(ii) The commissioner and the director shall jointly appoint an appropriate number of stakeholders.

(b) The coordinating council shall:

(1) Advise and report to the directors on matters of policy and programs related to children with emotional disturbance and their families;

(2) Identify and recommend fiscal, policy, training, and program initiatives and revisions based on needs identified in the planning process;

(3) Provide specific guidelines for the development of regional services and plans based on the guiding principles of the system of care;

(4) Review and approve regional plans developed by regional program teams and incorporate the regional plans into the statewide plan;

(5) Ensure that mechanisms for accountability are developed and implemented;

(6) Submit a statewide plan and budget recommendations to the directors on or before March 15 of each even-numbered year thereafter preceding the legislative session;

(7) Develop and recommend special projects to the directors;

(8) Provide a written report on a quarterly basis to the House Interim Committee on Aging, Children and Youth, Legislative and Military Affairs and the Senate Interim Committee on Children and Youth that summarizes progress implementing this subchapter;

(9) Establish guidelines and procedures for the voting membership, officers, and annual planning of both the coordinating council and the regional program planning teams which the coordinating council will review and update on an annual basis; and

(10) Make recommendations for corrective action plans to the directors in the event that a regional program planning team does not produce a timely regional plan that meets a plan of care or fails to implement the approved regional plan.

ARK. CODE ANN. § 20-47-506 (2011). Regional CASSP Coordinating Council planning teams

(a) A regional Child and Adolescent Service System Program planning team shall be established in each community mental health center catchment area.

(b)(1) Each team shall include individuals who are not state employees and who are not providers of services to children with emotional disturbance or their families but who are parents, parent surrogates, family members, or consumers.

(2) Every effort shall be made to encourage and assist parents, parent surrogates, family members, consumers, and advocates to participate in program planning teams.

(c) The regional program planning teams shall include agency representatives from the community mental health centers, the Division of Developmental Disabilities Services, the Division of Children and Family Services, the Department of Health, the local school districts or education service cooperatives, and any willing provider.

(d) Additional representatives of other local services and programs shall be added by the regional team and will include representatives from the juvenile justice system or youth services providers and local preschool programs, if possible.

(e) Each regional team member may appoint a single person to serve as his or her proxy.

(f) The regional program planning team shall:

(1) Advise and report to the Child and Adolescent Service System Program Coordinating Council on matters of policies, resources, programs, and services relating to children with emotional disturbance and their families;

- (2) Identify and recommend program initiatives and revisions based on area and community-based needs;
- (3) Submit a regional plan and guidelines for interagency service delivery teams to the coordinating council on or before February 15 of each even-numbered year preceding the legislative session;
- (4) Develop and implement special projects for community-based services; and
- (5)(A) Ensure that interagency service teams are established and utilized in coordinating services for children and adolescents referred to the program.
- (B) Each service delivery team shall have sufficient and appropriate representation from identified service providers and will complete a multiagency plan of services for each child or adolescent receiving program services.
- (C) Each member of the service delivery teams shall share information, evaluations, and data necessary to produce an effective, individualized multiagency plan of services.
- (D) Every effort shall be made to assist parents, parent surrogates, family members, and consumers to participate as members of the interagency service delivery team.

ARK. CODE ANN. § 20-47-507 (2011). Child and Adolescent Service System Program Coordinating Council staff

- (a) The staff for the Child and Adolescent Service System Program Coordinating Council shall be provided by the Child and Adolescent Service System Program project for the first two (2) years and subsequently by the Division of Behavioral Health of the Department of Human Services.
- (b) The division shall serve as the coordinating agency and shall develop and support the regional program team network and the coordinating council and shall provide training and technical assistance relevant to the system of care.
- (c) Annual site reviews and program evaluations of regional program teams will be coordinated by the division and shall involve a multiagency team of professionals, family members, consumers, and advocates.
- (d) The division's program staff shall provide an annual report summarizing program regional and coordinating council activities, strategic plans, and outcomes to the Director of the Department of Human Services and the Commissioner of Education each year on or before October 15.

ARK. CODE ANN. § 20-47-508 (2011). Evaluation and treatment

- (a) Children suspected of having emotional disturbance who are referred for Child and Adolescent Service System Program services shall be given a screening and assessment through the single point of entry, after which an initial interagency service plan shall be defined and developed.
- (b) The community mental health centers are hereby designated as the single point of entry.
- (c) The assessment shall be conducted by the community mental health center serving the area in which the child or adolescent lives.
- (d) The community mental health center shall be accessible on a twenty-four-hour basis, shall accept referrals from multiple sources, have interagency linkages, involve parents, ensure immediate access to crisis intervention services, and have authority to seek needed services.
- (e) If after screening and assessment or collaborative evaluations it is determined that a child with emotional disturbance needs multiagency services, then initial and subsequent individualized multiagency service plans for the child and the child's family shall be jointly developed by the appropriate local or regional representatives of the community mental health centers, of the Department of Human Services county office, of the Department of Health, of the Special Education Division of the Department of Education, of the local school district, and of any other service provider identified to meet the needs of the child and his or her family. The individualized service plan shall reflect an integrated service delivery that specifies services or programs with funding to be provided by each agency. The service plan shall also designate responsibility for case management.

ARK. CODE ANN. § 20-47-510 (2011). Coordination and oversight--Annual reports

- (a) The Division of Behavioral Health of the Department of Human Services is designated the state agency responsible for the coordination and oversight of the Comprehensive Children's Behavioral Health System of Care Plan.
- (b) All state agencies that receive funding, either state or federal, shall participate in collaborative planning for the system of care to support behavioral health services for children and adolescents.
- (c) Each state agency that receives funding, either state or federal, to support behavioral health services for children and adolescents shall:

(1)(A) Enter into an interagency collaborative agreement with the division on or before July 2005 with regard to the responsibilities of each agency in the development and implementation of the Comprehensive Children's Behavioral Health System of Care Plan.

(B) The agreements shall be updated annually; and

(2) Submit all pertinent information, including expenditures and programming data, to the division in the time and manner established through the collaborative agreements.

(d)(1) On or before April 15, 2006, for the fiscal year beginning July 1, 2006, and annually thereafter, the division shall submit the state plan for the comprehensive child and adolescent system of care to:

(A) The commissioner and the director; and

(B) The House Interim Committee on Aging, Children and Youth, Legislative and Military Affairs and the Senate Interim Committee on Children and Youth.

(2) The state plan for the Child and Adolescent Service System Comprehensive System of Care Plan shall include, but not be limited to:

(A) The projected budget for each state agency that will be used to support behavioral health services;

(B) Prevention and early intervention;

(C) The service array and capacity for services supported through public funds that are available statewide and county by county; and

(D) An assessment of service deficits with recommendations for a plan to address service deficits with available funds.

(e)(1) On or before October 15, 2006, for the fiscal year beginning July 1, 2005, and annually thereafter, the division shall submit a report concerning the operation of the Comprehensive Children's Behavioral Health System of Care Plan to:

(A) The commissioner and the director; and

(B) The House Interim Committee on Aging, Children and Youth, Legislative and Military Affairs and the Senate Interim Committee on Children and Youth.

(2) The report shall include, but not be limited to:

(A) Actual funds expended for child and adolescent behavioral health services;

- (B) Prevention and early intervention services;
- (C) Service utilization data at all levels of care; and
- (D) Outcome data for the system of care.

CALIFORNIA

CAL. PENAL CODE § 11174.32 (2012). Interagency child death review team; autopsy protocol; records exempt from disclosure; report on findings, conclusions, and recommendations of review team

- (a) Each county may 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. Interagency child death review teams have been used successfully to ensure that incidents of child abuse or neglect are recognized and other siblings and nonoffending family members receive the appropriate services in cases where a child has expired.
- (b) Each county may develop a protocol that may be used as a guideline by persons performing autopsies on children 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 written reporting procedures for child abuse or neglect, including the designation of the cause and mode of death.
- (c) In developing an interagency child death review team and an autopsy protocol, each county, working in consultation with local members of the California State Coroner's Association and county child abuse prevention coordinating councils, may solicit suggestions and final comments from persons, including, but not limited to, the following:
 - (1) Experts in the field of forensic pathology.

(2) Pediatricians with expertise in child abuse.

(3) Coroners and medical examiners.

(4) Criminologists.

(5) District attorneys.

(6) Child protective services staff.

(7) Law enforcement personnel.

(8) Representatives of local agencies which are involved with child abuse or neglect reporting.

(9) County health department staff who deals with children's health issues.

(10) Local professional associations of persons described in paragraphs (1) to (9), inclusive.

(d) Records exempt from disclosure to third parties pursuant to state or federal law shall remain exempt from disclosure when they are in the possession of a child death review team.

(e)(1) No less than once each year, each child death review team shall make available to the public findings, conclusions and recommendations of the team, including aggregate statistical data on the incidences and causes of child deaths.

(2) In its report, the child death review team shall withhold the last name of the child that is subject to a review or the name of the deceased child's siblings unless the name has been publicly disclosed or is required to be disclosed by state law, federal law, or court order.

CAL. PENAL CODE § 11174.33 (2012). Interagency child death team protocol

Subject to available funding, the Attorney General, working with the California Consortium of Child Abuse Councils, shall develop a protocol for the development and implementation of interagency child death teams for use by counties, which shall include relevant procedures for both urban and rural counties. The protocol shall be designed to facilitate communication among persons who perform autopsies and the various persons and agencies involved in child abuse or neglect cases so that incidents of child abuse or neglect are recognized and other siblings and nonoffending family members receive the appropriate services in cases where a child has expired. The protocol shall be completed on or before January 1, 1991.

CAL. PENAL CODE § 11174.34 (2012). Child death cases; investigation and findings; abuse and neglect; plan to track and maintain data

Coordination and integration of state and local efforts; sharing of data and other information; California State Child Death Review Council

(a)(1) The purpose of this section shall be to coordinate and integrate state and local efforts to address fatal child abuse or neglect, and to create a body of information to prevent child deaths.

(2) It is the intent of the Legislature that the California State Child Death Review Council, the Department of Justice, the State Department of Social Services, the State Department of Health Services, and state and local child death review teams shall share data and other information necessary from the Department of Justice Child Abuse Central Index and Supplemental Homicide File, the State Department of Health Services Vital Statistics and the Department of Social Services Child Welfare Services/Case Management System files to establish accurate information on the nature and extent of child abuse- or neglect-related fatalities in California as those documents relate to child fatality cases. Further, it is the intent of the Legislature to ensure that records of child abuse- or neglect-related fatalities are entered into the State Department of Social Services, Child Welfare Services/Case Management System. It is also the intent that training and technical assistance be provided to child death review teams and professionals in the child protection system regarding multiagency case review.

(b)(1) It shall be the duty of the California State Child Death Review Council to oversee the statewide coordination and integration of state and local efforts to address fatal child abuse or neglect and to create a body of information to prevent child deaths. The Department of Justice, the State Department of Social Services, the State Department of Health Services, the California Coroner's Association, the County Welfare Directors Association, Prevent Child Abuse California, the California Homicide Investigators Association, the California Emergency Management Agency, the Inter-Agency Council on Child Abuse and Neglect/National Center on Child Fatality Review, the California Conference of Local Health Officers, the California Conference of Local Directors of Maternal, Child, and Adolescent Health, the California Conference of Local Health Department Nursing Directors, the California District Attorneys Association, and at least three regional representatives, chosen by the other members of the council, working collaboratively for the purposes of this section, shall be known as the California State Child Death Review Council. The council shall select a chairperson or cochairpersons from the members.

(2) The Department of Justice is hereby authorized to carry out the purposes of this section by coordinating council activities and working collaboratively with the agencies and organizations in paragraph (1), and may consult with other representatives of other agencies and private organizations, to help accomplish the purpose of this section.

(c) Meetings of the agencies and organizations involved shall be convened by a representative of the Department of Justice. All meetings convened between the Department of Justice and any organizations required to carry out the purpose of this section shall take place in this state. There shall be a minimum of four meetings per calendar year.

(d) To accomplish the purpose of this section, the Department of Justice and agencies and organizations involved shall engage in the following activities:

(1) Analyze and interpret state and local data on child death in an annual report to be submitted to local child death review teams with copies to the Governor and the Legislature, no later than July 1 each year. Copies of the report shall also be distributed to public officials in the state who deal with child abuse issues and to those agencies responsible for child death investigation in each county. The report shall contain, but not be limited to, information provided by state agencies and the county child death review teams for the preceding year.

The state data shall include the Department of Justice Child Abuse Central Index and Supplemental Homicide File, the State Department of Health Services Vital Statistics, and the State Department of Social Services Child Welfare Services/Case Management System.

(2) In conjunction with the California Emergency Management Agency, coordinate statewide and local training for county death review teams and the members of the teams, including, but not limited to, training in the application of the interagency child death investigation protocols and procedures established under Sections 11166.7 and 11166.8 to identify child deaths associated with abuse or neglect.

(e) The State Department of Health Services, in collaboration with the California State Child Death Review Council, shall design, test and implement a statewide child abuse or neglect fatality tracking system incorporating information collected by local child death review teams. The department shall:

(1) Establish a minimum case selection criteria and review protocols of local child death review teams.

(2) Develop a standard child death review form with a minimum core set of data elements to be used by local child death review teams, and collect and analyze that data.

(3) Establish procedural safeguards in order to maintain appropriate confidentiality and integrity of the data.

(4) Conduct annual reviews to reconcile data reported to the State Department of Health Services Vital Statistics, Department of Justice Homicide Files and Child Abuse Central Index, and the State Department of Social Services Child Welfare Services/Case Management System data systems, with data provided from local child death review teams.

(5) Provide technical assistance to local child death review teams in implementing and maintaining the tracking system.

(6) This subdivision shall become operative on July 1, 2000, and shall be implemented only to the extent that funds are appropriated for its purposes in the Budget Act.

(f) Local child death review teams shall participate in a statewide child abuse or neglect fatalities monitoring system by:

(1) Meeting the minimum standard protocols set forth by the State Department of Health Services in collaboration with the California State Child Death Review Council.

(2) Using the standard data form to submit information on child abuse or neglect fatalities in a timely manner established by the State Department of Health Services.

(g) The California State Child Death Review Council shall monitor the implementation of the monitoring system and incorporate the results and findings of the system and review into an annual report.

(h) The Department of Justice shall direct the creation, maintenance, updating, and distribution electronically and by paper, of a statewide child death review team directory, which shall contain the names of the members of the agencies and private organizations participating under this section, and the members of local child death review teams and local liaisons to those teams. The department shall work in collaboration with members of the California State Child Death Review Council to develop a directory of professional experts, resources, and information from relevant agencies and organizations and local child death review teams, and to facilitate regional working relationships among teams. The Department of Justice shall maintain and update these directories annually.

(i) The agencies or private organizations participating under this section shall participate without reimbursement from the state. Costs incurred by participants for travel or per diem shall be borne by the participant agency or organization. The participants shall be responsible for collecting and compiling information to be included in the annual report. The Department of Justice shall be responsible for printing and distributing the annual report using available funds and existing resources.

(j) The California Emergency Management Agency, in coordination with the State Department of Social Services, the Department of Justice, and the California State Child Death Review Council shall contract with state or nationally recognized organizations in the area of child death review to conduct statewide training and technical assistance for local child death review teams and relevant organizations, develop standardized definitions for fatal child abuse or neglect, develop protocols for the investigation of fatal

child abuse or neglect, and address relevant issues such as grief and mourning, data collection, training for medical personnel in the identification of child abuse or neglect fatalities, domestic violence fatality review, and other related topics and programs. The provisions of this subdivision shall only be implemented to the extent that the agency can absorb the costs of implementation within its current funding, or to the extent that funds are appropriated for its purposes in the Budget Act.

(k) Law enforcement and child welfare agencies shall cross-report all cases of child death suspected to be related to child abuse or neglect whether or not the deceased child has any known surviving siblings.

(l) County child welfare agencies shall create a record in the Child Welfare Services/Case Management System (CWS/CMS) on all cases of child death suspected to be related to child abuse or neglect, whether or not the deceased child has any known surviving siblings. Upon notification that the death was determined not to be related to child abuse or neglect, the child welfare agency shall enter that information into the Child Welfare Services/Case Management System.

CAL. PENAL CODE § 11174.35 (2012). Child death cases; investigation and findings; abuse and neglect; plan to track and maintain data

The State Department of Social Services shall work with state and local child death review teams and child protective services agencies in order to identify child death cases that were, or should have been, reported to or by county child protective services agencies. Findings made pursuant to this section shall be used to determine the extent of child abuse or neglect fatalities occurring in families known to child protective services agencies and to define child welfare training needs for reporting, cross-reporting, data integration, and involvement by child protective services agencies in multiagency review in child deaths. The State Department of Social Services, the State Department of Health Services, and the Department of Justice shall develop a plan to track and maintain data on child deaths from abuse or neglect, and submit this plan, not later than December 1, 1997, to the Senate Committee on Health and Human Services, the Assembly Committee on Human Services, and the chairs of the fiscal committees of the Legislature.

COLORADO

COLO. REV. STAT. § 25-20.5-401 (2012). Short title

This part 4 shall be known and may be cited as the “Child Fatality Prevention Act”.

COLO. REV. STAT. § 25-20.5-402 (2012). Legislative declaration

National Center for Prosecution of Child Abuse
National District Attorney Association

(1) The general assembly hereby finds and declares that protection of the health and welfare of the children of this state is an important goal of the citizens of this state, and the injury and death of infants and children are serious public health concerns that require legislative action. The general assembly further finds that the prevention of the abuse, neglect, and death of children is a community responsibility; that professionals from disparate disciplines have responsibilities to children and have expertise that can promote the safety and well-being of children; and that multidisciplinary reviews of the abuse, neglect, and death of children can lead to a greater understanding of the causes of, and methods of preventing, the abuse, neglect, and death of children.

(2) It is, therefore, the intent of the general assembly in enacting this part 4 to establish a statewide multidisciplinary, multi-agency child fatality prevention system. The purpose of the system is to:

(a) Review specified deaths of children from birth to eighteen years of age occurring in Colorado involving circumstances in which the children are receiving services from a county department or in which there has been a report of suspected abuse or neglect in order to develop a community approach to the problem of child abuse and neglect;

(b) Review the records of all other unexpected and unexplained deaths of children from birth to eighteen years of age occurring in Colorado in order to develop a community approach to the prevention of childhood fatalities;

(c) Understand the incidence and causes of childhood deaths;

(d) Identify services provided by public agencies to children and their families that are designed to prevent child abuse, neglect, or death, and that are effective in preventing child abuse, neglect, or death;

(e) Identify any gaps or deficiencies that may exist in the delivery of services provided by public agencies to children and their families that are designed to prevent child abuse, neglect, or death; and

(f) Make recommendations for, act as a catalyst for, and implement any changes to laws, rules, and policies that will support the safe and healthy development of the children in this state and prevent child abuse, neglect, and death.

COLO. REV. STAT. § 25-20.5-403 (2012). Definitions

As used in this part 4, unless the context otherwise requires:

(1) “County department” means the county or district department of social services.

(2) “Local review team” means a local child fatality prevention review team established pursuant to section 25-20.5-404.

(3) “State review team” means the Colorado state child fatality prevention review team created pursuant to section 25-20.5-406.

(4) “Unexpected and unexplained death” means a death that, prior to investigation, appears to have been caused by trauma, suspicious or obscure circumstances, or child abuse or neglect. An “unexpected and unexplained death” includes, but is not limited to, death from vehicular trauma, fire, drowning, abuse, suicide, and unknown causes.

COLO. REV. STAT. § 25-20.5-404 (2012). Local review teams--creation--membership--authority

(1) Each judicial district may establish, subject to available appropriations, a local child fatality prevention review team. The first meeting of a local review team shall be called by the district attorney of the judicial district in which the local review team is located.

(2) Each local review team shall consist of representatives of public and nonpublic agencies in the judicial district that provide services to children and their families and of other individuals who represent the community.

(3)(a) Local review teams shall include representatives from the following entities located in the judicial district:

(I) Each county department;

(II) Local law enforcement agencies;

(III) The district attorney's office;

(IV) School districts;

(V) Each county department of public health;

(VI) Each coroner's office or county medical examiner's office; and

(VII) Each county attorney's office.

(b) Local review teams may include but are not limited to representatives from the following entities or groups located in the judicial district:

(I) Hospitals, trauma centers, or other providers of emergency medical services;

- (II) Each county board of social services;
 - (III) Mental health professionals;
 - (IV) Medical professionals specializing in pediatrics;
 - (V) Each court-appointed special advocate program;
 - (VI) Child advocacy centers;
 - (VII) Private out-of-home placement providers;
 - (VIII) Victim advocates associated with law enforcement agencies; and
 - (IX) The community at large.
- (4) Each local review team has the authority to establish committees to review specific types of childhood deaths.

COLO. REV. STAT. § 25-20.5-405 (2012). Local review teams--duties--authority

- (1) Each local review team shall review the following types of cases:
- (a) A case of unexpected and unexplained death of a child eighteen years of age or younger occurring in the judicial district of the local review team;
 - (b) A case occurring in the judicial district involving the death of a child eighteen years of age or younger who was:
 - (I) In the custody of the department of human services or the county department at the time of death;
 - (II) The subject of an open child welfare case maintained by a county department of social services; or
 - (III) Reported as a child involved in an investigation of suspected abuse or neglect by a county department of social services or a law enforcement agency at any time during the twelve months preceding the child's death.
- (2) With respect to each case reviewed, the local review team shall:
- (a) Review the cause and manner of the child's death as determined by the local coroner, pathologist, or medical examiner, and attempt to determine whether the local review team concurs with the coroner's, pathologist's, or medical examiner's findings;

(b) In cases in which the local review team does not concur with the cause or manner of death as determined by the local coroner, pathologist, or medical examiner, forward a report of the local review team's analysis of the cause and manner of the child's death to the local coroner, pathologist, or medical examiner for his or her consideration;

(c) Evaluate means by which the death might have been prevented;

(d) Report case review findings to public and private agencies that have responsibilities for children and make recommendations to these agencies that may help to reduce the number of child deaths;

(e) Request from an agency a plan of action for improvements to prevent child deaths based upon a report submitted to the agency pursuant to paragraph (d) of this subsection (2) when the case review involves a child in the custody of the agency at the time of death or involves identified system problems at the agency;

(f) Submit to the state review team the following information:

(I) Information about each death reviewed;

(II) A listing of any system issues identified through the review process and recommendations to the state review team and the appropriate agencies for system improvements and needed resources, training, and information dissemination where gaps and deficiencies may exist;

(III) Any changes, positive or negative, that appear to have resulted from implementation of previous recommendations made by the local review team to the state review team and appropriate agencies;

(IV) Examples of services known by the local review team to be provided by public agencies to children and their families that are designed to prevent child abuse, neglect, or death and that are effective in preventing child abuse, neglect, or death; and

(V) Any additional information requested by the state review team.

(3) Each local review team may, within existing appropriations and community resources:

(a) Promote continuing education for professionals involved in investigating, treating, and preventing child abuse and neglect as a means of preventing child deaths due to abuse or neglect; and

(b) Promote public education related to preventing unexpected and unexplained child deaths and deaths related to abuse or neglect.

COLO. REV. STAT. § 25-20.5-406 (2012). State review team--creation--membership--vacancies

(1) There is hereby created the Colorado state child fatality prevention review team in the department of public health and environment.

(2)(a) On or before September 1, 2005, the governor shall appoint the seventeen voting members of the state review team specified in this paragraph (a), as follows:

(I) Two members who represent the county sheriffs within the state, one of whom represents a rural area of the state;

(II) Two members who represent the county coroners within the state;

(III) Two members who represent peace officers within the state who specialize in crimes against children;

(IV) Two members who represent the district attorneys within the state, one of whom represents a rural area of the state;

(V) Six members who represent members of the medical profession within the state who specialize in traumatic injury or children's health, including four physicians and two nurses;

(VI) One member who represents local fire department employees within the state;

(VII) One member who represents county attorneys within the state who practice in the area of dependency and neglect; and

(VIII) One member who represents county commissioners within the state.

(b) The executive director of the department of human services shall appoint six ex officio nonvoting members, as follows:

(I) Two members who represent the unit within the department of human services that is responsible for child welfare;

(II) One member who represents the unit within the department of human services that is responsible for mental health services;

(III) One member who represents the unit in the department of human services that administers behavioral health programs and services, including those related to mental health and substance abuse;

(IV) One member who represents the division of youth corrections; and

(V) One member who represents the directors of county departments of social services.

(c) The executive director of the department of public health and environment shall appoint eight ex officio nonvoting members who represent the department of public health and environment, one of whom represents county or district public health agencies.

(d) The commissioner of education shall appoint one ex officio nonvoting member who represents the department of education.

(e) The executive director of the department of public safety shall appoint one ex officio nonvoting member who represents the department of public safety.

(f) A member of the department of public health and environment shall call a preliminary meeting of the members of the state review team specified in paragraphs (a) to (e) of this subsection (2), and the voting members appointed pursuant to said paragraphs may, by a majority vote, select an additional twelve nonvoting members of the state review team as follows:

(I) Four members who represent injury prevention or safety specialists from hospitals within the state;

(II) One member who represents organizations specializing in auto safety or driver safety within the state;

(III) One member who represents sudden infant death specialists within the state;

(IV) One member who represents the state network of child advocacy centers within the state;

(V) One member who represents a state domestic violence coalition;

(VI) One member who represents the court-appointed special advocate program directors, described in section 19-1-203, C.R.S., within the state;

(VII) One member who represents the office of the child's representative, established in section 13-91-104, C.R.S.;

(VIII) One member who represents a private out-of-home placement provider; and

(IX) One member of the community with experience in childhood death.

(3) Members shall be appointed for three-year terms and shall be eligible for reappointment upon the expiration of the terms. Vacancies in the appointed membership shall be filled by the appointing entity.

COLO. REV. STAT. § 25-20.5-407 (2012). State review team--duties

(1) The state review team shall:

(a) Form committees to review, at a minimum, childhood deaths in the state of Colorado related to the following causes:

(I) Natural causes;

(II) Unintentional injury;

(III) Violence;

(IV) Motor vehicle incidents;

(V) Child abuse or neglect; and

(VI) Sudden infant death syndrome;

(b) Outline trends and patterns of childhood death in Colorado;

(c) Identify and investigate risk factors that may lead to childhood death;

(d) Characterize groups of children who are at risk for childhood death;

(e) Evaluate the services offered and the system responses to children who are at risk of childhood death, review recommendations of local review teams, if any, and plans of action submitted by agencies for improvements to prevent childhood deaths, if any, offer recommendations for improvement to these services and system responses, and request plans of action for improvement from agencies, when necessary;

- (f) Take steps to improve the quality and scope of data obtained through investigations and review of childhood deaths;
- (g) Report to the governor and to the health and human services committees and the judiciary committees of the house of representatives and the senate of the Colorado general assembly concerning any recommendations for changes to any law, rule, or policy that the state review team has determined will promote the safety and well-being of children. The state review team shall report annually within the first week of convening or reconvening the general assembly.
- (h) Subject to available appropriations and community resources, distribute information to the public concerning risks to children and recommendations for promoting the safety and well-being of children;
- (i) Serve as a link with child death review teams throughout the country and participate in national child death review team activities; and
- (j) Perform any other functions necessary to enhance the capability of the state of Colorado to reduce and prevent childhood injuries and death.

COLO. REV. STAT. § 25-20.5-408 (2012). Access to records

- (1) Review team access to records. (a) Notwithstanding any other state law to the contrary but subject to the requirements of applicable provisions of federal law, the state review team and the local review teams shall have access to all records and information in the possession of the department of human services and the county departments of social services that are relevant to the review of a child death, including records and information related to previous reports and investigations of suspected child abuse or neglect.
- (b) Except as otherwise provided in paragraph (c) of this subsection (1), notwithstanding any other state law to the contrary, but subject to the requirements of applicable provisions of federal law, the state review team and the local review teams shall have access to all other records and information that are relevant to a review of a child death and that are in the possession of a state or local governmental agency. These records include, but are not limited to, birth certificates, records of coroner or medical examiner investigations, and records of the department of corrections.
- (c) Mental health and substance abuse treatment records may be accessed only with the written consent of appropriate parties in accordance with applicable federal and state law.
- (2) Public access to records and information. (a) Open meetings. Meetings of the state review team and local review teams shall be subject to the provisions of section 24-6-402, C.R.S.

(b) Confidentiality. Each member of the state review team, each member of a local review team, and each invited participant at a meeting shall sign a statement indicating an understanding of and adherence to confidentiality requirements. A person who knowingly violates confidentiality requirements commits a class 3 misdemeanor and, upon conviction, shall be punished as provided in section 18-1.3-501, C.R.S.

(c) Release of information. (I) Members of the state review team, members of the local review teams, a person who attends a review team meeting, and a person who presents information to a review team may release information to governmental agencies as necessary to fulfill the requirements of this part 4.

(II) Members of the state review team, members of the local review teams, a person who attends a review team meeting, and a person who presents information to a review team shall not be subject to examination, in any civil or criminal proceeding, concerning information presented to members of the review team or opinions formed by the review team based on that information. A person may, however, be examined concerning information reviewed by the state review team or a local review team that is otherwise available to the public or that is required to be revealed by that person in another official capacity.

(III) Information, documents, and records of the state review team and the local review teams shall not be subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding; except that information, documents, and records that would otherwise be available from a person serving on the state review team or a local review team or that would otherwise be required to be revealed by law shall not be immune from subpoena, discovery, or introduction into evidence solely because the information was presented at or became available due to a proceeding of the state review team or a local review team.

(IV) Information received by the state review team or a local review team that contains information exculpatory to a person charged with a criminal offense shall be subject to release pursuant to the rules of criminal procedure.

COLO. REV. STAT. § 25-20.5-409 (2012). Administration--funding--cash fund

(1) To the extent funds are available, the state review team and the local review teams may hire staff or consultants to assist them in completing their duties.

(2) Staff and consultants of the state review team or the local review teams shall receive reimbursement for travel and expenses to offset the costs incurred in fulfilling their duties, which shall be paid from moneys appropriated to implement this part 4 and within the limits of those moneys.

(3) The division of prevention services in the department of public health and environment, on behalf of the state review team, is authorized to receive contributions, grants, services, and donations from any public or private entity for any direct or indirect costs associated with the duties of the state review team set forth in this part 4.

(4) All private and public funds received by the state review team through grants, contributions, and donations pursuant to this part 4 shall be transmitted to the state treasurer, who shall credit the same to the child fatality prevention cash fund, which fund is hereby created and referred to in this section as the “fund”. The moneys in the fund shall be subject to annual appropriation by the general assembly for the direct and indirect costs associated with the implementation of this part 4. All moneys in the fund not expended for the purpose of this part 4 may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund. Any unexpended and unencumbered moneys remaining in the fund at the end of a fiscal year shall remain in the fund and shall not be credited or transferred to the general fund or another fund.

CONNECTICUT

CONN. GEN. STAT. § 46a-13k (2011). Office of the Child Advocate established

(a) There is established, within the Office of Governmental Accountability established under section 58 of public act 11-48, an Office of the Child Advocate. The Governor, with the approval of the General Assembly, shall appoint a person with knowledge of the child welfare system and the legal system to fill the Office of the Child Advocate. Such person shall be qualified by training and experience to perform the duties of the office as set forth in section 46a-13l. Upon any vacancy in the position of Child Advocate, the advisory committee established pursuant to section 70 of public act 11-48 shall meet to consider and interview successor candidates and shall submit to the Governor a list of not fewer than five and not more than seven of the most outstanding candidates, not later than sixty days after the occurrence of said vacancy. Such list shall rank the candidates in the order of committee preference. Not later than eight weeks after receiving the list of candidates from the advisory committee, the Governor shall designate a candidate for Child Advocate from among the choices on such list. If at any time any of the candidates withdraw from consideration prior to confirmation by the General Assembly, the designation shall be made from the remaining candidates on the list submitted to the Governor. If, not later than eight weeks after receiving the list, the Governor fails to designate a candidate from the list, the candidate ranked first shall receive the designation and be referred to the General Assembly for confirmation. If the General Assembly is not in session, the designated candidate shall serve as acting Child Advocate and be entitled to the compensation, privileges and powers of the Child Advocate until the General Assembly meets to take action on said appointment. The person appointed Child

Advocate shall serve for a term of four years and may be reappointed or shall continue to hold office until such person's successor is appointed and qualified. Upon any vacancy in the position of Child Advocate and until such time as a candidate has been confirmed by the General Assembly or, if the General Assembly is not in session, has been designated by the Governor, the Associate Child Advocate shall serve as the acting Child Advocate and be entitled to the compensation, privileges and powers of the Child Advocate.

(b) Notwithstanding any other provision of the general statutes, the Child Advocate shall act independently of any state department in the performance of the advocate's duties.

(c) The Child Advocate may, within available funds, appoint such staff as may be deemed necessary provided, for the fiscal years ending June 30, 1996, and June 30, 1997, such staff shall not exceed one and one-half full-time positions or the equivalent thereof. The duties of the staff may include the duties and powers of the Child Advocate if performed under the direction of the Child Advocate.

(d) The General Assembly shall annually appropriate such sums as necessary for the payment of the salaries of the staff and for the payment of office expenses and other actual expenses incurred by the Child Advocate in the performance of his or her duties. Any legal or court fees obtained by the state in actions brought by the Child Advocate shall be deposited in the General Fund.

(e) The Child Advocate shall annually submit, in accordance with the provisions of the section 11-4a, to the Governor, the joint standing committees of the General Assembly having cognizance of matters relating to the judiciary, children and human services and the advisory committee established pursuant to section 70 of public act 11-48 a detailed report analyzing the work of the Office of the Child Advocate.

CONN. GEN. STAT. § 46a-13l (2012). Child Advocate's duties. Child fatality review panel. Reports to the Governor and the General Assembly. Investigations

(a) The Child Advocate shall:

(1) Evaluate the delivery of services to children by state agencies and those entities that provide services to children through funds provided by the state;

(2) Review periodically the procedures established by any state agency providing services to children to carry out the provisions of sections 46a-13k to 46a-13p, inclusive,

with a view toward the rights of the children and recommend revisions to such procedures;

(3) Review complaints of persons concerning the actions of any state or municipal agency providing services to children and of any entity that provides services to children through funds provided by the state, make appropriate referrals and investigate those where the Child Advocate determines that a child or family may be in need of assistance from the Child Advocate or that a systemic issue in the state's provision of services to children is raised by the complaint;

(4) Pursuant to an investigation, provide assistance to a child or family who the Child Advocate determines is in need of such assistance including, but not limited to, advocating with an agency, provider or others on behalf of the best interests of the child;

(5) Periodically review the facilities and procedures of any and all institutions or residences, public or private, where a juvenile has been placed by any agency or department;

(6) Recommend changes in state policies concerning children including changes in the system of providing juvenile justice, child care, foster care and treatment;

(7) Take all possible action including, but not limited to, conducting programs of public education, undertaking legislative advocacy and making proposals for systemic reform and formal legal action, in order to secure and ensure the legal, civil and special rights of children who reside in this state;

(8) Provide training and technical assistance to attorneys representing children and guardians ad litem appointed by the Superior Court;

(9) Periodically review the number of special needs children in any foster care or permanent care facility and recommend changes in the policies and procedures for the placement of such children;

(10) Serve or designate a person to serve as a member of the child fatality review panel established in subsection (b) of this section; and

(11) Take appropriate steps to advise the public of the services of the Office of the Child Advocate, the purpose of the office and procedures to contact the office.

(b) There is established a child fatality review panel composed of thirteen permanent members as follows: The Child Advocate, or a designee; the Commissioners of Children and Families, Public Health and Public Safety, or their designees; the Chief Medical Examiner, or a designee; the Chief State's Attorney, or a designee; a pediatrician, appointed by the Governor; a representative of law enforcement, appointed by the president pro tempore of the Senate; an attorney, appointed by the majority leader of the Senate; a social work professional, appointed by the minority leader of the Senate; a representative of a community service group appointed by the speaker of the House of Representatives; a psychologist, appointed by the majority leader of the House of Representatives; and an injury prevention representative, appointed by the minority leader of the House of Representatives. A majority of the panel may select not more than three additional temporary members with particular expertise or interest to serve on the panel. Such temporary members shall have the same duties and powers as the permanent members of the panel. The chairperson shall be elected from among the panel's permanent members. The panel shall, to the greatest extent possible, reflect the ethnic, cultural and geographic diversity of the state.

(c) The panel shall review the circumstances of the death of a child placed in out-of-home care or whose death was due to unexpected or unexplained causes to facilitate development of prevention strategies to address identified trends and patterns of risk and to improve coordination of services for children and families in the state. Members of the panel shall not be compensated for their services, but may be reimbursed for necessary expenses incurred in the performance of their duties.

(d) On or before January 1, 2000, and annually thereafter, the panel shall issue an annual report which shall include its findings and recommendations to the Governor and the General Assembly on its review of child fatalities for the preceding year.

(e) Upon request of two-thirds of the members of the panel and within available appropriations, the Governor, the General Assembly or at the Child Advocate's discretion, the Child Advocate shall conduct an in-depth investigation and review and issue a report with recommendations on the death or critical incident of a child. The report shall be submitted to the Governor, the General Assembly and the commissioner of any state agency cited in the report and shall be made available to the general public.

(f) Any state agency cited in a report issued by the Office of the Child Advocate, pursuant to the Child Advocate's responsibilities under this section, shall submit a written response to the report and recommendations made in the report to the Governor and the General Assembly not later than ninety days after receipt of such report and recommendations. The General Assembly shall submit a copy of such response to the Office of the Child Advocate immediately upon receipt.

(g) The Chief Medical Examiner shall provide timely notice to the Child Advocate and to the chairperson of the child fatality review panel of the death of any child that is to be investigated pursuant to section 19a-406.

(h) Any agency having responsibility for the custody or care of children shall provide timely notice to the Child Advocate and the chairperson of the child fatality review panel of the death of a child or a critical incident involving a child in its custody or care.

CONN. GEN. STAT. § 46a-13m (2012). Access to information

(a) Notwithstanding any provision of the General Statutes concerning the confidentiality of records and information, the Child Advocate shall have access to, including the right to inspect and copy, any records necessary to carry out the responsibilities of the Child Advocate as provided in subsection (a) of section 46a-13l. If the Child Advocate is denied access to any records necessary to carry out said responsibilities, he may issue a subpoena for the production of such records as provided in subsection (c) of this section.

(b) In the performance of his responsibilities under subsection (a) of section 46a-13l the Child Advocate may communicate privately with any child or person who has received, is receiving or should have received services from the state. Such communications shall be confidential and not be subject to disclosure except as provided in subsection (a) of section 46a-13n.

(c) The Child Advocate may issue subpoenas to compel the attendance and testimony of witnesses or the production of books, papers and other documents and to administer oaths to witnesses in any matter under his investigation. If any person to whom such subpoena is issued fails to appear or, having appeared, refuses to give testimony or fails to produce the evidence required, the Child Advocate may apply to the Superior Court for the Judicial District of Hartford which shall have jurisdiction to order such person to appear and give testimony or to produce such evidence, as the case may be.

(d) The Child Advocate may apply for and accept grants, gifts and bequests of funds from other states, federal and interstate agencies and independent authorities and private firms, individuals and foundations, for the purpose of carrying out his responsibilities. There is established within the general fund a child advocate account which shall be a separate nonlapsing account. Any funds received under this subsection shall, upon deposit in the general fund, be credited to said account and may be used by the Child Advocate in the performance of his duties.

CONN. GEN. STAT § 46a-13n (2012). Confidentiality of information

(a) The name, address and other personally identifiable information of a person who makes a complaint to the Child Advocate as provided in section 46a-13l, all information obtained or generated by the office in the course of an investigation and all confidential records obtained by the Child Advocate or a designee shall be confidential and shall not be subject to disclosure under the Freedom of Information Act [FN1] or otherwise, except that such information and records, other than confidential information concerning a pending law enforcement investigation or a pending prosecution, may be disclosed if the Child Advocate determines that disclosure is (1) in the general public interest or (2) necessary to enable the Child Advocate to perform his responsibilities under subsection (a) of section 46a-13l. If the Child Advocate determines that disclosure of confidential information is not in the public interest but is necessary to enable the Child Advocate to perform responsibilities under subsection (a) of section 46a-13l, or to identify, prevent or treat the abuse or neglect of a child, the Child Advocate may disclose such information to the appropriate agency responsible for the welfare of such child.

(b) No state or municipal agency shall discharge, or in any manner discriminate or retaliate against, any employee who in good faith makes a complaint to the Child Advocate or cooperates with the Office of the Child Advocate in an investigation.

CONN. GEN. STAT § 46a-13o (2012). Representation of child. Judgments or settlements for compensation

(a) In addition to the powers set forth in section 46a-13m, and notwithstanding section 3-125, the Child Advocate, or his designee, may represent, appear, intervene in or bring an action on behalf of any child in any proceeding before any court, agency, board or commission in this state in which matters related to sections 46a-13k to 46a-13p, inclusive, are in issue. Prior to the institution of any action brought pursuant to this subsection, the Child Advocate shall make a good faith effort to resolve issues or problems through mediation.

(b) Any judgment for compensation or order for settlement of the claim for compensation entered by the court pursuant to the provisions of subsection (a) of this section shall be

considered as the estate of the child for whose benefit the judgment or order is entered, to be held by the Office of the Child Advocate as guardian of such compensation, and shall be deposited into a trust account established by the office for the purposes of distributing such funds to such child in accordance with the plan adopted by the Family Division of the Superior Court.

CONN. GEN. STAT § 46a-13p (2012). Indemnification of employees and volunteers

The state of Connecticut shall protect and hold harmless any attorney, director, investigator, social worker or other person employed by the Office of the Child Advocate and any volunteer appointed by the Child Advocate from financial loss and expense, including legal fees and costs, if any, arising out of any claim, demand or suit for damages resulting from acts or omissions committed in the discharge of his duties with the program within the scope of his employment or appointment which may constitute negligence but which acts are not wanton, malicious or grossly negligent as determined by a court of competent jurisdiction.

DELAWARE

DEL. CODE ANN. TIT § 320 (2011). Declaration of legislative intent

The General Assembly hereby declares that the health and safety of the children and pregnant women of the State will be safeguarded if deaths of children under the age of 18, near deaths of abused and/or neglected children, and stillbirths occurring after at least 20 weeks of gestation and maternal death are reviewed, in order to provide recommendations to alleviate those practices or conditions which impact the mortality of children and pregnant women. This subchapter establishes the Child Death, Near Death and Stillbirth Commission. For the purposes of this subchapter, “Commission” means the Child Death, Near Death and Stillbirth Commission. Stillbirths occurring after at least 20 weeks of gestation shall not include stillbirths which occur as a result of an elective medical procedure.

DEL. CODE ANN. TIT § 321 (2011). Organization and composition

(a) The following shall be members of the Commission: The State Attorney General, the Secretary of the State Department of Health and Social Services, the Secretary of the State Department of Services to Children, Youth and Their Families, the person appointed as the child advocate pursuant to § 9003A of Title 29, the Chair of Child Protection Accountability Commission, the State Secretary of Education, the State Medical Examiner, the Director of the Division of Public Health, the Chief Judge of the Family Court and the Superintendent of the Delaware State Police, or the designee of any of the preceding persons. Additionally, the following shall be appointed by the Governor as members of the Commission:

National Center for Prosecution of Child Abuse
National District Attorney Association

- (1) A representative of the Medical Society of Delaware specializing in each of pediatrics, neonatology, obstetrics and perinatology;
- (2) A representative of the Delaware Nurses Association;
- (3) A representative of the National Association of Social Workers;
- (4) A representative of the Police Chiefs' Council of Delaware who is an active law enforcement officer;
- (5) A representative of the New Castle County Police Department; and
- (6) 2 child advocates from state-wide non-profit organizations.

A Chairperson of each regional child death and near death review panel, each maternal death panel and each Fetal and Infant Mortality Review Case Review Team established pursuant to subsections (d) and (e) hereof shall also serve as members of the Commission. The term of members appointed by the Governor shall be 3 years and shall terminate upon the Governor's appointment of a new member to the Commission. The members of the Commission, the regional panels, Case Review Teams and Community Action Teams shall serve without compensation. The Commission shall be staffed, and its staff shall include an Executive Director. The General Assembly may annually appropriate such sums as it may deem necessary for the payment of the salary of the Executive Director and the staff, and for the payment of actual expenses incurred by the Commission.

(b) The Commission shall, by affirmative vote of a majority of all members of the Commission, appoint a chairperson from its membership for a term of 1 year. The Commission shall meet at least semi-annually.

(c) Meetings of the Commission, regional panels, Case Review Teams and Community Action Teams shall be closed to the public. The Commission shall meet at least annually with the Child Protection Accountability Commission to jointly discuss the public

recommendations generated from reviews conducted pursuant to § 323(e) of this title. This meeting shall be open to the public.

(d) The Commission shall by resolution passed by a majority of its members establish at least 1 but no more than 3 regional panels authorized to review child deaths and near deaths. One of the panels shall be designated to review cases pursuant to § 323(e) of this title; however, for good cause shown to the Commission, any panel may investigate and review any death, near death, or stillbirth entitled to review by the Commission. Members of the Commission shall appoint representatives to each regional panel such that the regional panel reflects the disciplines of the Commission. The Commission shall also appoint to each regional panel:

(1) A representative from each of the 3 police departments which investigate the majority of child deaths in the region covered by the panel, and

(2) A citizen of the region interested in child death, near death and stillbirth issues.

(e) The Commission shall by resolution passed by a majority of its members establish Fetal and Infant Mortality Review Case Review Teams and Community Action Teams based on the National Fetal and Infant Mortality Review Program model.

(f) Each regional panel and the Fetal and Infant Mortality Review Case Review Teams shall have the powers, duties and authority of the Commission as delegated by the Commission. Each regional panel and Fetal and Infant Mortality Review Case Review Team shall, by affirmative vote of a majority of all members of that regional panel or team, appoint cochairpersons from its membership for a term of 1 year.

(g) The Commission shall by resolution passed by a majority of its members establish 1 regional panel authorized to review maternal deaths.

DEL. CODE ANN. TIT § 322 (2011). Voting

Except as expressly provided herein, an affirmative vote of 60% of all members of the Commission, any regional panel, Case Review Team or Community Action Team shall be required to adopt any findings or recommendations of the Commission or such regional panel or team.

DEL. CODE ANN. TIT § 323 (2011). Powers and duties

National Center for Prosecution of Child Abuse
National District Attorney Association

<Text of section effective until fulfillment of 78 Laws 2011, ch. 137, § 15. See also section effective upon fulfillment of 78 Laws 2011, ch. 137, § 15.>

(a) The Commission shall have the power to investigate and review the facts and circumstances of all deaths and near deaths of children under the age of 18 and stillbirths and all maternal deaths which occur in Delaware. The review of deaths involving criminal investigations will be delayed until the later of the conclusion of such investigation, or the adjudication of related criminal charges, if any. The Commission shall make recommendations to the Governor and the General Assembly and Child Protection Accountability Commission, at least annually, regarding those practices or conditions which impact the mortality of children and mothers. System-wide recommendations arising from an investigation and review conducted pursuant to subsection (e) of this section shall be made to the Governor and General Assembly and Child Protection Accountability Commission, as well as any members of the public requesting the recommendations, within 20 days of the completion of such investigation and review. In addition to the Commission's release of recommendations, the Commission shall release summary information and findings resulting from reviews of child deaths and near deaths due to abuse and neglect. Said release of information and findings shall occur at the completion of prosecution. All recommendations made pursuant to this subsection shall comply with applicable state and federal confidentiality provisions, including but not limited to those enumerated in § 324 of this title and § 9017(d) of Title 29. Notwithstanding any provision of this subchapter to the contrary, such recommendation shall not specifically identify any individual or any nongovernmental agency, organization or entity.

(b) The Commission shall conduct child death and near death reviews according to procedures promulgated by the Commission. The Commission shall conduct maternal death reviews which utilize a public health model and shall include information gathered through a clinical review and summary of medical and other subpoenaed records. The Commission may amend such procedures upon a three-quarters affirmative vote of all members of the Commission.

(c) The Commission shall conduct fetal and infant mortality reviews and facilitate the implementation of recommendations based on the National Fetal and Infant Mortality Review Program model. Utilizing a public health model, the reviews shall include information gathered through a clinical review and summary of medical and all other subpoenaed records, and maternal interviews. The Commission may amend such procedures upon a three-quarters affirmative vote of all members of the Commission.

(d) In connection with any review, the Commission shall have the power and authority to:

(1) Administer oaths; and

(2) Compel the attendance of witnesses whose testimony is related to the death or near death under review and the production of records related to the death, near death or stillbirth under review by filing a praecipe for a subpoena, through the Attorney General or a Deputy Attorney General, with the Prothonotary of any county of this State, such a subpoena to be effective throughout the State and service of such a subpoena to be made by any sheriff of the State; failure to obey said subpoena will be punishable according to the rules of the Superior court.

(e) Notwithstanding the above, the Commission shall investigate and review the facts and circumstances of the death or near death of an abused and/or neglected child within 6 months of a report to the Commission by the Attorney General, the Department of Services for Children, Youth and Their Families, or other state agency that the child was the victim of abuse or neglect. The Attorney General, the Department of Services for Children, Youth and Their Families, and any other state or local agency with responsibility for investigating child deaths shall report to the Commission any death or near death of a child who is determined to have been abused and/or neglected within 14 days of that determination. For good cause shown to the Commission, completion of an investigation and review under this subsection may be extended from 6 to 9 months.

(f) Notwithstanding any provision of this subchapter to the contrary, no person identified by the Attorney General's office as a potential witness in any criminal prosecution arising from the death or near death of an abused or neglected child shall be questioned, deposed or interviewed by or for the Commission in connection with its investigation and review of such death or near death until the completion of such prosecution.

DEL. CODE ANN. TIT § 323 (2011). § 323. Powers and duties

<Text of section effective upon fulfillment of 78 Laws 2011, ch. 137, § 15. See also section effective until fulfillment of 78 Laws 2011, ch. 137, § 15.>

(a) The Commission shall have the power to investigate and review the facts and circumstances of all deaths and near deaths of children under the age of 18 and stillbirths and all maternal deaths which occur in Delaware. The review of deaths involving criminal investigations will be delayed until the later of the conclusion of such investigation, or the adjudication of related criminal charges, if any. The Commission shall make recommendations to the Governor and the General Assembly and Child

Protection Accountability Commission, at least annually, regarding those practices or conditions which impact the mortality of children and mothers. System-wide recommendations arising from an investigation and review conducted pursuant to subsection (e) of this section shall be made to the Governor and General Assembly and Child Protection Accountability Commission, as well as any members of the public requesting the recommendations, within 20 days of the completion of such investigation and review. In addition to the Commission's release of recommendations, the Commission shall release summary information and findings resulting from reviews of child deaths and near deaths due to abuse and neglect. Said release of information and findings shall occur at the completion of prosecution. All recommendations made pursuant to this subsection shall comply with applicable state and federal confidentiality provisions, including but not limited to those enumerated in § 324 of this title and § 9017(e) of Title 29. Notwithstanding any provision of this subchapter to the contrary, such recommendation shall not specifically identify any individual or any nongovernmental agency, organization or entity.

(b) The Commission shall conduct child death and near death reviews according to procedures promulgated by the Commission. The Commission shall conduct maternal death reviews which utilize a public health model and shall include information gathered through a clinical review and summary of medical and other subpoenaed records. The Commission may amend such procedures upon a three-quarters affirmative vote of all members of the Commission.

(c) The Commission shall conduct fetal and infant mortality reviews and facilitate the implementation of recommendations based on the National Fetal and Infant Mortality Review Program model. Utilizing a public health model, the reviews shall include information gathered through a clinical review and summary of medical and all other subpoenaed records, and maternal interviews. The Commission may amend such procedures upon a three-quarters affirmative vote of all members of the Commission.

(d) In connection with any review, the Commission shall have the power and authority to:

(1) Administer oaths; and

(2) Compel the attendance of witnesses whose testimony is related to the death or near death under review and the production of records related to the death, near death or stillbirth under review by filing a praecipe for a subpoena, through the Attorney General or a Deputy Attorney General, with the Prothonotary of any county of this State, such a subpoena to be effective throughout the State and service of such a subpoena to be made

by any sheriff of the State; failure to obey said subpoena will be punishable according to the rules of the Superior court.

(e) Notwithstanding the above, the Commission shall investigate and review the facts and circumstances of the death or near death of an abused and/or neglected child within 6 months of a report to the Commission by the Attorney General, the Department of Services for Children, Youth and Their Families, or other state agency that the child was the victim of abuse or neglect. The Attorney General, the Department of Services for Children, Youth and Their Families, and any other state or local agency with responsibility for investigating child deaths shall report to the Commission any death or near death of a child who is determined to have been abused and/or neglected within 14 days of that determination. For good cause shown to the Commission, completion of an investigation and review under this subsection may be extended from 6 to 9 months.

(f) Notwithstanding any provision of this subchapter to the contrary, no person identified by the Attorney General's office as a potential witness in any criminal prosecution arising from the death or near death of an abused or neglected child shall be questioned, deposed or interviewed by or for the Commission in connection with its investigation and review of such death or near death until the completion of such prosecution.

DEL. CODE ANN. TIT § 324 (2011). Confidentiality of records and immunity from suit

(a) The records of the Commission and of all regional panels and the Fetal and Infant Mortality Review Case Review Teams and Community Action Teams, including original documents and documents produced in the review process with regard to the facts and circumstances of each death, near death or stillbirth, shall be confidential and shall not be released to any person except as expressly provided in subchapter II of this chapter. Such records shall be used by the Commission, and any regional panel or team only in the exercise of the proper function of the Commission, regional panel or team and shall not be public records and shall not be available for Court subpoena or subject to discovery. Subject to constitutional requirements, statements, records or information shall not be subject to any statute or rule that would require those statements to be disclosed in the course of a criminal trial or associated discovery. Aggregate statistical data compiled by the Commission, regional panels or teams, however, may be released at the discretion of the Commission or regional panels.

(b) Members of the Commission, regional panels, Case Review Teams and Community Action Teams, and their agents or employees, shall not be subject to, and shall be immune from, claims, suits, liability, damages or any other recourse, civil or criminal,

arising from any act, proceeding, decision or determination undertaken or performed or recommendation made, provided such persons acted in good faith and without malice in carrying out their responsibilities, authority, duties, powers and privileges of the offices conferred by this law upon them or by any other provisions of the Delaware law, federal law or regulations, or duly adopted rules and regulations of the Commission or its regional panels or teams. Complainants shall bear the burden of proving malice or a lack of good faith to defeat the immunity provided herein.

(c) No person in attendance at a meeting of any such Commission, regional panel, Case Review Team or Community Action Team shall be required to testify as to what transpired thereat. No organization, institution or person furnishing information, data, reports or records to the Commission or any regional panel or team with respect to any subject examined or treated by such organizations, institution, or person, by reason of furnishing such information, shall be liable in damages to any person or subject to any other recourse, civil or criminal.

DISTRICT OF COLUMBIA

D.C. Code § 4-1371.01 (2012). Short title.

This subchapter may be cited as the “Child Fatality Review Committee Establishment Act of 2001”.

D.C. Code § 4-1371.02 (2012). Definitions.

For the purposes of this subchapter, the term:

(1) “Child” means an individual who is 18 years of age or younger, or up to 21 years of age if the child is a committed ward of the child welfare, mental retardation and developmental disabilities, or juvenile systems of the District of Columbia.

(2) “Committee” means the Child Fatality Review Committee.

D.C. Code § 4-1371.03 (2012). Establishment and purpose.

(a) There is established, as part of the District of Columbia government, a Child Fatality Review Committee. Facilities and other administrative support may be provided in a specific department or through the Committee, as determined by the Mayor.

(b) The Committee shall:

(1) Identify and characterize the scope and nature of child deaths in the jurisdiction, particularly those that are violent, accidental, unexpected, or unexplained;

(2) Examine past events and circumstances surrounding child deaths by reviewing the records and other pertinent documents of public and private agencies responsible for serving families and children, investigating deaths, or treating children in an effort to reduce the number of preventable child fatalities and shall give special attention to child deaths that may have been caused by abuse, negligence, or other forms of maltreatment;

(3) Develop and revise as necessary operating rules and procedures for the review of child deaths, including identification of cases to be reviewed, coordination among the agencies and professionals involved, and improvement of the identification, data collection, and record keeping of the causes of child death;

(4) Recommend systemic improvements to promote improved and integrated public and private systems serving families and children;

(5) Recommend components for prevention and education programs; and

(6) Recommend training to improve the investigation of child deaths.

D.C. Code § 4-1371.04 (2012). Composition of the Child Fatality Review Committee.

(a) The Mayor shall appoint a minimum of one representative from appropriate programs providing services to children within the following public agencies:

(1) Department of Human Services;

(2) Department of Health;

(3) Office of the Chief Medical Examiner;

- (4) Child and Family Services Agency;
- (5) Metropolitan Police Department;
- (6) Fire and Emergency Medical Services Department,
- (7) D.C. Public Schools;
- (8) Department of Housing and Community Development; and
- (9) Office of the Corporation Counsel.

(b) The Mayor shall appoint, or request the designation of, members from federal, judicial, and private agencies and the general public who are knowledgeable in child development, maternal and child health, child abuse and neglect, prevention, intervention, treatment or research, with due consideration given to representation of ethnic or racial minorities and to geographic areas of the District of Columbia. The appointments shall include representatives from the following:

- (1) Superior Court of the District of Columbia;
- (2) Office of the United States Attorney for the District of Columbia;
- (3) District of Columbia hospitals where children are born or treated;
- (4) College or university schools of social work; and
- (5) Mayor's Committee on Child Abuse and Neglect.

(c) The Mayor, with the advice and consent of the Council, shall appoint 8 community representatives, none of whom shall be employees of the District of Columbia.

(d) Governmental appointees shall serve at the will of the Mayor, or of the federal or judicial body designating their availability for appointment. Community representatives shall serve for 3-year terms.

(e) Vacancies in membership shall be filled in the same manner in which the original appointment was made.

(f) The Committee shall select co-chairs according to rules set forth by the Committee.

(g) The Committee shall establish quorum and other procedural requirements as it considers necessary.

D.C. Code § 4-1371.05 (2012). Criteria for case review.

(a) The Committee shall be responsible for reviewing the deaths of children who were residents of the District of Columbia and of such children who, or whose families, at the time of death:

(1) Or at any point during the 2 years prior to the child's death, were known to the juvenile justice or mental retardation or developmental disabilities systems of the District of Columbia; and

(2) Or at any point during the 4 years prior to the child's death, were known to the child welfare system of the District of Columbia.

(b) The Committee may review the deaths of nonresidents if the death is determined to be accidental or unexpected and occurs within the District.

(c) The Committee shall establish, by regulation, the manner of review of cases, including use of the following approaches:

- (1) Multidisciplinary review of individual fatalities;
 - (2) Multidisciplinary review of clusters of fatalities identified by special category or characteristic;
 - (3) Statistical reviews of fatalities; or
 - (4) Any combination of such approaches.
- (d) The Committee shall establish 2 review teams to conduct its review of child fatalities. The Infant Mortality Review Team shall review the deaths of children under the age of one year and the Child Fatality Review Team shall review the deaths of children over the age of one year. Each team may include designated public officials with responsibilities for child and juvenile welfare from each of the agencies and entities listed in § 4-1371.04.
- (e) Full multidisciplinary/multi-agency reviews shall be conducted, at a minimum, on the following fatalities:
- (1) Those children known to the juvenile justice system;
 - (2) Those children who are known to the mental retardation/developmental disabilities system;
 - (3) Those children for which there is or has been a report of child abuse or neglect concerning the child's family;
 - (4) Those children who were under the jurisdiction of the Superior Court of the District of Columbia (including protective service, foster care, and adoption cases);
 - (5) Those children who, for some other reason, were wards of the District; and
 - (6) Medical Examiner Office cases.

D.C. Code § 4-1371.06 (2012). Access to information.

(a) Notwithstanding any other provision of law, immediately upon the request of the Committee and as necessary to carry out the Committee's purpose and duties, the Committee shall be provided, without cost and without authorization of the persons to whom the information or records relate, access to:

(1) All information and records of any District of Columbia agency, or their contractors, including, but not limited to, birth and death certificates, law enforcement investigation data, unexpurgated juvenile and adult arrest records, mental retardation and developmental disabilities records, medical examiner investigation data and autopsy reports, parole and probation information and records, school records, and information records of social services, housing, and health agencies that provided services to the child, the child's family, or an alleged perpetrator of abuse which led to the death of the child.

(2) All information and records (including information on prenatal care) of any private health-care providers located in the District of Columbia, including providers of mental health services who provided services to the deceased child, the deceased child's family, or the alleged perpetrator of abuse which led to the death of the child.

(3) All information and records of any private child welfare agency, educational facility or institution, or child care provider doing business in the District of Columbia who provided services to the deceased child, the deceased child's immediate family, or the alleged perpetrator of abuse or neglect which led to the death of the child.

(4) Information made confidential by §§ 4-1302.03, 4-1303.06, 7-219, 7-1203.02, 7-1305.12, 16-2331, 16-2332, 16-2333, 16-2335, and 31-3426.

(b) The Committee shall have the authority to seek information from entities and agencies outside the District of Columbia by any legal means.

(c) Notwithstanding subsection (a)(1) of this section, information and records concerning a current law enforcement investigation may be withheld, at the discretion of the investigating authority, if disclosure of the information would compromise a criminal investigation.

(d) If information or records are withheld under subsection (c) of this section, a report on the status of the investigation shall be submitted to the Committee every 3 months until the earliest of the following events occurs:

(1) The investigation is concluded;

(2) The investigating authority determines that providing the information will no longer compromise the investigation; or

(3) The information or records are provided to the Committee.

(e) All records and information obtained by the Committee pursuant to subsections (a) and (b) of this section pertaining to the deceased child or any other individual shall be destroyed following the preparation of the final Committee report. All additional information concerning a review, except statistical data, shall be destroyed by the Committee one year after publication of the Committee's annual report.

D.C. Code § 4-1371.07 (2012). Subpoena power.

(a) When necessary for the discharge of its duties, the Committee shall have the authority to issue subpoenas to compel witnesses to appear and testify and to produce books, papers, correspondence, memoranda, documents, or other relevant records.

(b) Except as provided in subsection (c) of this section, subpoenas shall be served personally upon the witness or his or her designated agent, not less than 5 business days before the date the witness must appear or the documents must be produced, by one of the following methods, which may be attempted concurrently or successively:

(1) By a special process server, at least 18 years of age, designated by the Committee from among the staff of the Committee or any of the offices or organizations represented on the Committee; provided, that the special process server is not directly involved in the investigation; or

(2) By a special process server, at least 18 years of age, engaged by the Committee.

(c) If, after a reasonable attempt, personal service on a witness or witness' agent cannot be obtained, a special process server identified in subsection (b) of this section may serve a subpoena by registered or certified mail not less than 8 business days before the date the witness must appear or the documents must be produced.

(d) If a witness who has been personally summoned neglects or refuses to obey the subpoena issued pursuant to subsection (a) of this section, the Committee may report that fact to the Superior Court of the District of Columbia and the court may compel obedience to the subpoena to the same extent as witnesses may be compelled to obey the subpoenas of the court.

D.C. Code § 4-1371.08 (2012). Confidentiality of proceedings.

(a) Proceedings of the Committee shall be closed to the public and shall not be subject to § 1-207.42, when the Committee is discussing cases of individual child deaths or where the identity of any person, other than a person who has consented to be identified, can be ascertained. Persons other than Committee members who attend any Committee meeting which, pursuant to this section, is not open to the public, shall not disclose what occurred at the meeting to anyone who was not in attendance, except insofar as disclosure is necessary for that person to comply with a request for information from the Committee. Committee members who attend meetings not open to the public shall not disclose what occurred with anyone who was not in attendance (except other Committee members), except insofar as disclosure is necessary to carry out the duties of the Committee. Any party who discloses information pursuant to this subsection shall take all reasonable steps to ensure that the information disclosed, and the person to whom the information is disclosed, are as limited as possible.

(b) Members of the Committee, persons attending a Committee meeting, and persons who present information to the Committee may not be required to disclose, in any administrative, civil, or criminal proceeding, information presented at or opinions formed as a result of a Committee meeting, except that nothing in this subsection may be construed as preventing a person from providing information to another review committee specifically authorized to obtain such information in its investigation of a child death, the disclosure of information obtained independently of the Committee, or the disclosure of information which is public information.

(c) Information identifying a deceased child, a member of the child's immediate family, the guardian or caretaker of the child, or an alleged or suspected perpetrator of abuse or neglect upon the child, may not be disclosed publicly.

(d) Information identifying District of Columbia government employees or private health-care providers, social service agencies, and educational, housing, and child-care providers may not be disclosed publicly.

(e) Information and records which are the subject of this section may be disclosed upon a determination made in accordance with rules and procedures established by the Mayor.

D.C. Code § 4-1371.09 (2012).Confidentiality of information.

(a) All information and records generated by the Committee, including statistical compilations and reports, and all information and records acquired by, and in the possession of, the Committee are confidential.

(b) Except as permitted by this section, information and records of the Committee shall not be disclosed voluntarily, pursuant to a subpoena, in response to a request for discovery in any adjudicative proceeding, or in response to a request made under subchapter II of Chapter 5 of Title 2, nor shall it be introduced into evidence in any administrative, civil, or criminal proceeding.

(c) Committee information and records may be disclosed only as necessary to carry out the Committee's duties and purposes. The information and records may be disclosed by the Committee to another child fatality review committee if the other committee is governed by confidentiality provisions which afford the same or greater protections as those provided in this subchapter.

(d) Information and records presented to a Committee team during a child fatality review shall not be immune from subpoena or discovery, or prohibited from being introduced into evidence, solely because the information and records were presented to a team during a child death review, if the information and records have been obtained through other sources.

(e) Statistical compilations and reports of the Committee that contain information that would reveal the identity of any person, other than a person who has consented to be

identified, are not public records or information, and are subject to the prohibitions contained in subsection (a) of this section.

(f) The Committee shall compile an Annual Report of Findings and Recommendations which shall be made available to the Mayor, the Council, and the public, and shall be presented to the Council at a public hearing.

(g) Findings and recommendations on child fatalities defined in § 4-1371.05(e) shall be available to the public on request.

(h) At the direction of the Mayor and for good cause, special findings and recommendations pertaining to other specific child fatalities may be disclosed to the public.

(i) Nothing shall be disclosed in any report of findings and recommendations that would likely endanger the life, safety, or physical or emotional well-being of a child, or the life or safety of any other person, or which may compromise the integrity of a Mayor's investigation, a civil or criminal investigation, or a judicial proceeding.

(j) If the Mayor or the Committee denies access to specific information based on this section, the requesting entity may seek disclosure of the information through the Superior Court of the District of Columbia. The name or any other information identifying the person or entity who referred the child to the Department of Human Services or the Metropolitan Police Department shall not be released to the public.

(k) The Mayor shall promulgate rules implementing the provisions of §§ 4-1371.07 and 4-1371.08. The rules shall require that a subordinate agency director to whom a recommendation is directed by the Committee shall respond in writing within 30 days of the issuance of the report containing the recommendations.

(l) The policy recommendations to a particular agency authorized by this section shall be incorporated into the annual performance plans and reports required by subchapter XIV-A of Chapter 6 of Title 1.

D.C. Code § 4-1371.10 (2012). Immunity from liability for providing information to Committee.

Any health-care provider or any other person or institution providing information to the Committee pursuant to this subchapter shall have immunity from liability, administrative, civil, or criminal, that might otherwise be incurred or imposed with respect to the disclosure of the information.

D.C. Code § 4-1371.11 (2012). Unlawful disclosure of information; penalties.

Whoever discloses, receives, makes use of, or knowingly permits the use of information concerning a deceased child or other person in violation of this subchapter shall be subject to a fine of not more than \$1,000. Violations of this subchapter shall be prosecuted by the Corporation Counsel or his or her designee in the name of the District of Columbia. Subject to the availability of an appropriation for this purpose, any fines collected pursuant to this section shall be used by the Committee to fund its activities.

D.C. Code § 4-1371.12 (2012). Persons required to make reports; procedure.

(a) Notwithstanding, but in addition to, the provisions of any law, including § 14-307 and Chapter 12 of Title 7, any person or official specified in subsection (b) of this section who has knowledge of the death of a child who died in the District of Columbia, or a ward of the District of Columbia who died outside the District of Columbia, shall as soon as practicable but in any event within 5 business days report the death or cause to have a report of the death made to the Registrar of Vital Records.

(b) Persons required to report child deaths pursuant to subsection (a) of this section shall include every physician, psychologist, medical examiner, dentist, chiropractor, qualified mental retardation professional, registered nurse, licensed practical nurse, person involved in the care and treatment of patients, health professional licensed pursuant to Chapter 12 of Title 3, law-enforcement officer, school official, teacher, social service worker, day care worker, mental health professional, funeral director, undertaker, and embalmer. The Mayor shall issue rules and procedures governing the nature and contents of such reports.

(c) Any other person may report a child death to the Registrar of Vital Records.

(d) The Registrar of Vital Records shall accept the report of a death of a child and shall notify the Committee of the death within 5 business days of receiving the report.

(e) Nothing in this section shall affect other reporting requirements under District law.

D.C. Code § 4-1371.13 (2012). Immunity from liability for making reports.

Any person, hospital, or institution participating in good faith in the making of a report pursuant to this subchapter shall have immunity from liability, administrative, civil, and criminal, that might otherwise be incurred or imposed with respect to the making of the report. The same immunity shall extend to participation in any judicial proceeding involving the report. In all administrative, civil, or criminal proceedings concerning the child or resulting from the report, there shall be a rebuttable presumption that the maker of the report acted in good faith.

D.C. Code § 4-1371.14 (2012). Failure to make report.

Any person required to make a report under § 4-1371.12 who willfully fails to make the report shall be fined not more than \$100 or imprisoned for not more than 30 days, or both. Violations of § 4-1371.12 shall be prosecuted by the Corporation Counsel of the District of Columbia, or his or her agent, in the name of the District of Columbia.

FLORIDA

Fla. Stat. Ann. § 383.402 (2011). CHILD ABUSE DEATH REVIEW; STATE CHILD ABUSE DEATH REVIEW COMMITTEE; LOCAL CHILD ABUSE DEATH REVIEW COMMITTEES

(1) It is the intent of the Legislature to establish a statewide multidisciplinary, multiagency child abuse death assessment and prevention system that consists of state and local review committees. The state and local review committees shall review the facts and circumstances of all deaths of children from birth through age 18 which occur in this state as the result of verified child abuse or neglect. The purpose of the review shall be to:

(a) Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse.

(b) Whenever possible, develop a communitywide approach to address such cases and contributing factors.

(c) Identify any gaps, deficiencies, or problems in the delivery of services to children and their families by public and private agencies which may be related to deaths that are the result of child abuse.

(d) Make and implement recommendations for changes in law, rules, and policies, as well as develop practice standards that support the safe and healthy development of children and reduce preventable child abuse deaths.

(2)(a) The State Child Abuse Death Review Committee is established within the Department of Health and shall consist of a representative of the Department of Health, appointed by the State Surgeon General, who shall serve as the state committee coordinator. The head of each of the following agencies or organizations shall also appoint a representative to the state committee:

1. The Department of Legal Affairs.
2. The Department of Children and Family Services.
3. The Department of Law Enforcement.
4. The Department of Education.
5. The Florida Prosecuting Attorneys Association, Inc.
6. The Florida Medical Examiners Commission, whose representative must be a forensic pathologist.

(b) In addition, the State Surgeon General shall appoint the following members to the state committee, based on recommendations from the Department of Health and the agencies listed in paragraph (a), and ensuring that the committee represents the regional, gender, and ethnic diversity of the state to the greatest extent possible:

1. A board-certified pediatrician.
2. A public health nurse.
3. A mental health professional who treats children or adolescents.
4. An employee of the Department of Children and Family Services who supervises family services counselors and who has at least 5 years of experience in child protective investigations.
5. The medical director of a child protection team.
6. A member of a child advocacy organization.
7. A social worker who has experience in working with victims and perpetrators of child abuse.
8. A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program.
9. A law enforcement officer who has at least 5 years of experience in children's issues.
10. A representative of the Florida Coalition Against Domestic Violence.
11. A representative from a private provider of programs on preventing child abuse and neglect.

(3) The State Child Abuse Death Review Committee shall:

(a) Develop a system for collecting data on deaths that are the result of child abuse. The system must include a protocol for the uniform collection of data statewide, which uses existing data-collection systems to the greatest extent possible.

(b) Provide training to cooperating agencies, individuals, and local child abuse death review committees on the use of the child abuse death data system.

(c) Prepare an annual statistical report on the incidence and causes of death resulting from child abuse in the state during the prior calendar year. The state committee shall submit a copy of the report by December 31 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The report must include recommendations for state and local action, including specific policy, procedural, regulatory, or statutory changes, and any other recommended preventive action.

(d) Encourage and assist in developing the local child abuse death review committees.

(e) Develop guidelines, standards, and protocols, including a protocol for data collection, for local child abuse death review committees, and provide training and technical assistance to local committees.

(f) Develop guidelines for reviewing deaths that are the result of child abuse, including guidelines to be used by law enforcement agencies, prosecutors, medical examiners, health care practitioners, health care facilities, and social service agencies.

(g) Study the adequacy of laws, rules, training, and services to determine what changes are needed to decrease the incidence of child abuse deaths and develop strategies and recruit partners to implement these changes.

(h) Provide consultation on individual cases to local committees upon request.

(i) Educate the public regarding the provisions of chapter 99-168, Laws of Florida, the incidence and causes of child abuse death, and ways by which such deaths may be prevented.

(j) Promote continuing education for professionals who investigate, treat, and prevent child abuse or neglect.

(k) Recommend, when appropriate, the review of the death certificate of a child who died as a result of abuse or neglect.

(4) The members of the state committee shall be appointed to staggered terms of office which may not exceed 2 years, as determined by the State Surgeon General. Members are eligible for reappointment. The state committee shall elect a chairperson from among its members to serve for a 2-year term, and the chairperson may appoint ad hoc committees as necessary to carry out the duties of the committee.

(5) Members of the state committee shall serve without compensation but are entitled to reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.

(6) At the direction of the State Surgeon General, the director of each county health department, or the directors of two or more county health departments by agreement, may convene and support a county or multicounty child abuse death review committee in accordance with the protocols established by the State Child Abuse Death Review Committee. Each local committee must include a local state attorney, or his or her designee, and any other members that are determined by guidelines developed by the State Child Abuse Death Review Committee. The members of a local committee shall be appointed to 2-year terms and may be reappointed. The local committee shall elect a chairperson from among its members. Members shall serve without compensation but are entitled to reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.

(7) Each local child abuse death review committee shall:

(a) Assist the state committee in collecting data on deaths that are the result of child abuse, in accordance with the protocol established by the state committee.

(b) Submit written reports at the direction of the state committee. The reports must include nonidentifying information on individual cases and the steps taken by the local committee and private and public agencies to implement necessary changes and improve the coordination of services and reviews.

(c) Submit all records requested by the state committee at the conclusion of its review of a death resulting from child abuse.

(d) Abide by the standards and protocols developed by the state committee.

(e) On a case-by-case basis, request that the state committee review the data of a particular case.

(8) Notwithstanding any other law, the chairperson of the State Child Abuse Death Review Committee, or the chairperson of a local committee, shall be provided with access to any information or records that pertain to a child whose death is being reviewed by the committee and that are necessary for the committee to carry out its duties, including information or records that pertain to the child's family, as follows:

(a) Patient records in the possession of a public or private provider of medical, dental, or mental health care, including, but not limited to, a facility licensed under chapter 393, chapter 394, or chapter 395, or a health care practitioner as defined in s. 456.001. Providers may charge a fee for copies not to exceed 50 cents per page for paper records and \$1 per fiche for microfiche records.

(b) Information or records of any state agency or political subdivision which might assist a committee in reviewing a child's death, including, but not limited to, information or records of the Department of Children and Family Services, the Department of Health, the Department of Education, or the Department of Juvenile Justice.

(9) The State Child Abuse Death Review Committee or a local committee shall have access to all information of a law enforcement agency which is not the subject of an active investigation and which pertains to the review of the death of a child. A committee may not disclose any information that is not subject to public disclosure by the law enforcement agency, and active criminal intelligence information or criminal investigative information, as defined in s. 119.011(3), may not be made available for review or access under this section.

(10) The state committee and any local committee may share any relevant information that pertains to the review of the death of a child.

(11) A member of the state committee or a local committee may not contact, interview, or obtain information by request or subpoena directly from a member of a deceased child's

family as part of a committee's review of a child abuse death, except that if a committee member is also a public officer or state employee, that member may contact, interview, or obtain information from a member of the deceased child's family, if necessary, as part of the committee's review. A member of the deceased child's family may voluntarily provide records or information to the state committee or a local committee.

(12) The chairperson of the State Child Abuse Death Review Committee may require the production of records by requesting a subpoena, through the Department of Legal Affairs, in any county of the state. Such subpoena is effective throughout the state and may be served by any sheriff. Failure to obey the subpoena is punishable as provided by law.

(13) This section does not authorize the members of the state committee or any local committee to have access to any grand jury proceedings.

(14) A person who has attended a meeting of the state committee or a local committee or who has otherwise participated in activities authorized by this section may not be permitted or required to testify in any civil, criminal, or administrative proceeding as to any records or information produced or presented to a committee during meetings or other activities authorized by this section. However, this subsection does not prevent any person who testifies before the committee or who is a member of the committee from testifying as to matters otherwise within his or her knowledge. An organization, institution, committee member, or other person who furnishes information, data, reports, or records to the state committee or a local committee is not liable for damages to any person and is not subject to any other civil, criminal, or administrative recourse. This subsection does not apply to any person who admits to committing a crime.

(15) The Department of Health shall administer the funds appropriated to operate the review committees and may apply for grants and accept donations.

(16) To the extent that funds are available, the Department of Health may hire staff or consultants to assist a review committee in performing its duties. Funds may also be used to reimburse reasonable expenses of the staff and consultants for the state committee and the local committees.

(17) For the purpose of carrying out the responsibilities assigned to the State Child Abuse Death Review Committee and the local review committees, the State Surgeon General may substitute an existing entity whose function and organization include the function and organization of the committees established by this section.

(18) Each district administrator of the Department of Children and Family Services must appoint a child abuse death review coordinator for the district. The coordinator must have knowledge and expertise in the area of child abuse and neglect. The coordinator's general responsibilities include:

(a) Coordinating with the local child abuse death review committee.

(b) Ensuring the appropriate implementation of the child abuse death review process and all district activities related to the review of child abuse deaths.

(c) Working with the committee to ensure that the reviews are thorough and that all issues are appropriately addressed.

(d) Maintaining a system of logging child abuse deaths covered by this procedure and tracking cases during the child abuse death review process.

(e) Conducting or arranging for a Florida Abuse Hotline Information System (FAHIS) record check on all child abuse deaths covered by this procedure to determine whether there were any prior reports concerning the child or concerning any siblings, other children, or adults in the home.

(f) Coordinating child abuse death review activities, as needed, with individuals in the community and the Department of Health.

(g) Notifying the district administrator, the Secretary of Children and Family Services, the Deputy Secretary for Children's Medical Services, and the Department of Health Child Abuse Death Review Coordinator of all child abuse deaths meeting criteria for review as specified in this section within 1 working day after verifying the child's death was due to abuse, neglect, or abandonment.

(h) Ensuring that all critical issues identified by the local child abuse death review committee are brought to the attention of the district administrator and the Secretary of Children and Family Services.

- (i) Providing technical assistance to the local child abuse death review committee during the review of any child abuse death.

GEORGIA

GA. CODE ANN. § 19-15-1 (2011). Definitions

As used in this chapter, the term:

- (1) “Abused” means subjected to child abuse.

- (2) “Child” means any person under 18 years of age.

- (3) “Child abuse” means:

- (A) Physical injury or death inflicted upon a child by a parent or caretaker thereof by other than accidental means; provided, however, physical forms of discipline may be used as long as there is no physical injury to the child;

- (B) Neglect or exploitation of a child by a parent or caretaker thereof;

- (C) Sexual abuse of a child; or

- (D) Sexual exploitation of a child.

- (4) “Child protection professional” means any person who is employed by the state or a political subdivision of the state as a law enforcement officer, school teacher, school administrator, or school counselor or who is employed to render services to children by the Department of Public Health, the Department of Behavioral Health and

Developmental Disabilities, or the Department of Human Services or any county board of health, community service board, or county department of family and children services.

(5) “Eligible deaths” means deaths meeting the criteria for review by a county child fatality review committee including deaths resulting from Sudden Infant Death Syndrome, unintentional injuries, intentional injuries, medical conditions when unexpected or when unattended by a physician, or any manner that is suspicious or unusual.

(6) “Investigation” in the context of child death includes all of the following:

(A) A post-mortem examination which may be limited to an external examination or may include an autopsy;

(B) An inquiry by law enforcement agencies having jurisdiction into the circumstances of the death, including a scene investigation and interview with the child's parents, guardian, or caretaker and the person who reported the child's death;

(C) A review of information regarding the child and family from relevant agencies, professionals, and providers of medical care.

(7) “Panel” means the Georgia Child Fatality Review Panel established pursuant to Code Section 19-15-4. The panel oversees the local child fatality review process and reports to the Governor on the incidence of child deaths with recommendations for prevention.

(8) “Protocol committee” means a multidisciplinary, multiagency child abuse protocol committee established for a county pursuant to Code Section 19-15-2. The protocol committee is charged with developing local protocols to investigate and prosecute alleged cases of child abuse.

(9) “Report” means a standardized form designated by the panel which is required for collecting data on child fatalities reviewed by local child fatality review committees.

(10) “Review committee” means a multidisciplinary, multiagency child fatality review committee established for a county or circuit pursuant to Code Section 19-15-3. The

review committee is charged with reviewing all eligible child deaths to determine manner and cause of death and if the death was preventable.

(11) “Sexual abuse” means a person's employing, using, persuading, inducing, enticing, or coercing any minor who is not that person's spouse to engage in any act which involves:

(A) Sexual intercourse, including genital-genital, oral-genital, anal-genital, or oral-anal, whether between persons of the same or opposite sex;

(B) Bestiality;

(C) Masturbation;

(D) Lewd exhibition of the genitals or pubic area of any person;

(E) Flagellation or torture by or upon a person who is nude;

(F) Condition of being fettered, bound, or otherwise physically restrained on the part of a person who is nude;

(G) Physical contact in an act of apparent sexual stimulation or gratification with any person's clothed or unclothed genitals, pubic area, or buttocks or with a female's clothed or unclothed breasts;

(H) Defecation or urination for the purpose of sexual stimulation; or

(I) Penetration of the vagina or rectum by any object except when done as part of a recognized medical procedure.

“Sexual abuse” shall not include consensual sex acts involving persons of the opposite sex when the sex acts are between minors or between a minor and an adult who is not

more than three years older than the minor. This provision shall not be deemed or construed to repeal any law concerning the age or capacity to consent.

(12) “Sexual exploitation” means conduct by any person who allows, permits, encourages, or requires that child to engage in:

(A) Prostitution, as defined in Code Section 16-6-9; or

(B) Sexually explicit conduct for the purpose of producing any visual or print medium depicting such conduct, as defined in Code Section 16-12-100.

GA. CODE ANN. § 19-15-2 (2011). Child abuse protocol committees; adoption of written child abuse protocol

(a) Each county shall be required to establish a child abuse protocol as provided in this Code section.

(b) The chief superior court judge of the circuit in which the county is located shall establish a child abuse protocol committee as provided in subsection (c) of this Code section and shall appoint an interim chairperson who shall preside over the first meeting and the chief superior court judge shall appoint persons to fill any vacancies on the committee. Thus established, the committee shall thereafter elect a chairperson from its membership.

(c) (1) Each of the following agencies of the county shall designate a representative to serve on the committee:

(A) The office of the sheriff;

(B) The county department of family and children services;

(C) The office of the district attorney;

(D) The juvenile court;

(E) The magistrate court;

(F) The county board of education;

(G) The county mental health organization;

(H) The office of the chief of police of a county in counties which have a county police department;

(I) The office of the chief of police of the largest municipality in the county;

(J) The county board of health, which shall designate a physician to serve on the committee; and

(K) The office of the coroner or county medical examiner.

(2) In addition to the representatives serving on the committee as provided for in paragraph (1) of this subsection, the chief superior court judge shall designate a representative from a local citizen or advocacy group which focuses on child abuse awareness and prevention.

(3) If any designated agency fails to carry out its duties relating to participation on the committee, the chief superior court judge of the circuit may issue an order requiring the participation of such agency. Failure to comply with such order shall be cause for punishment as for contempt of court.

(d) Each protocol committee shall elect or appoint a chairperson who shall be responsible for ensuring that written protocol procedures are followed by all agencies. That person can be independent of agencies listed in paragraph (1) of subsection (c) of this Code section. The child abuse protocol committee thus established may appoint such additional members as necessary and proper to accomplish the purposes of the protocol committee.

(e) The protocol committee shall adopt a written child abuse protocol which shall be filed with the Division of Family and Children Services of the Department of Human Services and the Georgia Child Fatality Review Panel, a copy of which shall be furnished to each agency in the county handling the cases of abused children. The protocol shall be a written document outlining in detail the procedures to be used in investigating and prosecuting cases arising from alleged child abuse and the methods to be used in coordinating treatment programs for the perpetrator, the family, and the child. The protocol shall also outline procedures to be used when child abuse occurs in a household where there is violence between past or present spouses, persons who are parents of the same child, parents and children, stepparents and stepchildren, foster parents and foster children, or other persons living or formerly living in the same household. The protocol adopted shall not be inconsistent with the policies and procedures of the Division of Family and Children Services of the Department of Human Services.

(f) The purpose of the protocol shall be to ensure coordination and cooperation between all agencies involved in a child abuse case so as to increase the efficiency of all agencies handling such cases, to minimize the stress created for the allegedly abused child by the legal and investigatory process, and to ensure that more effective treatment is provided for the perpetrator, the family, and the child, including counseling.

(g) Upon completion of the writing of the child abuse protocol, the protocol committee shall continue in existence and shall meet at least semiannually for the purpose of evaluating the effectiveness of the protocol and appropriately modifying and updating same.

(h) Each protocol committee shall adopt or amend its written child abuse protocol no later than July 1, 2001, to specify the circumstances under which law enforcement officers will and will not be required to accompany child abuse investigators from the county department of family and children services when these investigators investigate reports of child abuse. In determining when law enforcement officers shall and shall not accompany child abuse investigators, the protocol committee shall consider the need to protect the alleged victim and the need to preserve the confidentiality of the report. Each protocol committee shall establish joint work efforts between the law enforcement and child abuse investigative agencies in child abuse investigations. The adoption or amendment of the protocol shall also describe measures which can be taken within the county to prevent child abuse and shall be filed with and furnished to the same entities with or to which an original protocol is required to be filed or furnished. The protocol will be further amended to specify procedures to be adopted by the protocol committee to ensure that written protocol procedures are followed.

(i) The protocol committee shall issue a report no later than the first day of July in 2001 and no later than the first day of July each year thereafter. That report shall evaluate the extent to which child abuse investigations during the 12 months prior to the report have complied with the child abuse protocols of the protocol committee, recommend measures to improve compliance, and describe which measures taken within the county to prevent child abuse have been successful. The report shall be transmitted to the county governing authority, the fall term grand jury of the judicial circuit, the Georgia Child Fatality Review Panel, and the chief superior court judge.

(j) By July 1, 2001, members of each protocol committee shall receive appropriate training. As new members are appointed, they will also receive training within 12 months after their appointment. The Office of the Child Advocate for the Protection of Children shall provide such training.

(k) The protocol committee shall adopt a written sexual abuse and exploitation protocol which shall be filed with the Division of Family and Children Services of the Department of Human Services and the Office of the Child Advocate for the Protection of Children, a copy of which shall be furnished to each agency in the county handling the cases of sexually abused or exploited children. The protocol shall be a written document outlining in detail the procedures to be used in investigating and prosecuting cases arising from alleged child sexual abuse and exploitation and the procedures to be followed concerning the obtainment of and payment for sexual assault examinations. Each protocol committee shall adopt or amend its written sexual abuse and exploitation protocol no later than December 31, 2004. The protocol may incorporate existing sexual abuse and exploitation protocols used within the county. The protocol adopted shall be consistent with the policies and procedures of the Division of Family and Children Services of the Department of Human Services. A failure by an agency to follow the protocol shall not constitute an affirmative or other defense to prosecution of a sexual abuse or exploitation offense, nor shall a failure by an agency to follow the protocol give rise to a civil cause of action.

GA. CODE ANN. § 19-15-3 (2011). Child fatality review committees; duties, powers, and reporting requirements

(a)(1) Each county shall establish a local multidisciplinary, multiagency child fatality review committee as provided in this Code section. The chief superior court judge of the circuit in which the county is located shall establish a child fatality review committee composed of, but not limited to, the following members:

National Center for Prosecution of Child Abuse
National District Attorney Association

(A) The county medical examiner or coroner;

(B) The district attorney or his or her designee;

(C) A county department of family and children services representative;

(D) A local law enforcement representative;

(E) The sheriff or county police chief or his or her designee;

(F) A juvenile court representative;

(G) A county board of health representative; and

(H) A county mental health representative.

(2) The district attorney or his or her designee shall serve as the chairperson to preside over all meetings.

(b) Review committee members shall recommend whether to establish a review committee for that county alone or establish a review committee with and for the counties within that judicial circuit.

(c) The chief superior court judge shall appoint persons to fill any vacancies on the review committee should the membership fail to do so.

(d) If any designated agency fails to carry out its duties relating to participation on the local review committee, the chief superior court judge of the circuit or any superior court judge who is a member of the Georgia Child Fatality Review Panel shall issue an order requiring the participation of such agency. Failure to comply with such order shall be cause for punishment as for contempt of court.

(e) Deaths eligible for review by local review committees are all deaths of children ages birth through 17 as a result of:

(1) Sudden Infant Death Syndrome;

(2) Any unexpected or unexplained conditions;

(3) Unintentional injuries;

(4) Intentional injuries;

(5) Sudden death when the child is in apparent good health;

(6) Any manner that is suspicious or unusual;

(7) Medical conditions when unattended by a physician. For the purpose of this paragraph, no person shall be deemed to have died unattended when the death occurred while the person was a patient of a hospice licensed under Article 9 of Chapter 7 of Title 31; or

(8) Serving as an inmate of a state hospital or a state, county, or city penal institution.

(f) It shall be the duty of any law enforcement officer, medical personnel, or other person having knowledge of the death of a child to immediately notify the coroner or medical examiner of the county wherein the body is found or death occurs.

(g) If the death of a child occurs outside the child's county of residence, it shall be the duty of the medical examiner or coroner in the county where the child died to notify the medical examiner or coroner in the county of the child's residence.

(h) When a county medical examiner or coroner receives a report regarding the death of any child he or she shall within 48 hours of the death notify the chairperson of the child fatality review committee of the county or circuit in which such child resided at the time of death.

(i) The coroner or county medical examiner shall review the findings regarding the cause and manner of death for each child death report received and respond as follows:

(1) If the death does not meet the criteria for review pursuant to subsection (e) of this Code section, the coroner or county medical examiner shall sign the form designated by the panel stating that the death does not meet the criteria for review. He or she shall forward the form and findings, within seven days of the child's death, to the chairperson of the child fatality review committee in the county or circuit of the child's residence; or

(2) If the death meets the criteria for review pursuant to subsection (e) of this Code section, the coroner or county medical examiner shall complete and sign the form designated by the panel stating the death meets the criteria for review. He or she shall forward the form and findings, within seven days of the child's death, to the chairperson of the child fatality review committee in the county or circuit of the child's residence.

(j) When the chairperson of a local child fatality review committee receives a report from the coroner or medical examiner regarding the death of a child, that chairperson shall review the report and findings regarding the cause and manner of the child's death and respond as follows:

(1) If the report indicates the child's death does not meet the criteria for review and the chairperson agrees with this decision, the chairperson shall sign the form designated by the panel stating that the death does not meet the criteria for review. He or she shall forward the form and findings to the panel within seven days of receipt;

(2) If the report indicates the child's death does not meet the criteria for review and the chairperson disagrees with this decision, the chairperson shall follow the procedures for deaths to be reviewed pursuant to subsection (k) of this Code section;

(3) If the report indicates the child's death meets the criteria for review and the chairperson disagrees with this decision, the chairperson shall sign the form designated

by the panel stating that the death does not meet the criteria for review. The chairperson shall also attach an explanation for this decision; or

(4) If the report indicates the child's death meets the criteria for review and the chairperson agrees with this decision, the chairperson shall follow the procedures for deaths to be reviewed pursuant to subsection (k) of this Code section.

(k) When a child's death meets the criteria for review, the chairperson shall convene the review committee within 30 days after receipt of the report for a meeting to review and investigate the cause and circumstances of the death. Review committee members shall provide information as specified below, except where otherwise protected by statute:

(1) The providers of medical care and the medical examiner or coroner shall provide pertinent health and medical information regarding a child whose death is being reviewed by the local review committee;

(2) State, county, or local government agencies shall provide all of the following data on forms designated by the panel for reporting child fatalities:

(A) Birth information for children who died at less than one year of age including confidential information collected for medical and health use;

(B) Death information for children who have not reached their eighteenth birthday;

(C) Law enforcement investigative data, medical examiner or coroner investigative data, and parole and probation information and records;

(D) Medical care, including dental, mental, and prenatal health care; and

(E) Pertinent information from any social services agency that provided services to the child or family; and

(3) The review committee may obtain from any superior court judge of the county or circuit for which the review committee was created a subpoena to compel the production

of documents or attendance of witnesses when that judge has made a finding that such documents or witnesses are necessary for the review committee's review. However, this Code section shall not modify or impair the privileged communications as provided by law except as otherwise provided in Code Section 19-7-5.

(1) The review committee shall complete its review and prepare a report of the child's death within 20 days, weekends and holidays excluded, following the first meeting held after receipt of the county medical examiner or coroner's report. The review committee's report shall:

(1) State the circumstances leading up to death and cause of death;

(2) Detail any agency involvement prior to death, including the beginning and ending dates and kinds of services delivered, the reasons for initial agency activity, and the reasons for any termination of agency activities;

(3) State whether any agency services had been delivered to the family or child prior to the circumstances leading to the child's death;

(4) State whether court intervention had ever been sought;

(5) State whether there have been any acts or reports of violence between past or present spouses, persons who are parents of the same child, parents and children, stepparents and stepchildren, foster parents and foster children, or other persons living or formerly living in the same household;

(6) Conclude whether services or agency activities delivered prior to death were appropriate and whether the child's death could have been prevented;

(7) Make recommendations for possible prevention of future deaths of similar incidents for children who are at risk for such deaths; and

(8) Include other findings as requested by the Georgia Child Fatality Review Panel.

(m) The review committee shall transmit a copy of its report within 15 days of completion to the panel.

(n) The review committee shall transmit a copy of its report within 15 days following its completion to the district attorney of the county or circuit for which the review committee was created if the report concluded that the child named therein died as a result of:

(1) Sudden Infant Death Syndrome when no autopsy was performed to confirm the diagnosis;

(2) Accidental death when it appears that the death could have been prevented through intervention or supervision;

(3) Any sexually transmitted disease;

(4) Medical causes which could have been prevented through intervention by an agency or by seeking medical treatment;

(5) Suicide of a child in custody or known to the Department of Human Services or when the finding of suicide is suspicious;

(6) Suspected or confirmed child abuse;

(7) Trauma to the head or body; or

(8) Homicide.

(o) Each local review committee shall issue an annual report no later than the first day of July in 2001 and in each year thereafter. The report shall:

(1) Specify the numbers of reports received by that review committee from a county medical examiner or coroner pursuant to subsection (h) of this Code section for the preceding calendar year;

(2) Specify the number of reports of child fatality reviews prepared by the review committee during such period;

(3) Be published at least once annually in the legal organ of the county or counties for which the review committee was established with the expense of such publication paid each by such county; and

(4) Be transmitted, no later than the fifteenth day of July in 2001 and in each year thereafter, to the Georgia Child Fatality Review Panel.

GA. CODE ANN. § 19-15-4 (2011). Georgia Child Fatality Review Panel; duties, powers, and reporting requirements

(a) There is created the Georgia Child Fatality Review Panel as defined in paragraph (7) of Code Section 19-15-1.

(b) The Office of the Child Advocate for the Protection of Children shall coordinate the work of the panel and shall provide such administrative and staff support to the panel as may be necessary to enable the panel to discharge its duties under this chapter. The panel shall be attached to the Office of Planning and Budget for administrative purposes, and its planning, policy, and budget functions shall be coordinated with those of the Office of the Child Advocate.

(c) The panel shall be composed as follows:

(1) One district attorney appointed by the Governor;

(2) One juvenile court judge appointed by the Governor;

(3) Two citizen members who shall be appointed by the Governor, who are not employed by or officers of the state or any political subdivision thereof and one of whom shall

come from each of the following: (A) a state-wide child abuse prevention organization; and (B) a state-wide childhood injury prevention organization;

(4) One forensic pathologist appointed by the Governor;

(5) The chairperson of the Board of Human Services;

(6) The director of the Division of Family and Children Services of the Department of Human Services;

(7) The director of the Georgia Bureau of Investigation;

(8) The chairperson of the Criminal Justice Coordinating Council;

(9) A member of the Georgia Senate appointed by the Lieutenant Governor;

(10) A member of the Georgia House of Representatives appointed by the Speaker of the House of Representatives;

(11) A local law enforcement official appointed by the Governor;

(12) A superior court judge appointed by the Governor;

(13) A coroner appointed by the Governor;

(14) The Child Advocate for the Protection of Children;

(15) The commissioner of public health; and

(16) The commissioner of behavioral health and developmental disabilities.

(d) The Governor shall appoint the chairperson of the panel.

(e)(1) All appointed members shall be appointed for terms of two years beginning on July 1 of the year appointed and shall serve until their respective successors are appointed and qualified.

(2) All ex officio members shall serve during the time such persons hold the offices or positions specified therein.

(3) Members of the General Assembly shall serve for terms of office concurrent with their terms of office as members of the General Assembly.

(4) Vacancies in the membership of the panel so appointed shall be filled in the same manner as the original appointment for the unexpired term of office.

(f) Members of the panel who are members of the General Assembly shall be compensated for service on the panel from legislative funds in the manner provided for service on interim study committees. Those members of the panel who are not state officials or employees shall receive from funds appropriated or otherwise available to the panel for their services on the panel the same daily expense and travel or mileage allowance authorized for members of the General Assembly for service on interim study committees. The members of the panel who are state officials or employees shall receive no additional compensation for their service on the panel but may be reimbursed for reasonable and necessary travel expenses which shall be payable from the department or agency of which such member is an employee or officer.

(g) The panel shall meet quarterly to review the reports of local review committees and shall meet when requested to do so by the Governor.

(h) The purpose of the panel is to recommend measures to decrease the incidence of child death by undertaking all of the following duties:

(1) Identify factors which place a child at risk for death;

- (2) Collect and share information among state agencies which provide services to children and families or investigate child deaths;
- (3) Make suggestions and recommendations to appropriate participating agencies regarding improving coordination of services and investigations;
- (4) Identify trends relevant to unexpected or unexplained child death;
- (5) Investigate the relationship, if any, between child deaths and violence between past or present spouses, persons who are parents of the same child, parents and children, stepparents and stepchildren, foster parents and foster children, or other persons living or formerly living in the same household;
- (6) Review each report from local child fatality review committees. The chairperson may call a special meeting of the panel to review any report when the chairperson has concluded the report warrants expedited review and has been requested by the submitting local review committee to make such expedited review;
- (7) Provide training and written materials to the local review committees to assist them in carrying out their duties. Such written materials shall include model protocols for the operation of the review committees;
- (8) Develop a protocol for child fatality investigations and revise the protocol as needed;
- (9) Monitor the operations of local review committees to determine training needs and service gaps. If the panel determines that changes to any statute, regulation, or policy is needed to decrease the risk of child death, it shall propose and recommend such changes in its annual report; and
- (10) Develop and implement such procedures and policies as are necessary for its own operation.
 - (i) By January 1 of each calendar year, the panel shall submit a report to the Governor, the Lieutenant Governor, the Speaker of the House of Representatives, and the Judiciary Committees of the Senate and House of Representatives regarding the prevalence and

circumstances of child fatalities in the state; recommend measures to reduce such fatalities caused by other than natural causes; and address in the report the following issues:

- (1) Whether the deaths could have been prevented;
 - (2) Whether the children were known to any state or local agency;
 - (3) The actions, if any, taken by any state or local agency or court;
 - (4) Whether agency or court intervention could have prevented their deaths;
 - (5) Whether policy, procedural, regulatory, or statutory changes are called for as a result of these findings; and
 - (6) Whether any referral should have been made to a law enforcement agency which was not made.
- (j) The panel shall also establish procedures for the conduct of reviews by local review committees into deaths of children and may obtain the assistance of child protection professionals in establishing such procedures.
- (k) The panel shall have the authority to obtain from any superior court judge of the county or circuit for which the matter is pending a subpoena to compel the production of documents or attendance of witnesses if the county multiagency child fatality review committee has not exercised its authority to subpoena the documents or witnesses as provided in paragraph (3) of subsection (k) of Code Section 19-15-3; provided, however, if a superior court judge has previously ruled that the records or witnesses are not necessary to the fatality review at issue, such finding shall be conclusive on the issuance of the subpoena.

GA. CODE ANN. § 19-15-5 (2011). Open and closed meetings

(a) A protocol committee or review committee in the exercise of its duties shall be closed to the public and shall not be subject to Chapter 14 of Title 50, relating to open meetings.

(b) The panel shall be open to the public as long as information identifying a deceased or abused child, any family member of the child, or alleged or suspected perpetrator of abuse upon the child is not disclosed during such meetings or proceedings, but the panel is authorized to close such meeting to the public when such identifying information is required to be disclosed to members of the panel in order for the panel to carry out its duties.

GA. CODE ANN. § 19-15-6 (2011). Public records; confidential information

(a) Records and other documents which are made public records pursuant to any other provisions of law shall remain public records notwithstanding their being obtained, considered, or both, by a protocol committee, a review committee, or the panel.

(b) Notwithstanding any other provision of law to the contrary, reports of a review committee made pursuant to Code Section 19-15-3 and reports of the panel made pursuant to Code Section 19-15-4 shall be public records and shall be released to any person making a request therefor but the panel protocol committee or review committee having possession of such records or reports shall only release them after expunging therefrom all information contained therein which would permit identifying the deceased or abused child, any family member of the child, any alleged or suspected perpetrator of abuse upon the child, or any reporter of suspected child abuse.

(c) Statistical compilations of data by a review committee or the panel based upon information received thereby and containing no information which would permit the identification of any person shall be public records.

(d) Members of a protocol committee, a review committee, or of the panel shall not disclose what transpires at any meeting other than one made public by Code Section 19-15-5 nor disclose any information the disclosure of which is prohibited by this Code section, except to carry out the purposes of this chapter. Any person who knowingly violates this subsection shall be guilty of a misdemeanor.

(e) A person who presents information to a protocol committee, a review committee, or the panel or who is a member of any such body shall not be questioned in any civil or

criminal proceeding regarding such presentation or regarding opinions formed by or confidential information obtained by such person as a result of serving as a member of any such body. This subsection shall not be construed to prohibit any person from testifying regarding information obtained independently of a protocol committee, a review committee, or the panel. In any proceeding in which testimony of such a member is offered the court shall first determine the source of such witness's knowledge.

(f) Except as otherwise provided in this Code section, information acquired by and records of a protocol committee, a review committee, or the panel shall be confidential, shall not be disclosed, and shall not be subject to Article 4 of Chapter 18 of Title 50, relating to open records, or subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding.

(g) A member of a protocol committee, a review committee, or the panel shall not be civilly or criminally liable for any disclosure of information made by such member as authorized by this Code section.

(h) Members of the review committee, persons attending a review committee meeting, and persons who present information to a review committee may release information to such government agencies as is necessary for the purpose of carrying out assigned review committee duties.

(i) Notwithstanding any other provisions of law, information acquired by and documents, records, and reports of the panel and child abuse protocol committees and review committees applicable to a child who at the time of his or her death was in the custody of a state department or agency or foster parent shall not be confidential and shall be subject to Article 4 of Chapter 18 of Title 50, relating to open records.

GA. CODE ANN. § 19-15-7 (2011). Construction of law as not to result in loss of federal funds

Nothing in this chapter shall be construed to authorize or require the inspection of any records or the release of any information if that inspection or release would result in the loss of any federal funds to the state.

HAWAII

HAW. REV. STAT. ANN. § 321-341 (2012). Multidisciplinary and multiagency reviews

The department of health may conduct multidisciplinary and multiagency reviews of child deaths in order to reduce the incidence of preventable child deaths.

HAW. REV. STAT. ANN. § 321-342 (2012). Definitions

As used in this part:

“Child” means a person under eighteen years of age.

“Child death review information” means information regarding the child and child's family, including but not limited to:

- (1) Social, medical, and legal histories;
- (2) Death and birth certificates;
- (3) Law enforcement investigative data;
- (4) Medical examiner or coroner investigative data;
- (5) Parole and probation information and records;
- (6) Information and records of social service agencies;
- (7) Educational records; and
- (8) Health care institution information.

“Department” means the department of health.

“Director” means the director of health or the director's designated representatives.

“Family” means:

- (1) Each legal parent;
- (2) The natural mother;
- (3) The natural father;
- (4) The adjudicated, presumed, or concerned natural father as defined under section 578-2;
- (5) Each parent's spouse or former spouses;
- (6) Each sibling or person related by consanguinity or marriage;
- (7) Each person residing in the same dwelling unit; and
- (8) Any other person who, or legal entity that, is a child's legal or physical custodian or guardian, or who is otherwise responsible for the child's care, other than an authorized agency that assumes such a legal status or relationship with the child under chapter 587A.

“Preventable death” means a death that reasonable medical, social, legal, psychological, or educational intervention may have prevented.

“Provider of medical care” means any health care practitioner who provides, or a facility through which is provided, any medical evaluation or treatment, including dental and mental health evaluation or treatment.

HAW. REV. STAT. ANN. § 321-343 (2012). Access to information

(a) Upon written request of the director, all providers of medical care and state and county agencies shall disclose to the department, and those individuals appointed by the director to participate in the review of child deaths, child death review information regarding the circumstances of a child's death so that the department may conduct a multidisciplinary and multiagency review of child deaths pursuant to section 321-31 and this part.

(b) To the extent that this section conflicts with other state confidentiality laws, this section shall prevail.

HAW. REV. STAT. ANN. § 321-344 (2012). Exception

Information regarding an ongoing civil or criminal investigation shall be disclosed at the discretion of the applicable state, county, or federal law enforcement agency.

HAW. REV. STAT. ANN. § 321-345 (2012). Use of child death review information and records

(a) Except as otherwise provided in this part, all child death review information acquired by the department during its review of child deaths pursuant to this part, is confidential and may only be disclosed as necessary to carry out the purposes of this part.

(b) Child death review information and statistical compilations of data that do not contain any information that would permit the identification of any person shall be public records.

(c) No individual participating in the department's multidisciplinary and multiagency review of a child's death may be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a child death review meeting. Nothing in this subsection shall be construed to prevent a person from testifying to information obtained independently of the department's multidisciplinary and multiagency review of a child's death, or which is public information, or where disclosure is required by law or court order.

(d) Child death review information held by the department as a result of child death reviews conducted under this part are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding, except that child death review

information otherwise available from other sources is not immune from subpoena, discovery, or introduction into evidence through those sources solely because they were provided as required by this part.

HAW. REV. STAT. ANN. § 321-346 (2012). Immunity from liability

All agencies and individuals participating in the review of child deaths pursuant to this part shall not be held civilly or criminally liable for providing the information required under this part.

IDAHO

Currently, the state of Idaho is working to re-establish the statewide team as funding becomes available.²

ILLINOIS

20 Ill. Comp. Stat. 515/1 (2011). SHORT TITLE

§ 1. Short title. This Act may be cited as the Child Death Review Team Act.

20 Ill. Comp. Stat. 515/5 (2011). STATE POLICY

§ 5. State policy. The following statements are the policy of this State:

(1) Every child is entitled to live in safety and in health and to survive into adulthood.

(2) Responding to child deaths is a State and a community responsibility.

(3) When a child dies, the response by the State and the community to the death must include an accurate and complete determination of the cause of death, the provision of services to surviving family members, and the development and implementation of measures to prevent future deaths from similar causes. The response may include court action, including prosecution of persons who may be responsible for the death and

² Nat'l Cent. For Child Death Review, *State Spotlight – Idaho* (last modified Feb 2012); <http://www.childdeathreview.org/spotlightID.htm>

juvenile proceedings to protect other children in the care of the person responsible for the care of the child who died.

(4) Professionals from disparate disciplines and agencies who have responsibilities for children and expertise that can promote child safety and well-being should share their expertise and knowledge so that the goals of determining the causes of children's deaths, planning and providing services to surviving children and nonoffending family members, and preventing future child deaths can be achieved.

(5) A greater understanding of the incidence and causes of child deaths is necessary if the State is to prevent future child deaths.

(6) Multidisciplinary and multiagency reviews of child deaths can assist the State and counties in (i) investigating child deaths, (ii) developing a greater understanding of the incidence and causes of child deaths and the methods for preventing those deaths, and (iii) identifying gaps in services to children and families.

(7) Access to information regarding deceased children and their families by multidisciplinary and multiagency child death review teams is necessary for those teams to achieve their purposes and duties.

20 ILL. COMP. STAT. 515/10 (2011). Definitions

§ 10. Definitions. As used in this Act, unless the context requires otherwise:

“Child” means any person under the age of 18 years unless legally emancipated by reason of marriage or entry into a branch of the United States armed services.

“Department” means the Department of Children and Family Services.

“Director” means the Director of Children and Family Services.

“Executive Council” means the Illinois Child Death Review Teams Executive Council.

515/15. Child death review teams; establishment

20 ILL. COMP. STAT. 515/15 (2011). Definitions Child death review teams; establishment.

(a) The Director, in consultation with the Executive Council, law enforcement, and other professionals who work in the field of investigating, treating, or preventing child abuse or neglect in that subregion, shall appoint members to a child death review team in each of the Department's administrative subregions of the State outside Cook County and at least one child death review team in Cook County. The members of a team shall be appointed for 2-year terms and shall be eligible for reappointment upon the expiration of the terms. The Director must fill any vacancy in a team within 60 days after that vacancy occurs.

(b) Each child death review team shall consist of at least one member from each of the following categories:

(1) Pediatrician or other physician knowledgeable about child abuse and neglect.

(2) Representative of the Department.

(3) State's attorney or State's attorney's representative.

(4) Representative of a local law enforcement agency.

(5) Psychologist or psychiatrist.

(6) Representative of a local health department.

(7) Representative of a school district or other education or child care interests.

(8) Coroner or forensic pathologist.

(9) Representative of a child welfare agency or child advocacy organization.

(10) Representative of a local hospital, trauma center, or provider of emergency medical services.

(11) Representative of the Department of State Police.

Each child death review team may make recommendations to the Director concerning additional appointments.

Each child death review team member must have demonstrated experience and an interest in investigating, treating, or preventing child abuse or neglect.

(c) Each child death review team shall select a chairperson from among its members. The chairperson shall also serve on the Illinois Child Death Review Teams Executive Council.

(d) The child death review teams shall be funded under a separate line item in the Department's annual budget.

20 ILL. COMP. STAT. 515/20 (2011). Reviews of child deaths

§ 20. Reviews of child deaths.

(a) Every child death shall be reviewed by the team in the subregion which has primary case management responsibility. The deceased child must be one of the following:

(1) A ward of the Department.

(2) The subject of an open service case maintained by the Department.

(3) The subject of a pending child abuse or neglect investigation.

(4) A child who was the subject of an abuse or neglect investigation at any time during the 12 months preceding the child's death.

(5) Any other child whose death is reported to the State central register as a result of alleged child abuse or neglect which report is subsequently indicated.

A child death review team may, at its discretion, review other sudden, unexpected, or unexplained child deaths, and cases of serious or fatal injuries to a child identified under the Children's Advocacy Center Act.

(b) A child death review team's purpose in conducting reviews of child deaths is to do the following:

(1) Assist in determining the cause and manner of the child's death, when requested.

(2) Evaluate means by which the death might have been prevented.

(3) Report its findings to appropriate agencies and make recommendations that may help to reduce the number of child deaths caused by abuse or neglect.

(4) Promote continuing education for professionals involved in investigating, treating, and preventing child abuse and neglect as a means of preventing child deaths due to abuse or neglect.

(5) Make specific recommendations to the Director and the Inspector General of the Department concerning the prevention of child deaths due to abuse or neglect and the establishment of protocols for investigating child deaths.

(c) A child death review team shall review a child death as soon as practical and not later than 90 days following the completion by the Department of the investigation of the death under the Abused and Neglected Child Reporting Act. When there has been no investigation by the Department, the child death review team shall review a child's death within 90 days after obtaining the information necessary to complete the review from the coroner, pathologist, medical examiner, or law enforcement agency, depending on the

nature of the case. A child death review team shall meet at least once in each calendar quarter.

(d) The Director shall, within 90 days, review and reply to recommendations made by a team under item (5) of subsection (b). With respect to each recommendation made by a team, the Director shall submit his or her reply both to the chairperson of that team and to the chairperson of the Executive Council. The Director's reply to each recommendation must include a statement as to whether the Director intends to implement the recommendation.

The Director shall implement recommendations as feasible and appropriate and shall respond in writing to explain the implementation or nonimplementation of the recommendations.

(e) Within 90 days after the Director submits a reply with respect to a recommendation as required by subsection (d), the Director must submit an additional report that sets forth in detail the way, if any, in which the Director will implement the recommendation and the schedule for implementing the recommendation. The Director shall submit this report to the chairperson of the team that made the recommendation and to the chairperson of the Executive Council.

(f) Within 180 days after the Director submits a report under subsection (e) concerning the implementation of a recommendation, the Director shall submit a further report to the chairperson of the team that made the recommendation and to the chairperson of the Executive Council. This report shall set forth the specific changes in the Department's policies and procedures that have been made in response to the recommendation.

20 ILL. COMP. STAT. 515/25 (2011). Team access to information

§ 25. Team access to information.

(a) The Department shall provide to a child death review team, on the request of the team chairperson, all records and information in the Department's possession that are relevant to the team's review of a child death, including records and information concerning previous reports or investigations of suspected child abuse or neglect.

(b) A child death review team shall have access to all records and information that are relevant to its review of a child death and in the possession of a State or local

governmental agency, including, but not limited to, information gained through the Child Advocacy Center protocol for cases of serious or fatal injury to a child. These records and information include, without limitation, birth certificates, all relevant medical and mental health records, records of law enforcement agency investigations, records of coroner or medical examiner investigations, records of the Department of Corrections concerning a person's parole, records of a probation and court services department, and records of a social services agency that provided services to the child or the child's family.

515/30. Public access to information

20 ILL. COMP. STAT. 515/30 (2011). Public access to information.

(a) Meetings of the child death review teams and the Executive Council shall be closed to the public. Meetings of the child death review teams and the Executive Council are not subject to the Open Meetings Act (5 ILCS 120), as provided in that Act.

(b) Records and information provided to a child death review team and the Executive Council, and records maintained by a team or the Executive Council, are confidential and not subject to the Freedom of Information Act (5 ILCS 140), as provided in that Act.

Nothing contained in this subsection (b) prevents the sharing or disclosure of records, other than those produced by a Child Death Review Team or the Executive Council, relating or pertaining to the death of a minor under the care of or receiving services from the Department of Children and Family Services and under the jurisdiction of the juvenile court with the juvenile court, the State's Attorney, and the minor's attorney.

(c) Members of a child death review team and the Executive Council are not subject to examination, in any civil or criminal proceeding, concerning information presented to members of the team or the Executive Council or opinions formed by members of the team or the Executive Council based on that information. A person may, however, be examined concerning information provided to a child death review team or the Executive Council that is otherwise available to the public.

(d) Records and information produced by a child death review team and the Executive Council are not subject to discovery or subpoena and are not admissible as evidence in any civil or criminal proceeding. Those records and information are, however, subject to

discovery or a subpoena, and are admissible as evidence, to the extent they are otherwise available to the public.

20 ILL. COMP. STAT. 515/35 (2011). Indemnification

§ 35. Indemnification. The State shall indemnify and hold harmless members of a child death review team and the Executive Council for all their acts, omissions, decisions, or other conduct arising out of the scope of their service on the team or Executive Council, except those involving willful or wanton misconduct. The method of providing indemnification shall be as provided in the State Employee Indemnification Act (5 ILCS 350/1 et seq. [FN1]).

[FN1] So in enrolled bill, probably should read 5 ILCS 350/0.01 et seq.
515/40. Illinois Child Death Review Teams Executive Council

20 ILL. COMP. STAT. 515/40 (2011). Illinois Child Death Review Teams Executive Council.

(a) The Illinois Child Death Review Teams Executive Council, consisting of the chairpersons of the 9 child death review teams in Illinois, is the coordinating and oversight body for child death review teams and activities in Illinois. The vice-chairperson of a child death review team, as designated by the chairperson, may serve as a back-up member or an alternate member of the Executive Council, if the chairperson of the child death review team is unavailable to serve on the Executive Council. The Inspector General of the Department, ex officio, is a non-voting member of the Executive Council. The Director may appoint to the Executive Council any ex-officio members deemed necessary. Persons with expertise needed by the Executive Council may be invited to meetings. The Executive Council must select from its members a chairperson and a vice-chairperson, each to serve a 2-year, renewable term.

The Executive Council must meet at least 4 times during each calendar year. At each such meeting, in addition to any other matters under consideration, the Executive Council shall review all replies and reports received from the Director pursuant to subsections (d), (e), and (f) of Section 20 since the Executive Council's previous meeting. The Executive Council's review must include consideration of the Director's proposed manner of and schedule for implementing each recommendation made by a child death review team.

(b) The Department must provide or arrange for the staff support necessary for the Executive Council to carry out its duties. The Director, in cooperation and consultation with the Executive Council, shall appoint, reappoint, and remove team members. From funds available, the Director may select from a list of 2 or more candidates recommended by the Executive Council to serve as the Child Death Review Teams Executive Director. The Child Death Review Teams Executive Director shall oversee the operations of the child death review teams and shall report directly to the Executive Council.

(c) The Executive Council has, but is not limited to, the following duties:

(1) To serve as the voice of child death review teams in Illinois.

(2) To oversee the regional teams in order to ensure that the teams' work is coordinated and in compliance with the statutes and the operating protocol.

(3) To ensure that the data, results, findings, and recommendations of the teams are adequately used to make any necessary changes in the policies, procedures, and statutes in order to protect children in a timely manner.

(4) To collaborate with the General Assembly, the Department, and others in order to develop any legislation needed to prevent child fatalities and to protect children.

(5) To assist in the development of quarterly and annual reports based on the work and the findings of the teams.

(6) To ensure that the regional teams' review processes are standardized in order to convey data, findings, and recommendations in a usable format.

(7) To serve as a link with child death review teams throughout the country and to participate in national child death review team activities.

(8) To develop an annual statewide symposium to update the knowledge and skills of child death review team members and to promote the exchange of information between teams.

(9) To provide the child death review teams with the most current information and practices concerning child death review and related topics.

(10) To perform any other functions necessary to enhance the capability of the child death review teams to reduce and prevent child injuries and fatalities.

(c-5) The Executive Council shall prepare an annual report. The report must include, but need not be limited to, (i) each recommendation made by a child death review team pursuant to item (5) of subsection (b) of Section 20 during the period covered by the report, (ii) the Director's proposed schedule for implementing each such recommendation, and (iii) a description of the specific changes in the Department's policies and procedures that have been made in response to the recommendation. The Executive Council shall send a copy of its annual report to each of the following:

(1) The Governor.

(2) Each member of the Senate or the House of Representatives whose legislative district lies wholly or partly within the region covered by any child death review team whose recommendation is addressed in the annual report.

(3) Each member of each child death review team in the State.

(d) In any instance when a child death review team does not operate in accordance with established protocol, the Director, in consultation and cooperation with the Executive Council, must take any necessary actions to bring the team into compliance with the protocol.

20 ILL. COMP. STAT. 515/45 (2011). Child Death Investigation Task Force; pilot program

§ 45. Child Death Investigation Task Force; pilot program. The Child Death Review Teams Executive Council may, from funds appropriated by the Illinois General Assembly to the Department and provided to the Child Death Review Teams Executive Council for this purpose, or from funds that may otherwise be provided for this purpose from other public or private sources, establish an 18-month pilot program in the Southern Region of the State, as designated by the Department, under which a special Child Death Investigation Task Force will be created by the Child Death Review Teams Executive

Council to develop and implement a plan for the investigation of sudden, unexpected, or unexplained deaths of children under 18 years of age occurring within that region. The plan shall include a protocol to be followed by child death review teams in the review of child deaths authorized under paragraph (a)(5) of Section 20 of this Act. The plan must include provisions for local or State law enforcement agencies, hospitals, or coroners to promptly notify the Task Force of a death or serious life-threatening injury to a child, and for the Child Death Investigation Task Force to review the death and submit a report containing findings and recommendations to the Child Death Review Teams Executive Council, the Director, the Department of Children and Family Services Inspector General, the appropriate State's Attorney, and the State Representative and State Senator in whose legislative districts the case arose. The plan may include coordination with any investigation conducted under the Children's Advocacy Center Act. By July 1, 2011, the Child Death Review Teams Executive Council shall submit a report to the Director, the General Assembly, and the Governor summarizing the results of the pilot program together with any recommendations for statewide implementation of a protocol for the investigation of all sudden, unexpected, or unexplained child deaths.

INDIANA

Ind. Code Ann. § 31-33-24-1 (2011). “CHILD” DEFINED

Sec. 1. As used in this chapter, “child” means an individual less than sixteen (16) years of age.

IND. CODE ANN. § 31-33-24-2 (2011). “Emergency medical services” defined

Sec. 2. As used in this chapter, “emergency medical services” means the provision of emergency ambulance services or other services, including extrication and rescue services, utilized in serving an individual's need for immediate medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury.

IND. CODE ANN. § 31-33-24-3 (2011). “Local child fatality review team” defined

Sec. 3. As used in this chapter, “local child fatality review team” refers to a county or regional child fatality review team established under this chapter.

IND. CODE ANN. § 31-33-24-4 (2011). “Mental health provider” defined

Sec. 4. As used in this chapter, “mental health provider” means any of the following:

- (1) A registered nurse or licensed practical nurse licensed under IC 25-23.
- (2) A clinical social worker licensed under IC 25-23.6-5.
- (3) A marriage and family therapist licensed under IC 25-23.6-8.
- (4) A psychologist licensed under IC 25-33.
- (5) A school psychologist licensed by the Indiana state board of education.
- (6) An individual who claims to be a mental health provider.

IND. CODE ANN. § 31-33-24-5 (2011). “Statewide child fatality review committee” defined

Sec. 5. As used in this chapter, “statewide child fatality review committee” refers to the statewide child fatality review committee established by IC 31-33-25-6.

IND. CODE ANN. § 31-33-24-6 (2011). Establishment

Sec. 6. (a) A county may establish a county child fatality review team to review the death of a child that is:

- (1) sudden;
- (2) unexpected; or
- (3) unexplained.

(b) The legislative body of a county (as defined in IC 36-1-2-9) must determine by majority vote whether the county will establish a local child fatality review team.

(c) If a county elects not to establish a county child fatality review team, the county may join with one (1) or more other counties that have not established a county child fatality review team and form a regional child fatality review team.

(d) To establish a regional child fatality review team as described in subsection (c), the legislative body of each county comprising the region must cast a majority of votes in favor of establishing a regional child fatality review team.

IND. CODE ANN. § 31-33-24-7 (2011). Determinations involved in review; requests for records

Sec. 7. (a) A child fatality review consists of determining:

(1) whether similar future deaths could be prevented; and

(2) agencies or resources that should be involved to adequately prevent future deaths of children.

(b) In conducting the child fatality review under subsection (a), the local child fatality review team shall review every record concerning the deceased child that is held by the department.

(c) If a local child fatality review team requests records from a hospital, physician, coroner, or mental health professional regarding a death that the local child fatality review team is investigating, the hospital, physician, coroner, or mental health professional shall provide the requested records, subject to IC 34-30-15, to the child fatality review team.

IND. CODE ANN. § 31-33-24-8 (2011). Local team request for review by statewide committee

Sec. 8. A local child fatality review team may request that the statewide child fatality review committee make a fatality review of a child from the area served by the local child fatality review team if a majority of the members of a local child fatality review team vote to make the request.

IND. CODE ANN. § 31-33-24-9 (2011). Membership

Sec. 9. (a) A local child fatality review team consists of the following members:

(1) A coroner or deputy coroner from the area served by the local child fatality review team.

(2) A representative from:

(A) the health and hospital corporation of Marion County as set forth in IC 16-22-8;

(B) a local health department established under IC 16-20-2; or

(C) a multiple county health department established under IC 16-20-3;

from the area served by the local child fatality review team.

(3) A physician residing or practicing medicine in the area served by the local child fatality review team.

(4) A representative of law enforcement from the area served by the local child fatality review team.

(5) A representative from an emergency medical services provider doing business in the area served by the local child fatality review team.

(6) A director or manager of a local or regional office of the department from the area served by the local child fatality review team.

(7) A representative of the prosecuting attorney from the area served by the local child fatality review team.

(8) A pathologist with forensic experience who is licensed to practice medicine in Indiana and who, if feasible, is certified by the American Board of Pathology in forensic pathology.

(9) A representative from a fire department or volunteer fire department (as defined in IC 36-8-12-2) from the area served by the local child fatality review team.

(b) If a local child fatality review team is established in one (1) county, the legislative body that voted to establish the local child fatality review team under section 6 of this chapter shall:

(1) adopt an ordinance for the appointment and reappointment of members of the local child fatality review team; and

(2) appoint members to the local child fatality review team under the ordinance adopted.

(c) If a local child fatality review team is established in a region, the county legislative bodies that voted to establish the local child fatality review team under section 6 of this chapter shall:

(1) each adopt substantially similar ordinances for the appointment and reappointment of members of the local child fatality review team; and

(2) appoint members to the local child fatality review team under the ordinances adopted.

IND. CODE ANN. § 31-33-24-10 (2011). Additional members

Sec. 10. A local child fatality review team may have additional members from the following categories:

(1) A representative of a hospital located in the county or region served by the local child fatality review team.

(2) A mental health provider providing services in the county or region served by the local child fatality review team.

(3) A representative from a juvenile or probate court in the county or region served by the local child fatality review team.

(4) Other representatives requested to serve by the members of the local child fatality review team.

IND. CODE ANN. § 31-33-24-11 (2011). Chairperson; call to have meeting; agenda

Sec. 11. (a) Any member of a local child fatality review team may serve as chairperson. The chairperson shall be elected by the members of the local child fatality review team at the first meeting of the local child fatality review team.

(b) The local child fatality review team shall meet at the call of the chairperson.

(c) The local child fatality review team chairperson shall determine the agenda for each meeting.

IND. CODE ANN. § 31-33-24-12 (2011). Meetings; open to public; executive sessions; confidentiality statements

Sec. 12. (a) Except as provided in subsection (b), meetings of a local child fatality review team are open to the public.

(b) Meetings of a local child fatality review team that involve confidential records or identifying information regarding the death of a child that is confidential under state or federal law shall be held as executive sessions.

(c) If an executive session is held under subsection (b), each individual who:

(1) attends a meeting of the local child fatality review team; and

(2) is not a member of the local child fatality review team;

shall sign a confidentiality statement prepared by the department. The local child fatality review team shall keep all confidentiality statements signed under this subsection.

IND. CODE ANN. § 31-33-24-13 (2011). Discussion of confidential matters; immunity from liability

Sec. 13. Members of a local child fatality review team and individuals who attend a meeting of a local child fatality review team as an invitee of the chairperson:

(1) may discuss among themselves confidential matters that are before the local child fatality review team;

(2) are bound by all applicable laws regarding the confidentiality of matters reviewed by the local child fatality review team; and

(3) except when acting:

(A) with malice;

(B) in bad faith; or

(C) with negligence;

are immune from any civil or criminal liability that might otherwise be imposed as a result of sharing among themselves confidential matters that are before the local child fatality review team.

IND. CODE ANN. § 31-33-24-14 (2011). Training

Sec. 14. The department shall provide training to local child fatality review teams.

IND. CODE ANN. § 31-33-24-15 (2011). Collection and documentation of information; data collection form

Sec. 15. (a) The department shall collect and document information surrounding the deaths of children reviewed by local child fatality review teams. The department shall develop a data collection form that includes:

(1) identifying and nonidentifying information;

(2) information regarding the circumstances surrounding a death;

(3) factors contributing to a death; and

(4) findings and recommendations.

(b) The data collection form developed under this section must also be provided to:

(1) the appropriate community child protection team;

(2) as appropriate:

(A) the health and hospital corporation of Marion County as set forth in IC 16-22-8;

(B) the local health department established under IC 16-20-2; or

(C) the multiple county health department established under IC 16-20-3; and

(3) the appropriate coroner and the pathologist who performed the autopsy on the child.

IOWA

Iowa Code § 135.43 (2011). IOWA CHILD DEATH REVIEW TEAM ESTABLISHED--DUTIES

1. An Iowa child death review team is established as part of the office of the state medical examiner. The office of the state medical examiner shall provide staffing and administrative support to the team.

2. The membership of the review team is subject to the provisions of sections 69.16 and 69.16A, relating to political affiliation and gender balance. Review team members who

are not designated by another appointing authority shall be appointed by the state medical examiner. Membership terms shall be for three years. A membership vacancy shall be filled in the same manner as the original appointment. The review team shall elect a chairperson and other officers as deemed necessary by the review team. The review team shall meet upon the call of the state medical examiner or as determined by the review team. The members of the team are eligible for reimbursement of actual and necessary expenses incurred in the performance of their official duties. The review team shall include the following:

- a. The state medical examiner or the state medical examiner's designee.
- b. A certified or licensed professional who is knowledgeable concerning sudden infant death syndrome.
- c. A pediatrician who is knowledgeable concerning deaths of children.
- d. A family practice physician who is knowledgeable concerning deaths of children.
- e. One mental health professional who is knowledgeable concerning deaths of children.
- f. One social worker who is knowledgeable concerning deaths of children.
- g. A certified or licensed professional who is knowledgeable concerning domestic violence.
- h. A professional who is knowledgeable concerning substance abuse.
- i. A local law enforcement official.
- j. A county attorney.
- k. An emergency room nurse who is knowledgeable concerning the deaths of children.
- l. A perinatal expert.
- m. A representative of the health insurance industry.
- n. One other appointed at large.

3. The review team shall perform the following duties:

- a. Collect, review, and analyze child death certificates and child death data, including patient records or other pertinent confidential information concerning the deaths of children under age eighteen, and other information as the review team deems appropriate

for use in preparing an annual report to the governor and the general assembly concerning the causes and manner of child deaths. The report shall include analysis of factual information obtained through review and recommendations regarding prevention of child deaths.

b. Recommend to the governor and the general assembly interventions to prevent deaths of children based on an analysis of the cause and manner of such deaths.

c. Recommend to the agencies represented on the review team changes which may prevent child deaths.

d. Except as authorized by this section, maintain the confidentiality of any patient records or other confidential information reviewed.

e. Recommend to the department of human services, appropriate law enforcement agencies, and any other person involved with child protection, interventions that may prevent harm to a child who is related to or is living in the same home as a child whose case is reviewed by the team.

f. If the sharing of information is necessary to assist in or initiate a child death investigation or criminal prosecution and the office or agency receiving the information does not otherwise have access to the information, share information possessed by the review team with the office of the attorney general, a county attorney's office, or an appropriate law enforcement agency. The office or agency receiving the information shall maintain the confidentiality of the information in accordance with this section. Unauthorized release or disclosure of the information received is subject to penalty as provided in this section.

g. In order to assist a division of the department in performing the division's duties, if the division does not otherwise have access to the information, share information possessed by the review team. The division receiving the information shall maintain the confidentiality of the information in accordance with this section. Unauthorized release or disclosure of the information received is subject to penalty as provided in this section.

4. The review team shall develop protocols for a child fatality review committee, to be appointed by the state medical examiner on an ad hoc basis, to immediately review the child abuse assessments which involve the fatality of a child under age eighteen. The state medical examiner shall appoint a medical examiner, a pediatrician, and a person involved with law enforcement to the committee.

a. The purpose of the review shall be to determine whether the department of human services and others involved with the case of child abuse responded appropriately. The protocols shall provide for the committee to consult with any multidisciplinary team, as defined in section 235A.13, that is operating in the area in which the fatality occurred.

b. The committee shall have access to patient records and other pertinent confidential information and, subject to the restrictions in this subsection, may redisseminate the confidential information in the committee's report.

c. Upon completion of the review, the committee shall issue a report which shall include findings concerning the case and recommendations for changes to prevent child fatalities when similar circumstances exist. The report shall include but is not limited to the following information, subject to the restrictions listed in paragraph “d”:

(1) The dates, outcomes, and results of any actions taken by the department of human services and others in regard to each report and allegation of child abuse involving the child who died.

(2) The results of any review of the case performed by a multidisciplinary team, or by any other public entity that reviewed the case.

(3) Confirmation of the department of human services receipt of any report of child abuse involving the child, including confirmation as to whether or not any assessment involving the child was performed in accordance with section 232.71B, the results of any assessment, a description of the most recent assessment and the services offered to the family, the services rendered to the family, and the basis for the department's decisions concerning the case.

d. Prior to issuing the report, the committee shall consult with the county attorney responsible for prosecution of the alleged perpetrator of the child fatality. The committee's report shall include child abuse information associated with the case and the child, but is subject to the restrictions applicable to the department of human services for release of information concerning a child fatality or near fatality in accordance with section 235A.15, subsection 9.

e. Following the completion of the trial of any alleged perpetrator of the child fatality and the appeal period for the granting of a new trial, the committee shall issue a supplemental report containing the information that was withheld, in accordance with paragraph “d”, so as not to jeopardize the prosecution or the rights of the alleged perpetrator to a fair trial as described in section 235A.15, subsection 9, paragraphs “e” and “f”.

f. The report and any supplemental report shall be submitted to the governor and general assembly.

g. If deemed appropriate by the committee, at any point in the review the committee may recommend to the department of human services, appropriate law enforcement agencies, and any other person involved with child protection, interventions that may prevent harm

to a child who is related to or is living in the same home as a child whose case is reviewed by the committee.

5. a. The following individuals shall designate a liaison to assist the review team in fulfilling its responsibilities:

- (1) The director of public health.
- (2) The director of human services.
- (3) The commissioner of public safety.
- (4) The attorney general.
- (5) The director of transportation.
- (6) The director of the department of education.

b. In addition, the chairperson of the review team shall designate a liaison from the public at large to assist the review team in fulfilling its responsibilities.

6. The review team may establish subcommittees to which the team may delegate some or all of the team's responsibilities under subsection 3.

7. a. The state medical examiner, the Iowa department of public health, and the department of human services shall adopt rules providing for disclosure of information which is confidential under chapter 22 or any other provision of state law, to the review team for purposes of performing its child death and child abuse review responsibilities.

b. A person in possession or control of medical, investigative, assessment, or other information pertaining to a child death and child abuse review shall allow the inspection and reproduction of the information by the office of the state medical examiner upon the request of the office, to be used only in the administration and for the duties of the Iowa child death review team. Except as provided for a report on a child fatality by an ad hoc child fatality review committee under subsection 4, information and records produced under this section which are confidential under section 22.7 and chapter 235A, and information or records received from the confidential records, remain confidential under this section. A person does not incur legal liability by reason of releasing information to the department or the office of the state medical examiner as required under and in compliance with this section.

8. Review team members and their agents are immune from any liability, civil or criminal, which might otherwise be incurred or imposed as a result of any act, omission, proceeding, decision, or determination undertaken or performed, or recommendation

made as a review team member or agent provided that the review team members or agents acted in good faith and without malice in carrying out their official duties in their official capacity. The state medical examiner shall adopt rules pursuant to chapter 17A to administer this subsection. A complainant bears the burden of proof in establishing malice or lack of good faith in an action brought against review team members involving the performance of their duties and powers under this section.

9. A person who releases or discloses confidential data, records, or any other type of information in violation of this section is guilty of a serious misdemeanor.

135.44. Repealed by Acts 1988 (72 G.A.) ch. 1158, § 102

KANSAS

KAN. STAT. ANN. 22a-241 (2011). Definitions

As used in K.S.A. 22a-241 through 22a-244, and amendments thereto:

- (a) “Child” means a person less than 18 years of age.
- (b) “Pathologist” means a forensic pathologist, if available. Otherwise, “pathologist” means a physician licensed to practice medicine and surgery and qualified to conduct an autopsy.
- (c) “State review board” means the state child death review board established by K.S.A. 22a-243.
- (d) “Suspicious circumstances” includes, but is not limited to, abuse or neglect.

KAN. STAT. ANN. 22a-242 (2011). Child death, notification of coroner; autopsy; notification of state review board; notification of parent or guardian; SIDS death; fee for autopsy

(a) When a child dies, any law enforcement officer, health care provider or other person having knowledge of the death shall immediately notify the coroner of the known facts concerning the time, place, manner and circumstances of the death. If the notice to the coroner identifies any suspicious circumstances or unknown cause, as described in the protocol developed by the state review board under K.S.A. 22a-243 and amendments thereto, the coroner shall immediately: (1) Investigate the death to determine whether the child's death included any such suspicious circumstance or unknown cause; and (2) direct a pathologist to perform an autopsy.

(b) If, after investigation and an autopsy, the coroner determines that the death of a child does not include any suspicious circumstances or unknown cause, as described in the protocol developed by the state review board under K.S.A. 22a-243 and amendments thereto, the coroner shall complete and sign a nonsuspicious child death form.

(c) If, after investigation and an autopsy, the coroner determines that the death of a child includes any suspicious circumstance or unknown cause, as described in the protocol developed by the state review board under K.S.A. 22a-243 and amendments thereto, the coroner shall notify, within 30 days, the chairperson of the state review board and shall notify, within 24 hours, the county or district attorney of the county where the death of the child occurred.

(d) The coroner shall attempt to notify any parent or legal guardian of the deceased child prior to the performance of an autopsy pursuant to this section and attempt to notify any such parent or legal guardian of the results of the autopsy.

(e) A coroner shall not make a determination that the death of a child less than one year of age was caused by sudden infant death syndrome unless an autopsy is performed.

(f) The fee for an autopsy performed under this section shall be the usual and reasonable fee and travel allowance authorized under K.S.A. 22a-233 and amendments thereto and shall be paid from the district coroners fund.

KAN. STAT. ANN. 22a-243 (2011). State child death review board; executive director; development of protocol; annual report; confidentiality of records; rules and regulations

(a) There is hereby established a state child death review board, which shall be composed of:

(1) One member appointed by each of the following officers to represent the officer's agency: The attorney general, the director of the Kansas bureau of investigation, the secretary of social and rehabilitation services, the secretary of health and environment and the commissioner of education;

(2) three members appointed by the state board of healing arts, one of whom shall be a district coroner and two of whom shall be physicians licensed to practice medicine and surgery, one specializing in pathology and the other specializing in pediatrics;

(3) one person appointed by the attorney general to represent advocacy groups which focus attention on child abuse awareness and prevention; and

(4) one county or district attorney appointed by the Kansas county and district attorneys association.

(b) The chairperson of the state review board shall be the member appointed by the attorney general to represent the office of the attorney general.

(c) The state child death review board shall be within the office of the attorney general as a part thereof. All budgeting, purchasing and related management functions of the board shall be administered under the direction and supervision of the attorney general. All vouchers for expenditures and all payrolls of the board shall be approved by the chairperson of the board and by the attorney general. The state review board shall establish and maintain an office in Topeka.

(d) The state review board shall meet at least annually to review all reports submitted to the board. The chairperson of the state review board may call a special meeting of the board at any time to review any report of a child death.

(e) Within the limits of appropriations therefor, the state review board shall appoint an executive director who shall be in the unclassified service of the Kansas civil service act and shall receive an annual salary fixed by the state review board.

(f) Within the limits of appropriations therefor, the state review board may employ other persons who shall be in the classified service of the Kansas civil service act.

(g) Members of the state review board shall not receive compensation, subsistence allowances, mileage and expenses as provided by K.S.A. 75-3223 and amendments thereto for attending meetings or subcommittee meetings of the board.

(h) The state review board shall develop a protocol to be used by the state review board. The protocol shall include written guidelines for coroners to use in identifying any suspicious deaths, procedures to be used by the board in investigating child deaths, methods to ensure coordination and cooperation among all agencies involved in child deaths and procedures for facilitating prosecution of perpetrators when it appears the cause of a child's death was from abuse or neglect. The protocol shall be adopted by the state review board by rules and regulations.

(i) The state review board shall submit an annual report to the governor and the legislature on or before October 1 of each year, commencing October 1993. Such report shall include the findings of the board regarding reports of child deaths, the board's analysis and the board's recommendations for improving child protection, including recommendations for modifying statutes, rules and regulations, policies and procedures.

(j) Information acquired by, and records of, the state review board shall be confidential, shall not be disclosed and shall not be subject to subpoena, discovery or introduction into

evidence in any civil or criminal proceeding, except that such information and records may be disclosed to any member of the legislature or any legislative committee which has legislative responsibility of the enabling or appropriating legislation, carrying out such member's or committee's official functions. The legislative committee, in accordance with K.S.A. 75-4319 and amendments thereto, shall recess for a closed or executive meeting to receive and discuss information received by the committee pursuant to this subsection.

(k) The state review board may adopt rules and regulations as necessary to carry out the provisions of K.S.A. 22a-241 through 22a-244 and amendments thereto.

KAN. STAT. ANN. 22a-244 (2011) Same; activation of board to investigate; access to records; subpoena power; report issued; disclosure of conclusions

(a) Within 72 hours after receipt of notification from a coroner pursuant to K.S.A. 22a-242, the chairperson of the state review board may activate the board to investigate and make a written report regarding the death.

(b) The state review board shall have access to all law enforcement investigative information regarding the death; any autopsy records and coroner's investigative records relating to the death; any medical records of the child; and any records of the department of social and rehabilitation services or any other social service agency which has provided services to the child or the child's family within three years preceding the child's death.

(c) The state review board may apply to the district court for the issuance of, and the district court may issue, a subpoena to compel the production of any books, records or papers relevant to the cause of any death being investigated by the board. Any books, records or papers received by the board pursuant to the subpoena shall be regarded as confidential and privileged information and not subject to disclosure.

(d) The state review board's report shall contain the circumstances leading up to the death and cause of death; any social service agency involvement prior to death, including the kinds of services delivered to the dead child or the child's parents, siblings or any other children in the home; the reasons for initial social service agency activity and the reasons for any termination of agency activities if involvement was terminated; whether court intervention had ever been sought and, if so, any action taken by the court; and recommendations for prevention of future death under similar circumstances.

(e) Within 15 days of its activation pursuant to this section, the state review board shall complete and transmit a copy of its written report to the county or district attorney of the county in which the child's death occurred. If the death of the child occurred in a different county than where the child resided, a copy of the report shall be sent to the county or

district attorney of the county where the child resided or, if the child resided in another state, to the child protective services agency of that state.

(f) The state review board shall maintain permanent records of all written reports concerning child deaths.

(g) The state review board may disclose its conclusions regarding a report of a child death but shall not disclose any information received by the board which is not subject to public disclosure by the agency that provided the information to the board.

(h) Information, documents and records otherwise available from other sources are not immune from discovery or use in a civil or criminal action solely because they were presented during proceedings of the state review board. A person who presented information before the board or who is a member of the board shall not be prevented from testifying about matters within the person's knowledge.

KENTUCKY

KY. REV. STAT. ANN. § 211.684 (2011). Authorization to establish state child fatality review team; annual report on child fatalities

(1) For the purposes of KRS Chapter 211:

(a) “Child fatality” means the death of a person under the age of eighteen (18) years; and

(b) “Local child fatality response team” and “local team” means a community team composed of representatives of agencies, offices, and institutions that investigate child deaths, including but not limited to, coroners, social service workers, medical professionals, law enforcement officials, and Commonwealth's and county attorneys.

(2) The Department for Public Health may establish a state child fatality review team. The state team may include representatives of public health, social services, law enforcement, prosecution, coroners, health-care providers, and other agencies or professions deemed appropriate by the commissioner of the department.

(3) If a state team is created, the duties of the state team may include the following:

(a) Develop and distribute a model protocol for local child fatality response teams for the investigation of child fatalities;

(b) Facilitate the development of local child fatality response teams which may include, but is not limited to, providing joint training opportunities and, upon request, providing technical assistance;

(c) Review and approve local protocols prepared and submitted by local teams;

(d) Receive data and information on child fatalities and analyze the information to identify trends, patterns, and risk factors;

(e) Evaluate the effectiveness of prevention and intervention strategies adopted; and

(f) Recommend changes in state programs, legislation, administrative regulations, policies, budgets, and treatment and service standards which may facilitate strategies for prevention and reduce the number of child fatalities.

(4) The department shall prepare an annual report to be submitted no later than November 1 of each year to the Governor, the Legislative Research Commission, the Chief Justice of the Kentucky Supreme Court, and to be made available to the citizens of the Commonwealth. The report shall include a statistical analysis of the incidence and causes of child fatalities in the Commonwealth during the past fiscal year and recommendations for action. The report shall not include any information which would identify specific child fatality cases.

KY. REV. STAT. ANN. § 211.686 (2011). Authorization for coroners to establish local child fatality response teams; confidentiality of team proceedings and records

(1) A local child fatality response team may be established in every county or group of contiguous counties by the coroner or coroners with jurisdiction in the county or counties. The local coroner may authorize the creation of additional local teams within the coroner's jurisdiction as needed.

(2) Membership of the local team may include representatives of the coroner, the local office of the Department for Community Based Services, law enforcement agencies with investigation responsibilities for child fatalities which occur within the jurisdiction of the local team, the Commonwealth's and county attorneys, representatives of the medical profession, and other members whose participation the local team believes is important to carry out its purpose. Each local team member shall be appointed by the agency the member is representing and shall serve at the pleasure of the appointing authority.

(3) The purpose of the local child fatality response team shall be to:

(a) Allow each member to share specific and unique information with the local team;

(b) Generate overall investigative direction and emphasis through team coordination and sharing of specialized information;

(c) Create a body of information that will assist in the coroner's effort to accurately identify the cause and reasons for death; and

(d) Facilitate the appropriate response by each member agency to the fatality, including but not limited to, intervention on behalf of other children who may be adversely affected by the situation, implementation of health services necessary for protection of other citizens, further investigation by law enforcement, or legal action by Commonwealth's or county attorneys.

(4) The local team may:

(a) Analyze information regarding local child fatalities to identify trends, patterns, and risk factors;

(b) Recommend to the state team, and any other entities deemed appropriate, changes in state or local programs, legislation, administrative regulations, policies, budgets, and treatment and service standards which may facilitate strategies for prevention and reduce the number of child fatalities; and

(c) Evaluate the effectiveness of local prevention and intervention strategies.

(5) The local team may establish a protocol for the investigation of child fatalities and may establish operating rules and procedures as it deems necessary to carry out the purposes of this section.

(6) The review of a child fatality by a local team may include information from reports generated or received by agencies, organizations, or individuals that are responsible for investigation, prosecution, or treatment in the case.

(7) The proceedings, records, opinions, and deliberations of the local team shall be privileged and shall not be subject to discovery, subpoena, or introduction into evidence in any civil action in any manner that would directly or indirectly identify specific persons or cases reviewed by the local team. Nothing in this subsection shall be construed to restrict or limit the right to discover or use in any civil action any evidence that is discoverable independent of the proceedings of the local team.

KY. REV. STAT. ANN. § 620.050 (2011). Immunity for good faith actions or reports; investigations; confidentiality of reports; exceptions; parent's access to records; sharing of information by children's advocacy centers; confidentiality of interview with child; exceptions; confidentiality of identifying information regarding reporting individual; internal review and report

(1) Anyone acting upon reasonable cause in the making of a report or acting under KRS 620.030 to 620.050 in good faith shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed. Any such participant shall have the same immunity with respect to participation in any judicial proceeding resulting from such report or action. However, any person who knowingly makes a false report and does so with malice shall be guilty of a Class A misdemeanor.

(2) Any employee or designated agent of a children's advocacy center shall be immune from any civil liability arising from performance within the scope of the person's duties as provided in KRS 620.030 to 620.050. Any such person shall have the same immunity with respect to participation in any judicial proceeding. Nothing in this subsection shall limit liability for negligence. Upon the request of an employee or designated agent of a children's advocacy center, the Attorney General shall provide for the defense of any civil action brought against the employee or designated agent as provided under KRS 12.211 to 12.215.

(3) Neither the husband-wife nor any professional-client/patient privilege, except the attorney-client and clergy-penitent privilege, shall be a ground for refusing to report under this section or for excluding evidence regarding a dependent, neglected, or abused child or the cause thereof, in any judicial proceedings resulting from a report pursuant to this section. This subsection shall also apply in any criminal proceeding in District or Circuit Court regarding a dependent, neglected, or abused child.

(4) Upon receipt of a report of an abused, neglected, or dependent child pursuant to this chapter, the cabinet as the designated agency or its delegated representative shall initiate a prompt investigation or assessment of family needs, take necessary action, and shall offer protective services toward safeguarding the welfare of the child. The cabinet shall work toward preventing further dependency, neglect, or abuse of the child or any other child under the same care, and preserve and strengthen family life, where possible, by enhancing parental capacity for adequate child care.

(5) The report of suspected child abuse, neglect, or dependency and all information obtained by the cabinet or its delegated representative, as a result of an investigation or assessment made pursuant to this chapter, except for those records provided for in subsection (6) of this section, shall not be divulged to anyone except:

(a) Persons suspected of causing dependency, neglect, or abuse;

(b) The custodial parent or legal guardian of the child alleged to be dependent, neglected, or abused;

(c) Persons within the cabinet with a legitimate interest or responsibility related to the case;

(d) Other medical, psychological, educational, or social service agencies, child care administrators, corrections personnel, or law enforcement agencies, including the county attorney's office, the coroner, and the local child fatality response team, that have a legitimate interest in the case;

(e) A noncustodial parent when the dependency, neglect, or abuse is substantiated;

(f) Members of multidisciplinary teams as defined by KRS 620.020 and which operate pursuant to KRS 431.600;

(g) Employees or designated agents of a children's advocacy center; or

(h) Those persons so authorized by court order.

(6) (a) Files, reports, notes, photographs, records, electronic and other communications, and working papers used or developed by a children's advocacy center in providing services under this chapter are confidential and shall not be disclosed except to the following persons:

1. Staff employed by the cabinet, law enforcement officers, and Commonwealth's and county attorneys who are directly involved in the investigation or prosecution of the case;

2. Medical and mental health professionals listed by name in a release of information signed by the guardian of the child, provided that the information shared is limited to that necessary to promote the physical or psychological health of the child or to treat the child for abuse-related symptoms; and

3. The court and those persons so authorized by a court order.

(b) The provisions of this subsection shall not be construed as to contravene the Rules of Criminal Procedure relating to discovery.

(7) Nothing in this section shall prohibit a parent or guardian from accessing records for his or her child providing that the parent or guardian is not currently under investigation by a law enforcement agency or the cabinet relating to the abuse of a child.

(8) Nothing in this section shall prohibit employees or designated agents of a children's advocacy center from disclosing information during a multidisciplinary team review of a child sexual abuse case as set forth under KRS 620.040. Persons receiving this information shall sign a confidentiality statement consistent with statutory prohibitions on disclosure of this information.

(9) Employees or designated agents of a children's advocacy center may confirm to another children's advocacy center that a child has been seen for services. If an information release has been signed by the guardian of the child, a children's advocacy center may disclose relevant information to another children's advocacy center.

(10) (a) An interview of a child recorded at a children's advocacy center shall not be duplicated, except that the Commonwealth's or county attorney prosecuting the case may:

1. Make and retain one (1) copy of the interview; and

2. Make one (1) copy for the defendant's counsel that the defendant's counsel shall not duplicate.

(b) The defendant's counsel shall file the copy with the court clerk at the close of the case.

(c) Unless objected to by the victim or victims, the court, on its own motion, or on motion of the attorney for the Commonwealth shall order all recorded interviews that are introduced into evidence or are in the possession of the children's advocacy center, law enforcement, the prosecution, or the court to be sealed.

(d) The provisions of this subsection shall not be construed as to contravene the Rules of Criminal Procedure relating to discovery.

(11) Identifying information concerning the individual initiating the report under KRS 620.030 shall not be disclosed except:

(a) To law enforcement officials that have a legitimate interest in the case;

(b) To the agency designated by the cabinet to investigate or assess the report;

(c) To members of multidisciplinary teams as defined by KRS 620.020 that operated under KRS 431.600; or

(d) Under a court order, after the court has conducted an in camera review of the record of the state related to the report and has found reasonable cause to believe that the reporter knowingly made a false report.

(12) (a) Information may be publicly disclosed by the cabinet in a case where child abuse or neglect has resulted in a child fatality or near fatality.

(b) The cabinet shall conduct an internal review of any case where child abuse or neglect has resulted in a child fatality or near fatality and the cabinet had prior involvement with the child or family. The cabinet shall prepare a summary that includes an account of:

1. The cabinet's actions and any policy or personnel changes taken or to be taken, including the results of appeals, as a result of the findings from the internal review; and

2. Any cooperation, assistance, or information from any agency of the state or any other agency, institution, or facility providing services to the child or family that were requested and received by the cabinet during the investigation of a child fatality or near fatality.

(c) The cabinet shall submit a report by September 1 of each year containing an analysis of all summaries of internal reviews occurring during the previous year and an analysis of historical trends to the Governor, the General Assembly, and the state child fatality review team created under KRS 211.684.

(13) When an adult who is the subject of information made confidential by subsection (5) of this section publicly reveals or causes to be revealed any significant part of the confidential matter or information, the confidentiality afforded by subsection (5) of this section is presumed voluntarily waived, and confidential information and records about the person making or causing the public disclosure, not already disclosed but related to the information made public, may be disclosed if disclosure is in the best interest of the child or is necessary for the administration of the cabinet's duties under this chapter.

(14) As a result of any report of suspected child abuse or neglect, photographs and X-rays or other appropriate medical diagnostic procedures may be taken or caused to be taken, without the consent of the parent or other person exercising custodial control or supervision of the child, as a part of the medical evaluation or investigation of these reports. These photographs and X-rays or results of other medical diagnostic procedures may be introduced into evidence in any subsequent judicial proceedings. The person performing the diagnostic procedures or taking photographs or X-rays shall be immune from criminal or civil liability for having performed the act. Nothing herein shall limit liability for negligence.

LOUISIANA

LA. REV. STAT. ANN. § 2019 (2011). Child death investigation

A. Findings and purpose.

(1) The legislature hereby finds and declares that:

(a) Protection of the health and welfare of the children of this state is a goal of its people, and the unexpected death of infants and children is an important public health concern that requires legislative action.

(b) Collecting data on the causes of unexpected deaths will better enable the state to protect some infants and children from preventable deaths and will help reduce the incidence of such deaths.

(c) Identifying persons responsible for abuse or neglect resulting in unexpected death will better enable the state to protect other children who may be under the care of the same persons and will help reduce the incidence of such deaths.

(d) Multidisciplinary and multiagency reviews of child deaths can assist the state in the investigation of child deaths, in the development of a greater understanding of the incidence and causes of child deaths and the methods for preventing such deaths, and in identifying gaps in services to children and families.

(2) The purpose of this Section is to identify the cause of death of children fourteen years of age and below, and thereby reduce the incidence of injury and death to infants and children by requiring that a death investigation be performed in the case of all unexpected deaths of children fourteen years of age and below, and establishing the Louisiana State Child Death Review Panel to collect data from such investigations and report to the legislature regarding the causes of such deaths and share information among local and regional panels, health care providers, and state agencies which provide services to children and families.

B. Definitions. For the purpose of this Section, the following terms shall have the following meaning:

(1) “Autopsy” means a post-mortem external and internal physical examination conducted in accordance with accepted medical practice and the laws of this state using a standardized child death investigation protocol performed by a forensic pathologist or, if a forensic pathologist is unavailable, a pathologist licensed or otherwise appointed to conduct such an examination under such laws.

(2) “Death investigation” means the process of determining the cause and manner of death and shall include the following:

(a) A postmortem examination which may be limited to an external examination or may include an autopsy.

(b) An inquiry by any law enforcement agency having jurisdiction into the circumstances of the death, including a death scene investigation and interview with the child's parent, legal guardian, or caretaker, and the person who reported the child's death.

(c) A review of information regarding the child from any other relevant agency, professional, or health care provider.

(3) “Unexpected death” means a death which is a result of undiagnosed disease, or trauma in which the surrounding circumstances are suspicious, obscure, or otherwise unexplained, or other death the circumstances of which are suspicious, obscure, or otherwise unexplained. A clinical diagnosis of death due to Sudden Infant Death Syndrome (SIDS) shall be deemed an unexpected death.

C. Child Death Review Panel. There is established within the Department of Health and Hospitals the Louisiana State Child Death Review Panel, hereinafter referred to as the “state panel” which shall be composed of twenty-five persons. Members of the panel shall include:

- (1) The state health officer or his designee.
- (2) The secretary of the Department of Health and Hospitals or his designee.
- (3) The secretary of the Department of Children and Family Services or his designee.
- (4) The superintendent of the office of state police or his designee.
- (5) The state registrar of vital records in the office of public health or his designee.
- (6) The attorney general or his designee.
- (7) A member of the Senate appointed by the president of the Senate.
- (8) A member of the House of Representatives appointed by the speaker of the House of Representatives.
- (9) The commissioner of the Department of Insurance or his designee.
- (10) The executive director of the Highway Safety Commission of the Department of Public Safety and Corrections or his designee.
- (11) The state fire marshal or his designee.
- (12) A representative of the injury research and prevention section of the office of public health appointed by the assistant secretary of the office of public health.
- (13) The executive director of the Louisiana Maternal and Child Health Coalition.
- (14) A district attorney appointed by the Louisiana District Attorneys Association.
- (15) A sheriff appointed by the Louisiana Sheriff's Association.

(16) A police chief appointed by the Louisiana Association of Chiefs of Police.

(17) A forensic pathologist certified by the American Board of Pathology and licensed to practice medicine in the state appointed by the chairman of the Louisiana State Child Death Review Panel subject to Senate confirmation.

(18) A pathologist experienced in pediatrics appointed by the Louisiana Pathology Society.

(19) A coroner appointed by the president of the Louisiana Coroner's Association.

(20) Six persons appointed by the governor, subject to Senate confirmation, for a term of three years as follows:

(a) A health professional with expertise in Sudden Infant Death Syndrome appointed from a list of three names submitted by the Louisiana State Medical Society.

(b) A pediatrician with experience in diagnosing and treating child abuse and neglect appointed from a list of three names submitted by the state chapter of the American Academy of Pediatrics.

(c) Four citizens from the state at large who represent different geographic areas of the state.

D. Functions and duties of panel.

(1) The state panel shall:

(a) Establish a standardized child death investigation protocol which shall require at a minimum that all death investigations be completed within thirty working days of the report of the death. The protocol shall include procedures for all law enforcement agencies and local departments of social services to follow in response to a child death.

(b) Establish criteria for information that must be included in a death investigation report and provide such information to the appropriate agencies and medical providers to be used as a guideline in preparing the death investigation report.

(c) Collect, review, and analyze all death investigation reports prepared in accordance with this Section, and such other information as the state panel deems appropriate, to use in preparation of reports to the legislature concerning the causes of and methods of decreasing unexpected deaths of infants and children.

(d) Recommend changes within the agencies represented on the state panel which may prevent child deaths.

(2) The state panel may:

(a) Establish local and regional panels to which it may delegate some or all of its responsibilities under this Section.

(b) Analyze any data available through any state systems that may decrease the incidence of injury and unexpected death to infants and children below the age of fourteen.

E. Child death investigation.

(1) In each unexpected death of a child fourteen years of age and below, a death investigation shall be performed in accordance with the child death investigation protocol established by the Louisiana State Child Death Review Panel which may include, at the discretion of the coroner but not be limited to, a complete autopsy performed by the coroner of the parish where the death occurred pursuant to the death investigation procedure established by R.S. 13:5713. The death investigation findings shall be reported to appropriate authorities including the police, health care providers, and the child protective services if appropriate, within three days of the conclusion of the death investigation.

(2) A copy of the death investigation report, or any portion thereof, including law enforcement, coroner, fire department, and medical providers, or any other information relative to the death investigation shall be provided to the state panel within thirty days from the date the state panel requests such information.

(3) Nothing in this Section shall be construed to change, alter, or restrict the authority or jurisdiction of a coroner as established in R.S. 13:5701 et seq.

(4) Nothing in this Section shall be construed as requiring a finding of negligent treatment or maltreatment when the state panel determines that the parents or guardians were treating the child solely according to the tenets and practices of a well-recognized religious method of treatment which has a reasonable, proven record of success.

F. Records; confidentiality; prohibited disclosure and discovery.

(1) Notwithstanding any other provision of law to the contrary, the state panel, and any local or regional panel or its agent thereof, shall be authorized to access medical and vital records in the custody of physicians, hospitals, clinics, and other health care providers, and the office of public health, and to any other information, documents, or records pertaining to the completed investigation of unexpected deaths of infants and children below the age of fourteen in the custody of any law enforcement agency or child

protective service agency in order that it may perform its functions and duties as provided in Subsection D. All such records obtained by the state panel or any local or regional panel or its agent in accordance with the provisions of this Subsection, as well as the results of any child death investigation report, shall be confidential and shall not be available for subpoena nor shall such information be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding nor shall such records be deemed admissible as evidence in any civil, criminal, administrative, or other tribunal or court for any reason.

(2) The furnishing of confidential information, documents, and reports in accordance with this Section by any person, agency, or entity furnishing such information, documents, and reports shall not expose such person, agency, or entity to liability and shall not be considered a violation of any privileged or confidential relationship, provided the participant has acted in good faith in the reporting as required in this Section.

(3) Nothing in this Subsection shall prohibit the publishing by the state panel of statistical compilations relating to unexpected child deaths of infants and children fourteen years of age or below which do not identify individual cases or individual physicians, hospitals, clinics, or other health care providers.

G. Report. The state panel shall report to the legislature annually concerning the causes of unexpected deaths of infants and children below the age of fourteen. The report shall include analysis of factual information obtained through review of death investigation reports required in Subsection D of this Section.

MAINE

ME. REV. STAT. ANN. tit. 22 § 261 (2011). Maternal and infant death review panel

The department shall establish the maternal and infant death review panel in accordance with this section.

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. “Center” means the Maine Center for Disease Control and Prevention.

B. “Deceased person” means a woman who died during pregnancy or within 42 days of giving birth or a child who died within 1 year of birth.

C. “Director” means the director of the center.

C-1. “Family” means a woman who has experienced a fetal death or the parent or parents or other authorized representative of a deceased person.

D. “Panel” means the maternal and infant death review panel established under this section.

E. “Panel coordinator” means an employee of the center who is appointed by the director or a person designated by the panel coordinator. The panel coordinator must be a licensed physician or registered nurse or other health care professional licensed or registered in this State.

2. Membership. The panel consists of health care and social service providers, public health officials, law enforcement officers and other persons with professional expertise on maternal and infant health and mortality. The director shall appoint the members of the panel, who serve at the pleasure of the director. The director shall appoint an employee of the center to serve as panel coordinator.

3. Contact with family. The first contact pursuant to this section with the family may not occur prior to 4 months after the death and must:

A. Be by letter from the State Health Officer on letterhead of the center; and

B. Include an invitation to participate in a review of the death of the deceased person or the fetal death from a statewide organization dedicated to improving the health of babies by preventing birth defects, premature birth and infant mortality.

4. Duties and powers of panel coordinator. The panel coordinator has the following duties and powers.

A. The panel coordinator shall review the deaths of all women during pregnancy or within 42 days of giving birth, the majority of cases in which a fetal death occurs after 28 weeks of gestation and the majority of deaths of infants under 1 year of age, with selection of cases of infant death based on the need to review particular causes of death or the need to obtain a representative sample of all deaths.

A-1. The panel coordinator may have access to the death certificates of deceased persons and to fetal death certificates of fetal deaths occurring after 28 weeks of gestation.

B. Prior to accessing medical records, the panel coordinator shall obtain permission in all cases for access to those records from the family.

C. Prior to conducting a voluntary interview, the panel coordinator shall obtain permission in all cases for the interview from the family.

D. The panel coordinator may conduct voluntary interviews with the family. The purpose of the voluntary interview is limited to gathering information or data for the purposes of the panel in summary or abstract form without family names or patient identifiers. A person who conducts interviews under this paragraph must meet the qualifications for panel coordinator and also have professional experience or training in bereavement services. A person conducting an interview under this paragraph may make a referral for bereavement counseling.

E. The panel coordinator shall prepare a summary or abstract of relevant information regarding the case, as determined to be useful to the panel, but without the name or identifier of the deceased person or the woman who experienced a fetal death, and shall present the summary or abstract to the panel.

5. Duties and powers of panel. The panel has the following duties and powers.

A. The panel shall conduct comprehensive multidisciplinary reviews of data presented by the panel coordinator.

B. The panel shall present an annual report to the department and to the joint standing committee of the Legislature having jurisdiction over health and human services matters. The report must identify factors contributing to maternal and infant death in the State, determine the strengths and weaknesses of the current maternal and infant health care delivery system and make recommendations to the department to decrease the rate of maternal and infant death.

The panel shall offer a copy of the annual report to the person or persons that granted permission to the panel coordinator for a voluntary interview under subsection 4, paragraph C.

C. The panel shall share the results of its data reviews and recommendations with the child death and serious injury review panel established pursuant to section 4004, subsection 1, paragraph E. The maternal and infant death review panel may request and review data from the child death and serious injury review panel, regardless of any prior work by the child death and serious injury review panel.

6. Limitations. The panel coordinator may not proceed with reviews of medical records or voluntary interviews without the permission of the family. The panel coordinator may not photocopy or retain copies of medical records or review cases of abortion. In performing work under this section, the panel coordinator shall minimize the burden imposed on health care practitioners, hospitals and facilities.

7. Confidentiality. All records created or maintained pursuant to this section, other than reports provided under subsection 5, paragraph B, are protected as provided in this subsection. The records are confidential under section 42, subsection 5. The records are

not open to public inspection, are not public records for the purposes of Title 1, chapter 13, subchapter 1 and are not subject to subpoena or civil process nor admissible in evidence in connection with any judicial, executive, legislative or other proceeding.

8. Immunity. A health care practitioner, hospital or health care facility or the employee or agent of that person or entity is not subject to civil or criminal liability arising from the disclosure or furnishing of records or information to the panel pursuant to this section.

9. Funding. The department may accept any public or private funds to carry out the purposes of this section.

10. Rulemaking. The department shall adopt rules to implement this section, including rules on collecting information and data, selecting members of the panel, collecting and using individually identifiable health information and conducting reviews under this section. The rules must ensure that access to individually identifiable health information is restricted as much as possible while enabling the panel to accomplish its work. The rules must establish a protocol to preserve confidentiality, specify the manner in which the family will be contacted for permission and maintain public confidence in the protection of individually identifiable information. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [FN1]

11. Deleted. Laws 2009, c. 531, § 1, eff. March 22, 2010.

MARYLAND

MD. CODE ANN. CRIM. LAW § 5-701 (2011). Definitions

In general

(a) In this subtitle the following words have the meanings indicated.

Child

(b) “Child” means an individual under the age of 18 years.

Child death review case reporting system

(c) “Child death review case reporting system” means a national, standardized, web-based reporting system for the confidential collection, analysis, aggregation, and reporting of child death data that is maintained and operated by a national center for child death review.

Data use agreement

(d) “Data use agreement” means a contract between the Department and a national center for child death review that establishes the terms and conditions for the State and local child fatality review teams' participation in a child death review case reporting system.

Health care provider

(e) “Health care provider” means:

- (1) An individual licensed or certified under the Health Occupations Article to provide health care; or
- (2) A facility that provides health care to individuals.

Local team

(f) “Local team” means the multidisciplinary and multiagency child fatality review team established for a county.

Meeting

(g) “Meeting” includes meetings through telephone conferencing.

National center for child death review

(h) “National center for child death review” means a public, private, nonprofit, or governmental organization or entity that is funded or otherwise recognized by the United States Department of Health and Human Services and is responsible for:

- (1) Developing a child death review case reporting system;
- (2) Training and serving as a liaison to State agencies participating in the system; and
- (3) Disseminating national child death review data generated by the system.

State team

(i) “State Team” means the State Child Fatality Review Team.

Unexpected child death

(j) “Unexpected child death” means a death of a child investigated by the office of the Chief Medical Examiner as required by § 5-309 of this title.

MD. CODE ANN. CRIM. LAW § 5-702 (2011). State Child Fatality Review Team

In general

(a) There is a State Child Fatality Review Team.

Budget, administration

(b) The State Team is part of the Department for budgetary and administrative purposes.

MD. CODE ANN. CRIM. LAW § 5-703 (2011). Team members

Composition

(a) The State Team shall be a multidisciplinary and multiagency review team, composed of at least 25 members, including:

- (1) The Attorney General;
- (2) The Chief Medical Examiner;
- (3) The Secretary of Human Resources;
- (4) The Secretary of Health and Mental Hygiene;
- (5) The State Superintendent of Schools;
- (6) The Secretary of Juvenile Services;
- (7) The Special Secretary for Children, Youth, and Families;
- (8) The Secretary of State Police;
- (9) The president of the State's Attorneys' Association;
- (10) The chief of the Division of Vital Records of the Department;
- (11) A representative of the State SIDS Information and Counseling Program;
- (12) The Director of the Alcohol and Drug Abuse Administration of the Department;

(13) Two pediatricians with experience in diagnosing and treating injuries and child abuse and neglect, appointed by the Governor from a list submitted by the State Chapter of the American Academy of Pediatrics; and

(14) Eleven members of the general public with interest or expertise in child safety and welfare, appointed by the Governor, including child advocates, CASA volunteers, health and mental health professionals, and attorneys who represent children.

Representatives

(b) The members described under subsection (a)(1) through (12) of this section may designate representatives from their departments or offices to represent them on the State Team.

Staff

(c) The State Team may employ a staff in accordance with the State budget. Each member of the Team under subsection (a)(1) through (12) of this section shall provide sufficient staff support to complete the State Team's responsibilities.

Compensation and reimbursement for expenses

(d) Members of the State Team shall serve without compensation, but may be reimbursed for reasonable expenses incurred in the performance of their duties in accordance with the Standard State Travel Regulations [FN1] and as provided in the State budget.

Chairperson

(e) The State Team shall select a chairperson from among its members.

Meetings

(f) The State Team shall meet not less than once every 3 months.

[FN1] COMAR 23.02.01.01 et seq.

MD. CODE ANN.CRIM. LAW § 5-704 (2011). Purpose of State Team

In general

(a) The purpose of the State Team is to prevent child deaths by:

- (1) Developing an understanding of the causes and incidence of child deaths;
- (2) Developing plans for and implementing changes within the agencies represented on the State Team to prevent child deaths; and
- (3) Advising the Governor, the General Assembly, and the public on changes to law, policy, and practice to prevent child deaths.

Duties of State Team

(b) To achieve its purpose, the State Team shall:

- (1) Undertake annual statistical studies of the incidence and causes of child fatalities in the State, including an analysis of community and public and private agency involvement with the decedents and their families before and after the deaths;
- (2) Review reports from local teams;
- (3) Provide training and written materials to the local teams established under § 5-705 of this subtitle to assist them in carrying out their duties, including model protocols for the operation of local teams;
- (4) In cooperation with local teams, develop a protocol for child fatality investigations, including procedures for local health departments, law enforcement agencies, local medical examiners, and local departments of social services, using best practices from other states and jurisdictions;
- (5) Develop a protocol for the collection of data regarding child deaths and provide training to local teams and county health departments on the use of the protocol;
- (6) Undertake a study of the operations of local teams, including the State and local laws, regulations, and policies of the agencies represented on the local teams, recommend appropriate changes to any regulation or policy needed to prevent child deaths, and include proposals for changes to State or local laws in the annual report required by paragraph (12) of this subsection;
- (7) Consider local and statewide training needs, including cross-agency training and service gaps, and make recommendations to member agencies to develop and deliver these training needs;
- (8) Examine confidentiality and access to information laws, regulations, and policies for agencies with responsibilities for children, including health, public welfare, education, social services, mental health, and law enforcement agencies, recommend appropriate changes to any regulations and policies that impede the exchange of information

necessary to protect children from preventable deaths, and include proposals for changes to statutes in the annual report required by paragraph (12) of this subsection;

(9) Examine the policies and procedures of State and local agencies and specific cases that the State Team considers necessary to perform its duties under this section, in order to evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities in accordance with:

(i) The State plan under 42 U.S.C. § 5106a(b);

(ii) The child protection standards set forth in 42 U.S.C. § 5106a(b); and

(iii) Any other criteria that the State Team considers important to ensure the protection of children;

(10) Educate the public regarding the incidence and causes of child deaths, the public role in preventing child deaths, and specific steps the public can undertake to prevent child deaths;

(11) Recommend to the Secretary any regulations necessary for its own operation and the operation of the local teams;

(12) Provide the Governor, the public, and subject to § 2-1246 of the State Government Article, the General Assembly, with annual written reports, which shall include the State Team's findings and recommendations; and

(13) In consultation with local teams:

(i) Define “near fatality”; and

(ii) Develop procedures and protocols that local teams and the State Team may use to review cases of near fatality.

Coordination of activities

(c) The State Team shall coordinate its activities under this section with the State Citizens Review Board for Children, local citizens review panels, and the State Council on Child Abuse and Neglect in order to avoid unnecessary duplication of effort.

Disclosure of information

(d)(1) Except as provided in paragraph (2) of this subsection, members and staff of the State Team:

(i) May not disclose to any person or government official any identifying information about any specific child protection case about which the State Team is provided information; and

(ii) May make public other information unless prohibited by law.

(2)(i) In carrying out the responsibilities under this section and subject to subparagraph (ii) of this paragraph, the members and staff of the State Team may provide identifying information to a national center for child death review in accordance with a data use agreement that:

1. Authorizes access to identifiable information only to the members and staff of the State Team;

2. Authorizes the national center for child death review to access only de-identified information; and

3. Requires the national center for child death review to act as a fiduciary agent of the State and local teams.

(ii) Information provided to a national center for child death review in accordance with this subsection is confidential and subject to the same confidentiality and discovery protections that apply to the State and local teams as set forth in § 5-709 of this subtitle.

Fines and penalties

(e) In addition to any other penalties provided by law, the Secretary may impose on any person who violates subsection (d) of this section a civil penalty not exceeding \$500 for each violation.

§ 5-705. Local child fatality review teams

In general

(a)(1) Except as provided in paragraph (2) of this subsection, there shall be a multidisciplinary and multiagency child fatality review team in each county.

(2) Instead of a local team in each county, two or more counties may agree to establish a single multicounty local team.

(3) A multicounty local team shall execute a memorandum of understanding on membership, staffing, and operation.

Members

(b) The local team membership shall be drawn from the following individuals, organizations, agencies, and areas of expertise, when available:

- (1) The county health officer;
- (2) The director of the local department of social services;
- (3) The State's Attorney;
- (4) The superintendent of schools;
- (5) A State, county, or municipal law enforcement officer;
- (6) The director of the county substance abuse treatment program;
- (7) The chief attorney who represents the local department of social services in child welfare proceedings;
- (8) The Early Childhood Development Division in the State Department of Education;
- (9) The director of the county mental health agency or core service agency;
- (10) A pediatrician with experience in diagnosing and treating injuries and child abuse and neglect, appointed by the county health officer;
- (11) A psychiatrist or psychologist with experience in child abuse and neglect or child injury, appointed by the director of the county mental health agency or core service agency;
- (12) A member of the general public with interest or expertise in the prevention and treatment of child abuse and neglect, appointed by the county health officer; and
- (13) Any other individual necessary to the work of the local team, recommended by the local team and appointed by the county health officer.

Representation

(c) The members described under subsection (b)(1) through (9) of this section may designate representatives from their departments or offices to represent them on the local team.

Chairperson

(d) From among its members, each local team shall elect a chairperson by majority vote.

§ 5-706. Purpose of local teams

In general

(a) The purpose of the local team is to prevent child deaths by:

- (1) Promoting cooperation and coordination among agencies involved in investigations of child deaths or in providing services to surviving family members;
- (2) Developing an understanding of the causes and incidence of child deaths in the county;
- (3) Developing plans for and recommending changes within the agencies the members represent to prevent child deaths; and
- (4) Advising the State Team on changes to law, policy, or practice to prevent child deaths.

Duties of local team

(b) To achieve its purpose, the local team shall:

- (1) In consultation with the State Team, establish and implement a protocol for the local team;
- (2) Set as its goal the investigation of child deaths in accordance with national standards;
- (3) Meet at least quarterly to review the status of child fatality cases, recommend actions to improve coordination of services and investigations among member agencies, and recommend actions within the member agencies to prevent child deaths;
- (4) Collect and maintain data as required by the State Team;
- (5) Provide requested reports to the State Team, including discussion of individual cases, steps taken to improve coordination of services and investigations, steps taken to implement changes recommended by the local team within member agencies, and recommendations on needed changes to State and local law, policy, and practice to prevent child deaths; and
- (6) In consultation with the State Team:

(i) Define “near fatality”; and

(ii) Develop procedures and protocols that local teams and the State Team may use to review cases of near fatality.

Additional duties of local team

(c) In addition to the duties specified in subsection (b) of this section, a local team may investigate the information and records of a child convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality described in § 5-707 of this subtitle.

§ 5-707. Local team access to information and records

Upon request of the chair of the local team and as necessary to carry out the local team's purpose and duties, the local team shall be immediately provided:

(1) Access to information and records, including information on prenatal care, maintained by a health care provider regarding:

(i) A child whose death is being reviewed by the local team; or

(ii) A child convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality; and

(2) Access to all information and records maintained by any State or local government agency, including birth certificates, law enforcement investigative information, medical examiner investigative information, parole and probation information and records, and information and records of a social services agency that provided services to:

(i) A child whose death is being reviewed by the local team;

(ii) A child convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality; or

(iii) The family of a child described in item (i) or (ii) of this paragraph.

§ 5-708. Local team meetings

Discussion of child death

(a) Meetings of the State Team and of local teams shall be closed to the public and not subject to Title 10, Subtitle 5 of the State Government Article when the State Team or local teams are discussing individual cases of child deaths.

Discussion not including child death

(b) Except as provided in subsection (c) of this section, meetings of the State Team and of local teams shall be open to the public and subject to Title 10, Subtitle 5 of the State Government Article when the State Team or local team is not discussing individual cases of child deaths.

Disclosure of information

(c)(1) During a public meeting, information may not be disclosed that identifies:

- (i) A deceased child;
- (ii) A family member, guardian, or caretaker of a deceased child;
- (iii) An alleged or suspected perpetrator of abuse or neglect upon a child; or
- (iv) A child convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality .

(2) During a public meeting, information may not be disclosed regarding the involvement of any agency with:

- (i) A deceased child;
- (ii) A family member, guardian, or caretaker of a deceased child;
- (iii) An alleged or suspected perpetrator of abuse or neglect upon a child; or
- (iv) A child convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality.

Attendance requests

(d) This section does not prohibit the State Team or a local team from requesting the attendance at a team meeting of a person who has information relevant to the team's exercise of its purpose and duties.

Fines and penalties

(e) Violation of this section is a misdemeanor and is punishable by a fine not exceeding \$500 or imprisonment not exceeding 90 days or both.

§ 5-709. Confidentiality of information and records

In general

(a) All information and records acquired by the State Team or by a local team, in the exercise of its purpose and duties under this subtitle, are confidential, exempt from disclosure under Title 10, Subtitle 6 of the State Government Article, and may only be disclosed as necessary to carry out the team's duties and purposes.

Statistical compilations

(b) Statistical compilations of data that do not contain any information that would permit the identification of any person to be ascertained are public records.

Reports without identifying information

(c) Reports of the State Team and of a local team that do not contain any information that would permit the identification of any person to be ascertained are public information.

Team meetings

(d) Except as necessary to carry out a team's purpose and duties, members of a team and persons attending a team meeting may not disclose what transpired at a meeting that is not public under § 5-708 of this subtitle or any information the disclosure of which is prohibited by this section.

Civil, criminal proceedings

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

Discovery of information or records

(f)(1) Except as provided in paragraph (2) of this subsection, information, documents, and records of the State Team or of a local team are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding.

(2) 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 during proceedings of the team or are maintained by a team.

Fines and penalties

(g) Violation of this section is a misdemeanor and is punishable by a fine not exceeding \$500 or imprisonment not exceeding 90 days or both.

The statutes and Constitution are current through the 2011 Regular Session and the 2011 Special Session of the General Assembly.

MASSACHUSETTS

MASS. ANN. LAWS CH. 38, § 2A (2011) . State and local multidisciplinary child fatality review teams

(a) As used in this section, the following words shall have the following meanings:-

“Child”, a person under the age of 18.

“Fatality”, any death of a child.

“Local team”, a local child fatality review team established pursuant to subsection (c).

“Near fatality”, an act that, as certified by a physician, places a child in serious or critical condition.

“State team”, the state fatality review team established by subsection (b).

“Team”, the state or a local team.

(b) There shall be a state child fatality review team within the office of the chief medical examiner. Notwithstanding section 172 of chapter 6, members of the state team shall be subject to criminal offender record checks to be conducted by the colonel of the state police, on behalf of the chief medical examiner. All members shall serve without compensation for their duties associated with membership on the state team.

The state team shall consist of at least the following members:- the chief medical examiner, who shall chair the state team; the attorney general or a designee; the

commissioner of children and families or a designee; the commissioner of public health or a designee; the commissioner of elementary and secondary education or a designee; a representative selected by the Massachusetts District Attorneys Association; the colonel of the state police or a designee; the commissioner of mental health or a designee; the commissioner of developmental services or a designee; the director of the Massachusetts center for sudden infant death syndrome, located at the Boston Medical Center, or a designee; the commissioner of youth services or a designee; a representative selected by the Massachusetts chapter of the American Academy of Pediatrics who has experience in diagnosing or treating child abuse and neglect; a representative selected by the Massachusetts Hospital Association; the chief justice of the juvenile division of the trial court or a designee; the president of the Massachusetts Chiefs of Police Association Incorporated or a designee; the child advocate appointed under section 3 of chapter 18C or a designee; and any other person, selected by the chair or by majority vote of the members of the state team, with expertise or information relevant to an individual case.

The purpose of the state team shall be to decrease the incidence of preventable child fatalities and near fatalities by: (i) developing an understanding of the causes and incidence of child fatalities and near fatalities; and (ii) advising the governor, the general court and the public by recommending changes in law, policy and practice that will prevent child fatalities and near fatalities.

To achieve its purpose, the state team shall:

- (i) develop model investigative and data collection protocols for local teams;
- (ii) provide information to local teams and law enforcement agencies for the purpose of the protection of children;
- (iii) provide training and written materials to local teams to assist them in carrying out their duties;
- (iv) review reports from local teams;
- (v) study the incidence and causes of child fatalities and near fatalities in the commonwealth;
- (vi) analyze community, public and private agency involvement with the children and their families prior to and subsequent to fatalities or near fatalities;
- (vii) develop a protocol for the collection of data regarding fatalities and near fatalities and provide training to local teams on the protocol;
- (viii) develop and implement rules and procedures necessary for its own operation; and

(ix) provide the governor, the general court and the public with annual written reports, subject to confidentiality restrictions, which shall include, but not be limited to, the state team's findings and recommendations.

(c) There shall be a local child fatality review team in each of the 11 districts headed by a district attorney. Notwithstanding section 172 of chapter 6, members of a local team shall be subject to criminal offender record checks to be conducted by the district attorney. All members shall serve without compensation for their duties associated with membership on a local team.

Each local team shall be comprised of at least the following members: the district attorney of the county, who shall chair the local team; the chief medical examiner or a designee; the commissioner of children and families or a designee; a pediatrician with experience in diagnosing or treating child abuse and neglect, appointed by the state team; a local police officer from the municipality where the child fatality or near fatality occurred, appointed by the chief of police of that municipality; a state law enforcement officer, appointed by the colonel of state police; the chief justice of the juvenile division of the trial court or a designee; the director of the Massachusetts center for sudden infant death syndrome, located at the Boston Medical Center, or a designee; the commissioner of public health or a designee; and any other person with expertise or information relevant to an individual case who may attend meetings, on an ad hoc basis, by agreement of the permanent members of each local team. Those other persons may include, but shall not be limited to, local or state law enforcement officers, hospital representatives, medical specialists or subspecialists, or designees of the commissioners of developmental services, mental health, youth services and education.

The purpose of each local team shall be to decrease the incidence of preventable child fatalities and near fatalities by: (i) coordinating the collection of information on fatalities and near fatalities; (ii) promoting cooperation and coordination between agencies responding to fatalities and near fatalities and in providing services to family members; (iii) developing an understanding of the causes and incidence of child fatalities and near fatalities in the county; and (iv) advising the state team on changes in law, policy or practice which may affect child fatalities and near fatalities.

To achieve its purpose, each local team shall:

- (i) review, establish and implement model protocols from the state team;
- (ii) review, subject to the approval of the local district attorney, all individual fatalities and near fatalities in accordance with the established protocol;
- (iii) meet periodically, but at least 4 times per calendar year, to review the status of fatality and near fatality cases and recommend methods of improving coordination of services between member agencies;

(iv) collect, maintain and provide confidential data as required by the state team; and

(v) provide law enforcement or other agencies with information for the purposes of the protection of children.

At the request of the local district attorney, the local team shall be immediately provided with:

(i) information and records relevant to the cause of the fatality or near fatality maintained by providers of medical or other care, treatment or services, including dental and mental health care;

(ii) information and records relevant to the cause of the fatality or near fatality maintained by any state, county or local government agency including, but not limited to, birth certificates, medical examiner investigative data, parole and probation information records, and law enforcement data post-disposition, except that certain law enforcement records may be exempted by the local district attorney;

(iii) information and records of any provider of social services, including the state department of children and families, relevant to the child or the child's family, that the local team deems relevant to the review; and

(iv) demographic information relevant to the child and the child's immediate family, including but not limited to, address, age, race, gender, and economic status. The district attorney may enforce this paragraph by seeking an order of the superior court.

(d) Any privilege or restriction on disclosure established pursuant to chapter 66A, section 70 of chapter 111, section 11 of chapter 111B, section 18 of 111E, chapters 112, 123, or sections 20B, 20J or 20K of chapter 233 or any other law relating to confidential communications shall not prohibit the disclosure of this information to the chair of the state team or a local team. Any information considered to be confidential pursuant to the aforementioned statutes may be submitted for a team's review upon the determination of that team's chair that the review of this information is necessary. The chair shall ensure that no information submitted for a team's review is disseminated to parties outside the team. Under no circumstances shall any member of a team violate the confidentiality provisions set forth in the aforementioned statutes.

Except as necessary to carry out a team's purpose and duties, members of a team and persons attending a team meeting may not disclose any information relating to the team's business.

Team meetings shall be closed to the public. Information and records acquired by the state team or by a local team pursuant to this chapter shall be confidential, exempt from disclosure under chapter 66, and may only be disclosed as necessary to carry out a team's duties and purposes.

Statistical compilations of data which do not contain any information that would permit the identification of any person may be disclosed to the public.

(e) Members of a team, persons attending a team meeting and persons who present information to a team may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a team meeting.

(f) Information, documents and records of the state team or of a local team shall not be subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding; provided, however, that information, documents and records otherwise available from any other source shall not be immune from subpoena, discovery or introduction into evidence through these sources solely because they were presented during proceedings of a team or are maintained by a team.

(g) Nothing in this section shall limit the powers and duties of the chief medical examiner or district attorneys.

MICHIGAN

MICH. COMP. LAWS § 722.627b (2011). County child fatality review team; department advisory committee

Sec. 7b. (1) Each county may have in place a standing child fatality review team. Two or more counties may appoint a single child fatality review team for those counties. The membership of a child fatality review team shall consist of at least all of the following:

(a) A county medical examiner or deputy county medical examiner appointed under 1953 PA 181, MCL 52.201 to 52.216.

(b) A representative of a local law enforcement agency.

(c) A representative of the department.

(d) The county prosecuting attorney or a designated assistant county prosecutor.

(e) A representative of the department of community health or a local health department.

(f) A representative of the local court.

(2) A child fatality review team established under subsection (1) shall review each child fatality occurring in the county or counties that established the child fatality review team.

(3) The department shall make available to each child fatality review team established under subsection (1) professional, interagency training and orientation on the review of child fatalities. The department shall make available, as necessary, training on specific types of child fatalities, investigation techniques, and prevention initiatives.

(4) The department shall establish a multiagency, multidisciplinary advisory committee to identify and make recommendations on policy and statutory changes pertaining to child fatalities and to guide statewide prevention, education, and training efforts.

(5) The advisory committee created under subsection (4) consists of the following:

(a) Two representatives of the department.

(b) Two representatives of the department of community health.

(c) One county medical examiner.

(d) One representative of law enforcement.

(e) One county prosecuting attorney.

(f) The children's ombudsman or his or her designee.

(g) A representative of a state or local court.

(6) The citizen review panel shall review each child fatality that involves allegations of child abuse or neglect for each child who, at the time of death or within the 12 months preceding the death, was under the court's jurisdiction under section 2(b) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2.

(7) Beginning December 31, 2012, and using the annual compilation of child fatalities reported by the state registrar under part 28 of the public health code, 1978 PA 368, MCL 333.2801 to 333.2899, and data received from the child fatality review teams established under subsection (1) and the citizen review panel established under subsection (6), the advisory committee established under subsection (4) shall author an annual report on child fatalities reviewed during the previous calendar year. The advisory committee shall include in the report, at a minimum, all of the following:

- (a) The total number of child fatalities and the type or cause of each child fatality.
 - (b) The number of child fatalities that occurred while the child was in foster care.
 - (c) The number of cases where the child's death occurred within 5 years after family preservation or family reunification.
 - (d) Trends in child fatalities.
- (8) The advisory committee established under subsection (4) shall break down the information required under subsection (7) by county or by groups of counties as described in subsection (1). The information contained in the report is public information. The advisory committee shall not include identifying information of persons named in the report. The advisory committee shall transmit the final report under subsection (7) to the department by December 31 of each year. Not less than 30 days and not more than 60 days after transmitting the report to the department, the department shall ensure publication of the report and transmit a copy to the governor and to the standing committees of the legislature with jurisdiction over matters pertaining to child protection.
- (9) Except as provided in subsection (11), information obtained by a child fatality review team established under subsection (1) is confidential and may be disclosed by the child fatality review team only to the department, the children's ombudsman, the county prosecutor's office, local law enforcement, or another child fatality review team. The information is not subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.
- (10) An individual who is a member of a child fatality review team established under subsection (1) or of the advisory committee established under subsection (4) is a member of a board, council, commission, or statutorily created task force of a governmental agency for the purposes of section 7 of 1964 PA 170, MCL 691.1407.
- (11) The department shall establish and maintain a registry of statistical information regarding children's deaths that shall be accessible to the public. The registry created in this section shall not disclose any identifying information and shall only include statistical information covering all of the following:
- (a) The number of children who died while under court jurisdiction for child abuse or neglect regardless of placement setting.
 - (b) The number of children who died as a result of child abuse or neglect after a parent had 1 or more child protective services complaints within the 2 years preceding the child's death and the category dispositions of those complaints.

(c) The total number of children as identified in subdivisions (a) and (b) who died in the preceding year.

(d) The child protective services disposition of the child fatality.

MINNESOTA

MINN. STAT. § 256.01 (2011). COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES

Subd. 12. Child mortality review panel.

(a) The commissioner shall establish a child mortality review panel to review deaths of children in Minnesota, including deaths attributed to maltreatment or in which maltreatment may be a contributing cause and to review near fatalities as defined in section 626.556, subdivision 11d. The commissioners of health, education, and public safety and the attorney general shall each designate a representative to the child mortality review panel. Other panel members shall be appointed by the commissioner, including a board-certified pathologist and a physician who is a coroner or a medical examiner. The purpose of the panel shall be to make recommendations to the state and to county agencies for improving the child protection system, including modifications in statute, rule, policy, and procedure.

(b) The commissioner may require a county agency to establish a local child mortality review panel. The commissioner may establish procedures for conducting local reviews and may require that all professionals with knowledge of a child mortality case participate in the local review. In this section, “professional” means a person licensed to perform or a person performing a specific service in the child protective service system. “Professional” includes law enforcement personnel, social service agency attorneys, educators, and social service, health care, and mental health care providers.

(c) If the commissioner of human services has reason to believe that a child's death was caused by maltreatment or that maltreatment was a contributing cause, the commissioner has access to not public data under chapter 13 maintained by state agencies, statewide systems, or political subdivisions that are related to the child's death or circumstances surrounding the care of the child. The commissioner shall also have access to records of private hospitals as necessary to carry out the duties prescribed by this section. Access to data under this paragraph is limited to police investigative data; autopsy records and coroner or medical examiner investigative data; hospital, public health, or other medical records of the child; hospital and other medical records of the child's parent that relate to prenatal care; and records created by social service agencies that provided services to the child or family within three years preceding the child's death. A state agency, statewide system, or political subdivision shall provide the data upon request of the commissioner.

Not public data may be shared with members of the state or local child mortality review panel in connection with an individual case.

(d) Notwithstanding the data's classification in the possession of any other agency, data acquired by a local or state child mortality review panel in the exercise of its duties is protected nonpublic or confidential data as defined in section 13.02, but may be disclosed as necessary to carry out the purposes of the review panel. The data is not subject to subpoena or discovery. The commissioner may disclose conclusions of the review panel, but shall not disclose data that was classified as confidential or private data on decedents, under section 13.10, or private, confidential, or protected nonpublic data in the disseminating agency, except that the commissioner may disclose local social service agency data as provided in section 626.556, subdivision 11d, on individual cases involving a fatality or near fatality of a person served by the local social service agency prior to the date of death.

(e) A person attending a child mortality review panel meeting shall not disclose what transpired at the meeting, except to carry out the purposes of the mortality review panel. The proceedings and records of the mortality review panel are protected nonpublic data as defined in section 13.02, subdivision 13, and are not subject to discovery or introduction into evidence in a civil or criminal action against a professional, the state or a county agency, arising out of the matters the panel is reviewing. Information, documents, and records otherwise available from other sources are not immune from discovery or use in a civil or criminal action solely because they were presented during proceedings of the review panel. A person who presented information before the review panel or who is a member of the panel shall not be prevented from testifying about matters within the person's knowledge. However, in a civil or criminal proceeding a person shall not be questioned about the person's presentation of information to the review panel or opinions formed by the person as a result of the review meetings.

MISSISSIPPI

MISS. CODE ANN. § 41-111-1 (2012). Child Death Review Panel

(1) There is created the Child Death Review Panel, whose primary purpose is to foster the reduction of infant and child mortality and morbidity in Mississippi and to improve the health status of infants and children.

(2) The Child Death Review Panel shall be composed of fifteen (15) voting members: the State Medical Examiner or his representative, a pathologist on staff at the University of Mississippi Medical Center, an appointee of the Lieutenant Governor, an appointee of the Speaker of the House of Representatives, and one (1) representative from each of the following: the State Coroners Association, the Mississippi Chapter of the American Academy of Pediatrics, the Office of Vital Statistics in the State Department of Health,

the Attorney General's Office, the State Sheriff's Association, the Mississippi Police Chiefs Association, the Department of Human Services, the Children's Advocacy Center, the State Chapter of the March of Dimes, the State SIDS Alliance, and Compassionate Friends.

(3) The Chairman of the Child Death Review Panel shall be elected annually by the Review Panel membership. The Review Panel shall develop and implement such procedures and policies necessary for its operation, including obtaining and protecting confidential records from the agencies and officials specified in subsection (4) of this section. The Review Panel shall be assigned to the State Department of Health for administrative purposes only, and the department shall designate staff to assist the Review Panel.

(4) The Child Death Review Panel shall submit a report annually to the Chairmen of the House Public Health and Human Services Committee and the Senate Public Health and Welfare Committee on or before December 1. The report shall include the numbers, causes and relevant demographic information on child and infant deaths in Mississippi, and appropriate recommendations to the Legislature on how to most effectively direct state resources to decrease infant and child deaths in Mississippi. Data for the Review Panel's review and reporting shall be provided to the Review Panel, upon the request of the Review Panel, by the State Medical Examiner's Office, State Department of Health, Department of Human Services, medical examiners, coroners, health care providers, law enforcement agencies, any other agencies or officials having information that is necessary for the Review Panel to carry out its duties under this section. The State Department of Health shall also be responsible for printing and distributing the annual report(s) on child and infant deaths in Mississippi.

(5) This section shall stand repealed on July 1, 2013.

REPEALER

<This section was to repeal by its own terms on July 1, 2010. However, the amendments of this section by Laws 2010, Ch. 310, § 1 and Laws 2010, Ch. 498, § 2 extended the repeal date to July 1, 2013>

MISSOURI

MO. REV. STAT. § 58.722 (2011). Child's death under age eighteen, notice to medical examiner by persons having knowledge--referral to child fatality review panel, when--procedure for nonsuspicious death, form, duties--autopsy, child death pathologist, when--disagreement on need for autopsy, procedure--violation by medical examiner, penalty

1. When any person dies within a county having a medical examiner and there are reasonable grounds to believe that such person was less than eighteen years of age, who

was eligible to receive a certificate of live birth, the police, sheriff, law enforcement officer or official, or any person having knowledge of such a death shall immediately notify the medical examiner of the known facts concerning the time, place, manner and circumstances of the death. The medical examiner shall notify the division of the child's death pursuant to section 210.115, RSMo. The medical examiner shall immediately evaluate the necessity for child fatality review and shall immediately notify the chairman of the child fatality review panel. The child fatality review panel shall be activated within twenty-four hours of such notice to review any death which includes one or more of the suspicious circumstances described in the protocol developed by the department of social services, state technical assistance team pursuant to section 210.194, RSMo.

2. If the medical examiner determines that the death of the person under age eighteen years, who is eligible to receive a certificate of live birth, does not include any suspicious circumstances listed in the protocol, the medical examiner shall complete a nonsuspicious child death form provided by the department of social services, state technical assistance team, have the form cosigned by the chairman of the child fatality review panel and forward the original to the department of social services, state technical assistance team within forty-eight hours of receiving notice of the child's death.

3. When a child under the age of eighteen years, who is eligible to receive a certificate of live birth, dies, the medical examiner shall notify a certified child death pathologist to determine the need for an autopsy. The certified child death pathologist, in conjunction with the medical examiner, shall determine the need for an autopsy. If there is disagreement concerning the need for the autopsy, the certified child death pathologist shall make the determination unless the child fatality review panel, within twelve hours, decides against the certified child death pathologist.

4. When there is a disagreement regarding the necessity for an autopsy, the certified child death pathologist shall file a report with the chairman of the child fatality review panel indicating the basis for the disagreement. The pathologist's report on the disagreement shall be included in the report to the department of social services, state technical assistance team. If an autopsy is determined necessary, the autopsy shall be performed by a certified child death pathologist within twenty-four hours of receipt of the body by the pathologist or within twenty-four hours of the agreement by the pathologist to perform the autopsy, whichever occurs later.

5. Knowing failure by a medical examiner to refer a suspicious death of a child under the age of eighteen years, who is eligible to receive a certificate of live birth, to a child fatality review panel or to a certified child death pathologist is a class A misdemeanor.

MO. REV. STAT. § 210.115 (2011). Reports of abuse, neglect, and under age eighteen deaths--persons required to report--deaths required to report--deaths required to be

reported to the division or child fatality review panel, when--report made to another state, when

1. When any physician, medical examiner, coroner, dentist, chiropractor, optometrist, podiatrist, resident, intern, nurse, hospital or clinic personnel that are engaged in the examination, care, treatment or research of persons, and any other health practitioner, psychologist, mental health professional, social worker, day care center worker or other child-care worker, juvenile officer, probation or parole officer, jail or detention center personnel, teacher, principal or other school official, minister as provided by section 352.400, RSMo, peace officer or law enforcement official, or other person with responsibility for the care of children has reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or observes a child being subjected to conditions or circumstances which would reasonably result in abuse or neglect, that person shall immediately report or cause a report to be made to the division in accordance with the provisions of sections 210.109 to 210.183. As used in this section, the term "abuse" is not limited to abuse inflicted by a person responsible for the child's care, custody and control as specified in section 210.110, but shall also include abuse inflicted by any other person.

2. Whenever such person is required to report pursuant to sections 210.109 to 210.183 in an official capacity as a staff member of a medical institution, school facility, or other agency, whether public or private, the person in charge or a designated agent shall be notified immediately. The person in charge or a designated agent shall then become responsible for immediately making or causing such report to be made to the division. Nothing in this section, however, is meant to preclude any person from reporting abuse or neglect.

3. Notwithstanding any other provision of sections 210.109 to 210.183, any child who does not receive specified medical treatment by reason of the legitimate practice of the religious belief of the child's parents, guardian, or others legally responsible for the child, for that reason alone, shall not be found to be an abused or neglected child, and such parents, guardian or other persons legally responsible for the child shall not be entered into the central registry. However, the division may accept reports concerning such a child and may subsequently investigate or conduct a family assessment as a result of that report. Such an exception shall not limit the administrative or judicial authority of the state to ensure that medical services are provided to the child when the child's health requires it.

4. In addition to those persons and officials required to report actual or suspected abuse or neglect, any other person may report in accordance with sections 210.109 to 210.183 if such person has reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or observes a child being subjected to conditions or circumstances which would reasonably result in abuse or neglect.

5. Any person or official required to report pursuant to this section, including employees of the division, who has probable cause to suspect that a child who is or may be under the age of eighteen, who is eligible to receive a certificate of live birth, has died shall report that fact to the appropriate medical examiner or coroner. If, upon review of the circumstances and medical information, the medical examiner or coroner determines that the child died of natural causes while under medical care for an established natural disease, the coroner, medical examiner or physician shall notify the division of the child's death and that the child's attending physician shall be signing the death certificate. In all other cases, the medical examiner or coroner shall accept the report for investigation, shall immediately notify the division of the child's death as required in section 58.452, RSMo, and shall report the findings to the child fatality review panel established pursuant to section 210.192.

6. Any person or individual required to report may also report the suspicion of abuse or neglect to any law enforcement agency or juvenile office. Such report shall not, however, take the place of reporting or causing a report to be made to the division.

7. If an individual required to report suspected instances of abuse or neglect pursuant to this section has reason to believe that the victim of such abuse or neglect is a resident of another state or was injured as a result of an act which occurred in another state, the person required to report such abuse or neglect may, in lieu of reporting to the Missouri division of family services, make such a report to the child protection agency of the other state with the authority to receive such reports pursuant to the laws of such other state. If such agency accepts the report, no report is required to be made, but may be made, to the Missouri division of family services.

MO. REV. STAT. § 210.150 (2011). Confidentiality of reports and records, exceptions--violations, penalty

1. The children's division shall ensure the confidentiality of all reports and records made pursuant to sections 210.109 to 210.183 and maintained by the division, its local offices, the central registry, and other appropriate persons, officials, and institutions pursuant to sections 210.109 to 210.183. To protect the rights of the family and the child named in the report as a victim, the children's division shall establish guidelines which will ensure that any disclosure of information concerning the abuse and neglect involving that child is made only to persons or agencies that have a right to such information. The division may require persons to make written requests for access to records maintained by the division. The division shall only release information to persons who have a right to such information. The division shall notify persons receiving information pursuant to subdivisions (2), (7), (8) and (9) of subsection 2 of this section of the purpose for which the information is released and of the penalties for unauthorized dissemination of information. Such information shall be used only for the purpose for which the information is released.

2. Only the following persons shall have access to investigation records contained in the central registry:

(1) Appropriate federal, state or local criminal justice agency personnel, or any agent of such entity, with a need for such information under the law to protect children from abuse or neglect;

(2) A physician or a designated agent who reasonably believes that the child being examined may be abused or neglected;

(3) Appropriate staff of the division and of its local offices, including interdisciplinary teams which are formed to assist the division in investigation, evaluation and treatment of child abuse and neglect cases or a multidisciplinary provider of professional treatment services for a child referred to the provider;

(4) Any child named in the report as a victim, or a legal representative, or the parent, if not the alleged perpetrator, or guardian of such person when such person is a minor, or is mentally ill or otherwise incompetent, but the names of reporters shall not be furnished to persons in this category. Prior to the release of any identifying information, the division shall determine if the release of such identifying information may place a person's life or safety in danger. If the division makes the determination that a person's life or safety may be in danger, the identifying information shall not be released. The division shall provide a method for confirming or certifying that a designee is acting on behalf of a subject;

(5) Any alleged perpetrator named in the report, but the names of reporters shall not be furnished to persons in this category. Prior to the release of any identifying information, the division shall determine if the release of such identifying information may place a person's life or safety in danger. If the division makes the determination that a person's life or safety may be in danger, the identifying information shall not be released. However, the investigation reports will not be released to any alleged perpetrator with pending criminal charges arising out of the facts and circumstances named in the investigation records until an indictment is returned or an information filed;

(6) A grand jury, juvenile officer, prosecuting attorney, law enforcement officer involved in the investigation of child abuse or neglect, juvenile court or other court conducting abuse or neglect or child protective proceedings or child custody proceedings, and other federal, state and local government entities, or any agent of such entity, with a need for such information in order to carry out its responsibilities under the law to protect children from abuse or neglect;

(7) Any person engaged in a bona fide research purpose, with the permission of the director; provided, however, that no information identifying the child named in the report as a victim or the reporters shall be made available to the researcher, unless the

identifying information is essential to the research or evaluation and the child named in the report as a victim or, if the child is less than eighteen years of age, through the child's parent, or guardian provides written permission;

(8) Any child-care facility; child-placing agency; residential-care facility, including group homes; juvenile courts; public or private elementary schools; public or private secondary schools; or any other public or private agency exercising temporary supervision over a child or providing or having care or custody of a child who may request an examination of the central registry from the division for all employees and volunteers or prospective employees and volunteers, who do or will provide services or care to children. Any agency or business recognized by the division or business which provides training and places or recommends people for employment or for volunteers in positions where they will provide services or care to children may request the division to provide an examination of the central registry. Such agency or business shall provide verification of its status as a recognized agency. Requests for examinations shall be made to the division director or the director's designee in writing by the chief administrative officer of the above homes, centers, public and private elementary schools, public and private secondary schools, agencies, or courts. The division shall respond in writing to that officer. The response shall include information pertaining to the nature and disposition of any report or reports of abuse or neglect revealed by the examination of the central registry. This response shall not include any identifying information regarding any person other than the alleged perpetrator of the abuse or neglect;

(9) Any parent or legal guardian who inquires about a child abuse or neglect report involving a specific person or child-care facility who does or may provide services or care to a child of the person requesting the information. Request for examinations shall be made to the division director or the director's designee, in writing, by the parent or legal guardian of the child and shall be accompanied with a signed and notarized release form from the person who does or may provide care or services to the child. The notarized release form shall include the full name, date of birth and Social Security number of the person who does or may provide care or services to a child. The response shall include information pertaining to the nature and disposition of any report or reports of abuse or neglect revealed by the examination of the central registry. This response shall not include any identifying information regarding any person other than the alleged perpetrator of the abuse or neglect. The response shall be given within ten working days of the time it was received by the division;

(10) Any person who inquires about a child abuse or neglect report involving a specific child-care facility, child-placing agency, residential-care facility, public and private elementary schools, public and private secondary schools, juvenile court or other state agency. The information available to these persons is limited to the nature and disposition of any report contained in the central registry and shall not include any identifying information pertaining to any person mentioned in the report;

- (11) Any state agency acting pursuant to statutes regarding a license of any person, institution, or agency which provides care for or services to children;
- (12) Any child fatality review panel established pursuant to section 210.192 or any state child fatality review panel established pursuant to section 210.195;
- (13) Any person who is a tenure-track or full-time research faculty member at an accredited institution of higher education engaged in scholarly research, with the permission of the director. Prior to the release of any identifying information, the director shall require the researcher to present a plan for maintaining the confidentiality of the identifying information. The researcher shall be prohibited from releasing the identifying information of individual cases.
3. Only the following persons shall have access to records maintained by the division pursuant to section 210.152 for which the division has received a report of child abuse and neglect and which the division has determined that there is insufficient evidence or in which the division proceeded with the family assessment and services approach:
- (1) Appropriate staff of the division;
- (2) Any child named in the report as a victim, or a legal representative, or the parent or guardian of such person when such person is a minor, or is mentally ill or otherwise incompetent. The names or other identifying information of reporters shall not be furnished to persons in this category. Prior to the release of any identifying information, the division shall determine if the release of such identifying information may place a person's life or safety in danger. If the division makes the determination that a person's life or safety may be in danger, the identifying information shall not be released. The division shall provide for a method for confirming or certifying that a designee is acting on behalf of a subject;
- (3) Any alleged perpetrator named in the report, but the names of reporters shall not be furnished to persons in this category. Prior to the release of any identifying information, the division shall determine if the release of such identifying information may place a person's life or safety in danger. If the division makes the determination that a person's life or safety may be in danger, the identifying information shall not be released. However, the investigation reports will not be released to any alleged perpetrator with pending criminal charges arising out of the facts and circumstances named in the investigation records until an indictment is returned or an information filed;
- (4) Any child fatality review panel established pursuant to section 210.192 or any state child fatality review panel established pursuant to section 210.195;
- (5) Appropriate criminal justice agency personnel or juvenile officer;

(6) Multidisciplinary agency or individual including a physician or physician's designee who is providing services to the child or family, with the consent of the parent or guardian of the child or legal representative of the child;

(7) Any person engaged in bona fide research purpose, with the permission of the director; provided, however, that no information identifying the subjects of the reports or the reporters shall be made available to the researcher, unless the identifying information is essential to the research or evaluation and the subject, or if a child, through the child's parent or guardian, provides written permission.

4. Any person who knowingly violates the provisions of this section, or who permits or encourages the unauthorized dissemination of information contained in the information system or the central registry and in reports and records made pursuant to sections 210.109 to 210.183, shall be guilty of a class A misdemeanor.

5. Nothing in this section shall preclude the release of findings or information about cases which resulted in a child fatality or near fatality. Such release is at the sole discretion of the director of the department of social services, based upon a review of the potential harm to other children within the immediate family.

MO. REV. STAT. § 210.192 (2011). Child fatality review panel to investigate deaths--qualifications--prosecutors and circuit attorneys to organize--report on investigations--immunity from civil liability--program for prevention

1. The prosecuting attorney or the circuit attorney shall impanel a child fatality review panel for the county or city not within a county in which he or she serves to investigate the deaths of children under the age of eighteen years, who are eligible to receive a certificate of live birth. The panel shall be formed and shall operate according to the rules, guidelines and protocols provided by the department of social services.

2. The panel shall include, but shall not be limited to, the following:

- (1) The prosecuting or circuit attorney;
- (2) The coroner or medical examiner for the county or city not within a county;
- (3) Law enforcement personnel in the county or city not within a county;
- (4) A representative from the division of family services;
- (5) A provider of public health care services;

(6) A representative of the juvenile court;

(7) A provider of emergency medical services.

3. The prosecuting or circuit attorney shall organize the panel and shall call the first organizational meeting of the panel. The panel shall elect a chairman who shall convene the panel to meet to review all deaths of children under the age of eighteen years, who are eligible to receive a certificate of live birth, which meet guidelines for review as set forth by the department of social services. In addition, the panel may review at its own discretion any child death reported to it by the medical examiner or coroner, even if it does not meet criteria for review as set forth by the department. The panel shall issue a final report, which shall be a public record, of each investigation to the department of social services, state technical assistance team and to the director of the department of health and senior services. The final report shall include a completed summary report form. The form shall be developed by the director of the department of social services in consultation with the director of the department of health and senior services. The department of health and senior services shall analyze the child fatality review panel reports and periodically prepare epidemiological reports which describe the incidence, causes, location and other factors pertaining to childhood deaths. The department of health and senior services and department of social services shall make recommendations and develop programs to prevent childhood injuries and deaths.

4. The child fatality review panel shall enjoy such official immunity as exists at common law.

MO. REV. STAT. § 210.194 (2011). Panels, coroners and medical examiners--rules authorized for protocol and identifying suspicious deaths, procedure

1. The director of the department of social services, in consultation with the director of the department of health and senior services, shall promulgate rules, guidelines and protocols for child fatality review panels established pursuant to section 210.192 and for state child fatality review panels.

2. The director shall promulgate guidelines and protocols for coroner and medical examiners to use to help them to identify suspicious deaths of children under the age of eighteen years, who are eligible to receive a certificate of live birth.

3. No rule or portion of a rule promulgated under the authority of sections 210.192 to 210.196 shall become effective unless it has been promulgated pursuant to the provisions of section 536.024, RSMo.

4. All meetings conducted, all reports and records made and maintained pursuant to sections 210.192 to 210.196 by the department of social services and department of

health and senior services and its divisions, including the state technical assistance team, or other appropriate persons, officials, or state child fatality review panel and local child fatality review panel shall be confidential and shall not be open to the general public except for the annual report pursuant to section 210.195.

MO. REV. STAT. § 210.195 (2011). State technical assistance team, duties--regional coordinators, appointment, duties--state child fatality review panel, appointment, duties, findings and recommendations, content

1. The director of the department of social services shall establish a special team which shall:

- (1) Develop and implement protocols for the evaluation and review of child fatalities;
- (2) Provide training, expertise and assistance to county child fatality review panels for the review of child fatalities;
- (3) When required and unanimously requested by the county fatality review panel, assist in the review and prosecution of specific child fatalities; and
- (4) The special team may be known as the department of social services, state technical assistance team.

2. The director of the department of social services shall appoint regional coordinators to serve as resources to child fatality review panels established pursuant to section 210.192.

3. The director of the department of social services shall appoint a state child fatality review panel which shall meet at least biannually to provide oversight and make recommendations to the department of social services, state technical assistance team. The department of social services, state technical assistance team shall gather data from local child fatality review panels to identify systemic problems and shall submit findings and recommendations to the director of the department of social services, the governor, the speaker of the house of representatives, the president pro tempore of the senate, the children's services commission, juvenile officers, and the chairman of the local child fatality review panel, at least once a year, on ways to prevent further child abuse and injury deaths.

MO. REV. STAT. § 210.196 (2011). Hospitals and physicians, rules authorized for protocol and identifying suspicious deaths--child death pathologist, qualification, certification--rules, procedure--records, disclosure

1. The director of the department of health and senior services, in consultation with the director of the department of social services, shall promulgate rules, guidelines and protocols for hospitals and physicians to use to help them to identify suspicious deaths of children under the age of eighteen years, who are eligible to receive a certificate of live birth.
2. The director of the department of health and senior services shall promulgate rules for the certification of child death pathologists and shall develop protocols for such pathologists. A certified child death pathologist shall be a board-certified forensic pathologist or a board-certified pathologist who through special training or experience is deemed qualified in the area of child fatalities by the department of health and senior services.
3. Except as provided in section 630.167, RSMo, any hospital, physician, medical professional, mental health professional, or department of mental health facility shall disclose upon request all records, medical or social, of any child eligible to receive a certificate of live birth under the age of eighteen who has died to the coroner or medical examiner, division of family services representative, or public health representative who is a member of the local child fatality review panel established pursuant to section 210.192 to investigate the child's death. Any legally recognized privileged communication, except that between attorney and client, shall not apply to situations involving the death of a child under the age of eighteen years, who is eligible to receive a certificate of live birth.

MONTANA

MONT. CODE ANN. § 44-5-303 (2011). Dissemination of confidential criminal justice information--procedure for dissemination through court

(1) Except as provided in subsections (2) through (4), dissemination of confidential criminal justice information is restricted to criminal justice agencies, to those authorized by law to receive it, and to those authorized to receive it by a district court upon a written finding that the demands of individual privacy do not clearly exceed the merits of public disclosure. Permissible dissemination of confidential criminal justice information under this subsection includes receiving investigative information from and sharing investigative information with a chief of a governmental fire agency organized under Title 7, chapter 33, or fire marshal concerning the criminal investigation of a fire.

(2) If the prosecutor determines that dissemination of confidential criminal justice information would not jeopardize a pending investigation or other criminal proceeding, the information may be disseminated to a victim of the offense by the prosecutor or by the investigating law enforcement agency after consultation with the prosecutor.

(3) Unless otherwise ordered by a court, a person or criminal justice agency that accepts confidential criminal justice information assumes equal responsibility for the security of the information with the originating agency. Whenever confidential criminal justice information is disseminated, it must be designated as confidential.

(4) The county attorney or the county attorney's designee is authorized to receive confidential criminal justice information for the purpose of cooperating with local fetal, infant, and child mortality review teams. The county attorney or the county attorney's designee may, in that person's discretion, disclose information determined necessary to the goals of the review team. The review team and the county attorney or the designee shall maintain the confidentiality of the information.

(5)(a) If a prosecutor receives a written request for release of confidential criminal justice information relating to a criminal investigation that has been terminated by declination of prosecution or relating to a criminal prosecution that has been completed by entry of judgment, dismissal, or acquittal, the prosecutor may file a declaratory judgment action with the district court pursuant to the provisions of the Uniform Declaratory Judgments Act, Title 27, chapter 8, for release of the information. The prosecutor shall:

(i) file the action in the name of the city or county that the prosecutor represents and describe the city's or county's interest;

(ii) list as defendants anyone known to the prosecutor who has requested the confidential criminal justice information and anyone affected by release of the information;

(iii) request that the prosecutor be allowed to deposit the investigative file and any edited version of the file with the court pursuant to the provisions of Title 27, chapter 8;

(iv) request the court to:

(A) conduct an in camera review of the confidential criminal justice information to determine whether the demands of individual privacy do not clearly exceed the merits of public disclosure; and

(B) order the release to the requesting party defendant of whatever portion of the investigative information or edited version of the information the court determines appropriate.

(b) In making an order authorizing the release of information under subsection (5)(a), the court shall make a written finding that the demands of individual privacy do not clearly exceed the merits of public disclosure and authorize, upon payment of reasonable reproduction costs, the release of appropriate portions of the edited or complete confidential criminal justice information to persons who request the information.

(c) In an action filed for the court-ordered release of confidential criminal justice information under subsection (5)(a), the parties shall bear their respective costs and attorney fees.

(6) The procedures set forth in subsection (5) are not an exclusive remedy. A person or organization may file any action for dissemination of information that the person or organization considers appropriate and permissible.

MONT. CODE ANN. § 50-19-401 (2011). Fetal, Infant, and Child Mortality Prevention Act

This part may be cited as the “Fetal, Infant, and Child Mortality Prevention Act”.

MONT. CODE ANN. § 50-19-402 (2011). Statement of policy--access to information

(1) The prevention of fetal, infant, and child deaths is both the policy of the state of Montana and a community responsibility. Many community professionals have expertise that can be used to promote the health, safety, and welfare of fetuses, infants, and children. The use of these professionals in reviewing fetal, infant, and child deaths can lead to a greater understanding of the causes of death and the methods of preventing deaths. It is the intent of the legislature to encourage local communities to establish voluntary multidisciplinary fetal, infant, and child mortality review teams to study the incidence and causes of fetal, infant, and child deaths and make recommendations for community or statewide change, if appropriate, that may help prevent future deaths.

(2) A health care provider may disclose information about a patient without the patient's authorization or without the authorization of the representative of a patient who is deceased upon request of a local fetal, infant, and child mortality review team. The review team may request and may receive information from a county attorney as provided in 44-5-303(4), from a tribal attorney, and from a health care provider as permitted in Title 50, chapter 16, part 5, or applicable federal law. The review team shall maintain the confidentiality of the information received.

(3) The local fetal, infant, and child mortality review team may:

(a) perform an indepth analysis of fetal, infant, and child deaths, including a review of records available by law;

(b) compile statistics of fetal, infant, and child mortality and communicate the statistics to the department of public health and human services for inclusion in statistical reports;

(c) analyze the preventable causes of fetal, infant, and child deaths, including child abuse and neglect; and

(d) recommend measures to prevent future fetal, infant, and child deaths.

(4) A local fetal, infant, and child mortality review team may not review deaths of fetuses, infants, or children who are Indians and which deaths occur within the boundaries of an Indian reservation with a tribal government that opposes the review.

MONT. CODE ANN. § 50-19-403 (2011). Local fetal, infant, and child mortality review team

(1) A local fetal, infant, and child mortality review team must be approved by the department of public health and human services. Approval may be given if:

(a) the county health department, a tribal health department, if the tribal government agrees, or both are represented on the team and the plan provided for in subsection (1)(d) includes the roles of the county health department, tribal health department, or both;

(b) a lead person has been designated for the purposes of management of the review team;

(c) at least five of the individuals listed in subsection (2) have agreed to serve on the review team; and

(d) a plan has been developed by the team that includes, at a minimum, operating policies of the review team covering collection and destruction of information obtained pursuant to 44-5-303(4) or 50-19-402(2).

(2) If a local fetal, infant, and child mortality review team is established, the team must be multidisciplinary and may include only:

(a) the county attorney or a designee;

(b) a law enforcement officer;

(c) the medical examiner or coroner for the jurisdiction;

(d) a physician;

(e) a school district representative;

(f) a representative of the local health department;

(g) a representative from a tribal health department, appointed by the tribal government;

- (h) a representative from a neighboring county or tribal government if there is an agreement to review deaths for that county or tribe;
- (i) a representative of the department of public health and human services;
- (j) a forensic pathologist;
- (k) a pediatrician;
- (l) a family practice physician;
- (m) an obstetrician;
- (n) a nurse practitioner;
- (o) a public health nurse;
- (p) a mental health professional;
- (q) a local trauma coordinator;
- (r) a representative of the bureau of Indian affairs or the Indian health service, or both, who is located within the county; and
- (s) representatives of the following:
 - (i) local emergency medical services;
 - (ii) a local hospital;
 - (iii) a local hospital medical records department;
 - (iv) a local governmental fire agency organized under Title 7, chapter 33; and
 - (v) the local registrar.
- (3) The designated lead person for the team shall submit membership lists to the department of public health and human services annually.

MONT. CODE ANN. § 50-19-404 (2011). Records--confidentiality

Material and information obtained by a local fetal, infant, and child mortality review team are not subject to disclosure under the public records law. Material and information

obtained by a local fetal, infant, and child mortality review team are not subject to subpoena.

MONT. CODE ANN. § 50-19-405 (2011). Unauthorized disclosure--civil penalty

A person aggrieved by the use of information obtained pursuant to 50-19-402(2) for a purpose not authorized by 50-19-402(3) or by a disclosure of that information in violation of 50-19-402(2) may bring a civil action in the district court of the county of the person's residence for damages, costs, and fees as provided in 50-16-553(6) through (8) or 50-16-817.

MONT. CODE ANN. § 50-19-406 (2011). Unauthorized disclosure--misdemeanor

A person who knowingly uses information obtained pursuant to 50-19-402(2) for a purpose not authorized by 50-19-402(3) or who discloses that information in violation of 50-19-402(2) is guilty of a misdemeanor and upon conviction is punishable as provided in 46-18-212.

NEBRASKA

NEB. REV. STAT. ANN. § 71-3401 (2011). Information, statements, and data; furnish without liability

Any person, hospital, sanitarium, nursing home, rest home, or other organization may provide information, interviews, reports, statements, memoranda, or other data relating to the condition and treatment of any person to the Department of Health and Human Services, the Nebraska Medical Association or any of its allied medical societies, the Nebraska Association of Hospitals and Health Systems, any inhospital staff committee, or any joint venture of such entities to be used in the course of any study for the purpose of reducing morbidity or mortality, and no liability of any kind or character for damages or other relief shall arise or be enforced against any person or organization by reason of having provided such information or material, by reason of having released or published the findings and conclusions of such groups to advance medical research and medical education, or by reason of having released or published generally a summary of such studies.

NEB. REV. STAT. ANN. § 71-3402 (2011). Publication of material; purpose; identity of person confidential

The Department of Health and Human Services, the Nebraska Medical Association or any of its allied medical societies, the Nebraska Association of Hospitals and Health Systems, any inhospital staff committee, or any joint venture of such entities shall use or publish the material specified in section 71-3401 only for the purpose of advancing medical research or medical education in the interest of reducing morbidity or mortality, except that a summary of such studies may be released by any such group for general publication. In all events the identity of any person whose condition or treatment has been studied shall be confidential and shall not be revealed under any circumstances.

NEB. REV. STAT. ANN. § 71-3403 (2011). Information, interviews, reports, statements, data; privileged communications; not received in evidence

All information, interviews, reports, statements, memoranda, or other data furnished by reason of sections 71-3401 to 71-3403 and any findings or conclusions resulting from such studies are declared to be privileged communications which may not be used or offered or received in evidence in any legal proceeding of any kind or character, and any attempt to use or offer any such information, interviews, reports, statements, memoranda or other data, findings or conclusions or any part thereof, unless waived by the interested parties, shall constitute prejudicial error resulting in a mistrial in any such proceeding.

(b) Child Deaths

NEB. REV. STAT. ANN. § 71-3404 (2011). Child deaths; legislative findings and intent

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

It is the intent of the Legislature by enactment of Laws 1993, LB 431, to: (1) Identify trends from the review of past records to prevent future deaths from similar causes when applicable; (2) recommend systematic changes for the creation of a cohesive method for responding to certain child deaths; and (3) when appropriate, cause referral to be made to those agencies as required in section 28-711 or as otherwise required by state law.

NEB. REV. STAT. ANN. § 71-3405 (2011). Terms, defined

For purposes of sections 71-3404 to 71-3411:

National Center for Prosecution of Child Abuse
National District Attorney Association

- (1) Child shall mean a person from birth to eighteen years of age;
- (2) Investigation shall mean a review of existing records and other information regarding the child 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, emergency and paramedic records, and law enforcement reports;
- (3) Preventable child death shall mean the death of any child which reasonable medical, social, legal, psychological, or educational intervention may have prevented. Preventable child death shall include, but not be limited to, the death of a child 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 medical care for various reasons, and (e) preventable premature birth;
- (4) Reasonable shall mean taking into consideration the condition, circumstances, and resources available; and
- (5) Team shall mean the State Child Death Review Team.

NEB. REV. STAT. ANN. § 71-3406 (2011). . State Child Death Review Team; core members; terms; chairperson; not considered public body; meetings; expenses

- (1) The chief executive officer of the Department of Health and Human Services shall appoint a minimum of eight and a maximum of twelve members to the State Child Death Review Team. The core members shall be (a) a physician employed by the department, who shall be a permanent member and shall serve as the chairperson of the team, (b) a senior staff member with child protective services of the department, (c) a forensic pathologist, (d) a law enforcement representative, and (e) an attorney. The remaining members appointed may be, but shall not be limited to, the following: A county attorney; a Federal Bureau of Investigation agent responsible for investigations on Native American reservations; a social worker; and members of organizations which represent hospitals or physicians.
- (2) Members shall serve four-year terms with the exception of the chairperson. In the absence of the chairperson, the chief executive officer may appoint another member of the core team to serve as chairperson.
- (3) The team shall not be considered a public body for purposes of the Open Meetings Act. The team shall meet a minimum of four times a year. Members of the team shall be

reimbursed for their actual and necessary expenses as provided in sections 81-1174 to 81-1177.

NEB. REV. STAT. ANN. § 71-3407 (2011). Team; purposes; duties

(1) The purposes of the team shall be to (a) develop an understanding of the causes and incidence of child deaths in this state, (b) develop recommendations for changes within relevant agencies and organizations which may serve to prevent child deaths, and (c) advise the Governor, the Legislature, and the public on changes to law, policy, and practice which will prevent child deaths.

(2) The team shall:

(a) Undertake annual statistical studies of the causes and incidence of child 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 and their families prior to and subsequent to the deaths;

(b) Develop a protocol for retrospective investigation of child deaths by the team;

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

(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 deaths;

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

(g) Provide the Governor, the Legislature, and the public with annual written reports which shall include the team's findings and recommendations for each of its duties; and

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

NEB. REV. STAT. ANN. § 71-3408 (2011). Chairperson; duties

The chairperson of the team shall:

- (1) Have the necessary information from investigative reports, medical records, coroner's reports, autopsy reports, and other relevant items made available to the team;
- (2) Ensure timely notification of the team members of an upcoming meeting;
- (3) Chair meetings of the team;
- (4) Ensure that all team reporting and data-collection requirements are met;
- (5) Ensure identification of strategies to prevent child deaths;
- (6) Oversee adherence to the review process established by sections 71-3404 to 71-3411; and
- (7) Perform such other duties as the team deems appropriate.

NEB. REV. STAT. ANN. § 71-3409 (2011). Review of child deaths; phases

- (1) The team shall review all child deaths occurring on or after January 1, 1993. The review process shall be conducted in three phases.
- (2) Phase one shall be conducted by the core members. The core 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 of Health and Human Services. The core 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. The core members may select cases from phase one for review in phase two.
- (3) Phase two shall be completed by the core members and shall not be conducted on any child death under active investigation by a law enforcement agency or under criminal prosecution. The core members may seek additional records described in section 71-3410. The core members 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. The core members may select cases from phase two for review by the team in phase three.
- (4) Phase three shall be a review by the team of those cases selected by the core members for further discussion, review, and analysis.

NEB. REV. STAT. ANN. § 71-3410 (2011). Provision of information and records; subpoenas

Upon request the team shall be immediately provided:

(1) 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

(2) All information and records maintained by any state, county, or local government agency, including, but not limited to, birth and death certificates, law enforcement investigative data and reports, coroner investigative data and reports, parole and probation information and records, and information and records of any social services agency that provided services to the child or the child's family.

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) and (2) of this section, except records and information on any child death 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 team.

NEB. REV. STAT. ANN. § 71-3411 (2011). Information and records; confidentiality; use prohibited

(1) All information and records acquired by the team in the exercise of its purposes and duties pursuant to sections 71-3404 to 71-3411 shall be confidential and exempt from disclosure and may only be disclosed as necessary to carry out the team's purposes and duties. Statistical compilations of data made by the team which do not contain any information that would permit the identification of any person to be ascertained shall be public records.

(2) Except as necessary to carry out a team's purposes and duties, members of a team and persons attending a team meeting may not disclose what transpired at a meeting and shall not disclose any information the disclosure of which is prohibited by this section.

(3) Members of a team and persons attending a team meeting shall not testify in any civil, administrative, licensure, or criminal proceeding, including depositions, regarding information reviewed in or opinions formed as a result of a team meeting. This subsection shall not be construed to prevent a person from testifying to information obtained independently of the team or which is public information.

(4) Information, documents, and records of the team shall not be subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding, except that information, documents, and records otherwise available from other sources shall not be

immune from subpoena, discovery, or introduction into evidence through those sources solely because they were presented during proceedings of the team or are maintained by the team.

NEVADA

NEV. REV. STAT. ANN. § 432B.403. (2011). PURPOSE OF ORGANIZING CHILD DEATH REVIEW TEAMS

The purpose of organizing multidisciplinary teams to review the deaths of children pursuant to NRS 432B.403 to 432B.4095, inclusive, is to:

1. Review the records of selected cases of deaths of children under 18 years of age in this State;
2. Review the records of selected cases of deaths of children under 18 years of age who are residents of Nevada and who die in another state;
3. Assess and analyze such cases;
4. Make recommendations for improvements to laws, policies and practice;
5. Support the safety of children; and
6. Prevent future deaths of children.

NEV. REV. STAT. ANN. § 432B.405 (2011). Organization of child death review teams

1. The director or other authorized representative of an agency which provides child welfare services:

(a) May provisionally appoint and organize one or more multidisciplinary teams to review the death of a child;

(b) Shall submit names to the Executive Committee to Review the Death of Children established pursuant to NRS 432B.409 for review and approval of persons whom the director or other authorized representative recommends for appointment to a multidisciplinary team to review the death of a child; and

(c) Shall organize one or more multidisciplinary teams to review the death of a child under any of the following circumstances:

(1) Upon receiving a written request from an adult related to the child within the third degree of consanguinity, if the request is received by the agency within 1 year after the date of death of the child;

(2) If the child dies while in the custody of or involved with an agency which provides child welfare services, or if the child's family previously received services from such an agency;

(3) If the death is alleged to be from abuse or neglect of the child;

(4) If a sibling, household member or day care provider has been the subject of a child abuse and neglect investigation within the previous 12 months, including, without limitation, cases in which the report was unsubstantiated or the investigation is currently pending;

(5) If the child was adopted through an agency which provides child welfare services; or

(6) If the child died of Sudden Infant Death Syndrome.

2. A review conducted pursuant to subparagraph (2) of paragraph (c) of subsection 1 must occur within 3 months after the issuance of a certificate of death.

NEV. REV. STAT. ANN. § 432B.406 (2011). Composition of child death review teams

1. A multidisciplinary team to review the death of a child that is organized by an agency which provides child welfare services pursuant to NRS 432B.405 must include, insofar as possible:

(a) A representative of any law enforcement agency that is involved with the case under review;

(b) Medical personnel;

(c) A representative of the district attorney's office in the county where the case is under review;

(d) A representative of any school that is involved with the case under review;

(e) A representative of any agency which provides child welfare services that is involved with the case under review; and

(f) A representative of the coroner's office.

2. A multidisciplinary team may include such other representatives of other organizations concerned with the death of the child as the agency which provides child welfare services deems appropriate for the review.

NEV. REV. STAT. ANN. § 432B.407 (2011). Information available to child death review teams; sharing of certain information; subpoena to obtain information; confidentiality of information

1. A multidisciplinary team to review the death of a child is entitled to access to:

(a) All investigative information of law enforcement agencies regarding the death;

(b) Any autopsy and coroner's investigative records relating to the death;

(c) Any medical or mental health records of the child; and

(d) Any records of social and rehabilitative services or of any other social service agency which has provided services to the child or the child's family.

2. Each organization represented on a multidisciplinary team to review the death of a child shall share with other members of the team information in its possession concerning the child who is the subject of the review, any siblings of the child, any person who was responsible for the welfare of the child and any other information deemed by the organization to be pertinent to the review.

3. A multidisciplinary team to review the death of a child may, if appropriate, meet and share information with a multidisciplinary team to review the death of the victim of a crime that constitutes domestic violence organized or sponsored pursuant to NRS 217.475 or section 1 of this act.

4. A multidisciplinary team to review the death of a child may petition the district court for the issuance of, and the district court may issue, a subpoena to compel the production of any books, records or papers relevant to the cause of any death being investigated by the team. Except as otherwise provided in NRS 239.0115, any books, records or papers received by the team pursuant to the subpoena shall be deemed confidential and

privileged and not subject to disclosure.

4. Information

5. Except as otherwise provided in this section, information acquired by, and the records of, a multidisciplinary team to review the death of a child are confidential, must not be disclosed, and are not subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding.

NEV. REV. STAT. ANN. § 432B.4075 (2011). Authority of Administrator to organize multidisciplinary team to oversee review conducted by child death review team; access to information and privileges

1. The Administrator of the Division of Child and Family Services may organize a multidisciplinary team to oversee any review of the death of a child conducted by a multidisciplinary team that is organized by an agency which provides child welfare services pursuant to NRS 432B.405.

2. A multidisciplinary team organized pursuant to subsection 1 is entitled to the same access and privileges granted to a multidisciplinary team to review the death of a child pursuant to NRS 432B.407.

NEV. REV. STAT. ANN. § 432B.4078 (2011). Administrative team to review report of child death review team

1. The report and recommendations of a multidisciplinary team to review the death of a child must be transmitted to an administrative team for review.

2. An administrative team must consist of administrators of agencies which provide child welfare services, and agencies responsible for vital statistics, public health, mental health and public safety.

3. The administrative team shall review the report and recommendations and respond in writing to the multidisciplinary team within 90 days after receiving the report.

NEV. REV. STAT. ANN. § 432B.4079 (2011). Establishment, composition and duties of Executive Committee to Review the Death of Children; creation of and use of money in Review of Death of Children Account

1. The Administrator of the Division of Child and Family Services shall establish an Executive Committee to Review the Death of Children, consisting of representatives from multidisciplinary teams formed pursuant to paragraph (a) of subsection 1 of NRS 432B.405 and NRS 432B.406, vital statistics, law enforcement, public health and the Office of the Attorney General.

2. The Executive Committee shall:

(a) Adopt statewide protocols for the review of the death of a child;

(b) Adopt regulations to carry out the provisions of NRS 432B.403 to 432B.4095, inclusive;

(c) Adopt bylaws to govern the management and operation of the Executive Committee;

(d) Appoint one or more multidisciplinary teams to review the death of a child from the names submitted to the Executive Committee pursuant to paragraph (b) of subsection 1 of NRS 432B.405;

(e) Oversee training and development of multidisciplinary teams to review the death of children; and

(f) Compile and distribute a statewide annual report, including statistics and recommendations for regulatory and policy changes.

3. The Review of Death of Children Account is hereby created in the State General Fund. The Executive Committee may use money in the Account to carry out the provisions of NRS 432B.403 to 432B.4095, inclusive.

NEV. REV. STAT. ANN. § 432B.4095 (2011). Civil penalty for disclosure of confidential information; authority to bring action; deposit of money

1. Each member of a multidisciplinary team organized pursuant to NRS 432B.405, a multidisciplinary team organized pursuant to NRS 432B.4075, an administrative team organized pursuant to NRS 432B.408 or the Executive Committee to Review the Death of Children established pursuant to NRS 432B.409 who discloses any confidential information concerning the death of a child is personally liable for a civil penalty of not more than \$500.

2. The Administrator of the Division of Child and Family Services:

(a) May bring an action to recover a civil penalty imposed pursuant to subsection 1 against a member of a multidisciplinary team organized pursuant to NRS 432B.4075, an administrative team or the Executive Committee; and

(b) Shall deposit any money received from the civil penalty with the State Treasurer for credit to the State General Fund.

3. Each director or other authorized representative of an agency which provides child welfare services that organized a multidisciplinary team pursuant to NRS 432B.405:

(a) May bring an action to recover a civil penalty pursuant to subsection 1 against a member of the multidisciplinary team; and

(b) Shall deposit any money received from the civil penalty in the appropriate county treasury.

NEW HAMPSHIRE

The Child New Hampshire Fatality Review Committee was created by executive order, and is housed in the New Hampshire Department of Justice.³

NEW JERSEY

N.J. STAT. ANN. § 9:6-8.88 (2011). Child fatality and near fatality review board established

There is established the Child Fatality and Near Fatality Review Board. For the purposes of complying with the provisions of Article V, Section IV, paragraph 1 of the New Jersey Constitution, the board is established within the Department of Children and Families,

^{3 3} Nat'l Cent. For Child Death Review, *State Spotlight – New Hampshire* (last modified Feb 2012); <http://www.childdeathreview.org/spotlightNH.htm>

but notwithstanding the establishment, the board shall be independent of any supervision or control by the department or any board or officer thereof.

The purpose of the board is to review fatalities and near fatalities of children in New Jersey in order to identify their causes, their relationship to governmental support systems, and methods of prevention. The board shall describe trends and patterns of child fatalities and near fatalities in New Jersey; identify risk factors and their prevalence in these populations of children; evaluate the responses of governmental systems to children in families who are considered to be at high risk and to offer recommendations for improvement in those responses; characterize risk groups in terms that are compatible with the development of public policy; improve the sources of data collection by developing protocols for autopsies, death investigations, and complete recording of cause of death on the death certificate; and provide case consultation to individuals or agencies represented by the board.

N.J. STAT. ANN. § 9:6-8.89 (2011). Child fatality and near fatality review board; membership; terms; officers; authority

a. The board shall consist of 14 members as follows: the Commissioner of Children and Families, the Commissioner of Health and Senior Services, the Director of the Division of Youth and Family Services in the Department of Children and Families, the Attorney General, the Child Advocate and the Superintendent of State Police, or their designees, the State Medical Examiner, and the Chairperson or Executive Director of the New Jersey Task Force on Child Abuse and Neglect, who shall serve ex officio; and six public members appointed by the Governor, one of whom shall be a representative of the New Jersey Prosecutors' Association, one of whom shall be a Law Guardian, one of whom shall be a pediatrician with expertise in child abuse and neglect, one of whom shall be a psychologist with expertise in child abuse and neglect, one of whom shall be a social work educator with experience and expertise in the area of child abuse or a related field and one of whom shall have expertise in substance abuse.

b. The public members of the board shall serve for three-year terms. Of the public members first appointed, three shall serve for a period of two years, and three shall serve for a term of three years. They shall serve without compensation but shall be eligible for reimbursement for necessary and reasonable expenses incurred in the performance of their official duties and within the limits of funds appropriated for this purpose. Vacancies in the membership of the board shall be filled in the same manner as the original appointments were made.

c. The Governor shall appoint a public member to serve as chairperson of the board who shall be responsible for the coordination of all activities of the board and who shall provide the technical assistance needed to execute the duties of the board.

d. The board is entitled to call to its assistance and avail itself of the services of employees of any State, county or municipal department, board, bureau, commission or agency as it may require and as may be available for the purposes of reviewing a case pursuant to the provisions of P.L.1997, c. 175 (C.9:6-8.83 et al.). The board may also seek the advice of experts, such as persons specializing in the fields of pediatric, radiological, neurological, psychiatric, orthopedic and forensic medicine; nursing; psychology; social work; education; law enforcement; family law; substance abuse; child advocacy or other related fields, if the facts of a case warrant additional expertise.

N.J. STAT. ANN. § 9:6-8.90 (2011). Child fatality and near fatality review board; duties

The board shall:

a. Identify the fatalities of children due to unusual circumstances according to the following criteria:

- (1) The cause of death is undetermined;
- (2) Death where substance abuse may have been a contributing factor;
- (3) Homicide, child abuse or neglect;
- (4) Death where child abuse or neglect may have been a contributing factor;
- (5) Malnutrition, dehydration, or medical neglect or failure to thrive;
- (6) Sexual abuse;
- (7) Head trauma, fractures or blunt force trauma without obvious innocent reason such as auto accidents;
- (8) Suffocation or asphyxia;
- (9) Burns without obvious innocent reason such as auto accident or house fire; and
- (10) Suicide.

b. Identify fatalities and near fatalities among children whose family, currently or within the last 12 months, were receiving services from the division.

N.J. STAT. ANN. § 9:6-8.91 (2011). Community-based investigation teams

a. The board shall determine which fatalities shall receive full review. The board may establish local or regional community-based teams to review information regarding children identified by the board. At least one team shall be designated to review information regarding child fatalities due to unusual circumstances. At least one team shall be designated to review child fatalities and near fatalities identified pursuant to subsection b. of section 8 of P.L.1997, c.175 (C.9:6-8.90) as well as child fatalities where information available to the board indicates that child abuse or neglect may have been a contributing factor.

b. Each team shall include, at a minimum, a person experienced in prosecution, a person experienced in local law enforcement investigation, a medical examiner, a public health advocate, a physician, preferably a pediatrician, and a casework supervisor from a division field office. As necessary to perform its functions, each team may add additional members or seek the advice of experts in other fields if the facts of a case warrant additional expertise.

c. Each team shall submit to the board chairperson a report of its findings and recommendations based upon its review of information regarding each child fatality or near fatality.

N.J. STAT. ANN. § 9:6-8.92 (2011).. Child fatality and near fatality review board; records

a. The board shall record the name, age, date of birth, place of death or pronouncement of death, date and time of death, and circumstances surrounding the death in a confidential master file. Similar information shall be recorded for each near fatality reviewed by the board. The file shall serve as the minimum record of the case and shall be the only file that contains the name of the child and shall not be subject to discovery, but may be used by the chairperson of the board to refer an individual case, including the board's deliberations and conclusions, to the extent necessary for an appropriate agency to investigate or to provide services.

b. Except as provided in subsection a. of this section, the deliberations and conclusions of the board and of its teams, related to a specific case, shall be confidential. Summary records that are prepared by the board and the teams on each reported case shall be free of information that would identify the child.

c. The summary reports, deliberations and conclusions of the board or its teams shall not supersede or replace the conclusions or opinions of the agencies that contribute information from their own records.

d. The board shall review the reports submitted by each team and issue an annual report to the Governor and the Legislature which includes the number of cases reviewed and specific non-identifying information regarding cases of particular significance. The board shall also include in the report recommendations for achieving better coordination and collaboration among State and local agencies and recommendations for system-wide improvements in services to prevent fatalities and near fatalities among children.

N.J. STAT. ANN. § 9:6-8.93 (2011).. Child fatality and near fatality review board; subpoenas; notice to prosecutors

a. The board may subpoena and review records that pertain to the child, except as provided in any statute, regulation or Executive Order relating to the confidentiality of criminal investigations and criminal investigative files. The records subject to subpoena and review shall include, but are not limited to, private medical and hospital records, school records, mental health records, and other records which may be deemed pertinent to the review process and necessary for the formulation of a conclusion by the board.

b. Records obtained by the board pursuant to subsection a. of this section shall not be subject to subpoena.

c. If, at the time of initial notification or during the subsequent review, the board has reasonable cause to believe that the death is the result of child abuse or neglect, or has reasonable cause to believe that the death is the result of an on-going hazard to other members of the household, then the board shall notify or shall verify that notification has been made to the county prosecutor of the county wherein the death occurred or was pronounced, and to the division.

N.J. STAT. ANN. § 9:6-8.94 (2011).. Child fatality and near fatality review board; member immunity

A member of the board shall not be liable for any civil damages as a result of providing in good faith any reports, records, opinions or recommendations pursuant to P.L.1997, c. 175 (C.9:6-8.83 et al.).

N.J. STAT. ANN. § 9:6-8.95 (2011).. Child fatality and near fatality review board; grants and funding

The board may solicit and receive grants and other funds made available from a governmental, public, private, nonprofit, or for-profit agency, including funds made available under any federal or State law, regulation or program.

N.J. STAT. ANN. § 9:6-8.96 (2011). Child fatality and near fatality review board; rules and regulations

The board shall adopt regulations pursuant to the “Administrative Procedure Act,” P.L.1968, c. 410 (C.52:14B-1 et seq.) concerning the operation of the board, procedures for conducting reviews of cases involving child fatalities and near fatalities, and other matters necessary to effectuate the purposes of this act.

NEW MEXICO

N.M. STAT. ANN. § 7.4.5.1 (2011). ISSUING AGENCY:
New Mexico Department of Health, Public Health Division, Family Health Bureau
[01/01/98; Recompiled 10/31/01]

N.M. STAT. ANN. § 7.4.5.2 (2011). SCOPE:
These regulations shall apply to the operations of the New Mexico maternal mortality review team, fetal and infant mortality review team, child fatality review team and any other team which is deemed necessary by the department and their policies and procedures, confidentiality provisions, management of records, dissemination of findings and recommendations; and to the public and private entities from whom data, information or records are requested for the purpose of mortality or fatality review.

[01/01/98; Recompiled 10/31/01]

N.M. STAT. ANN. § 7.4.5.3 (2011). STATUTORY AUTHORITY:

A. The regulation set forth herein is promulgated by the secretary of the department of health by authority of the Department of Health Act, Section 9-7-6.E. NMSA 1978 and the Public Health Act, Section 24-1-3 NMSA 1978, specifically Section 24-1-3. C. NMSA 1978, which states: ‘The department has authority to: investigate, control and abate the causes of disease, especially epidemics, sources of mortality and other conditions of public health; and Section 24-1-3. F. NMSA 1978, which states: ‘The department has authority to: establish programs and adopt regulations to prevent infant mortality, birth defects and morbidity; and Section 24-1-3. H. NMSA 1978, which states: ‘The department has authority to: provide educational programs and disseminate information on public health.’ The administration and enforcement of these regulations is the responsibility of the public health division of the department.

B. Related statutes and regulations: New Mexico law provides for other statutes and regulations that support or limit the statutory authority of the department to regulate the review of maternal, fetal, infant or child deaths.

[01/01/98; Recompiled 10/31/01]

N.M. STAT. ANN. § 7.4.5.4 (2011). DURATION: Permanent

[01/01/98; Recompiled 10/31/01]

N.M. STAT. ANN. § 7.4.5.5 (2011). EFFECTIVE DATE:

January 1, 1998, unless a later date is cited at the end of a section or paragraph.

[01/01/98; Recompiled 10/31/01]

[Compiler's note: The words or paragraph, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

N.M. STAT. ANN. § 7.4.5.6 (2011). OBJECTIVE:

The purpose of the retrospective case review of death in the maternal, fetal, infant and child population in New Mexico by a multidisciplinary team of experts is to reduce future rates of such deaths by identification of prevention factors, risk reduction factors and/or systems failure factors and the dissemination of such information to policy makers, providers, communities and to the public.

[01/01/98; Recompiled 10/31/01]

N.M. STAT. ANN. § 7.4.5.7 (2011). DEFINITIONS:

A. "AAP" means the American academy of pediatrics

B. "ACOG" means the American college of obstetricians and gynecologists.

C. "CYFD" means the New Mexico children, youth and families department.

D. "Child fatality review" or "CFR" means a review that includes all reported deaths of children due to fatal injury or other undetermined cause from birth through 24 years of age, or a specific age range as determined appropriate by a special panel.

E. "Community based review" means the review that takes place in the community where the death occurs, is staffed by Team members approved by the department and may involve follow-back interview with informed consent to surviving family, providers of care or other relevant persons.

F. "Coordinator" means the person designated by the department to administer and manage the day to day operations of the review teams.

G. “Confidentiality” means the protection of the privacy of the decedent, the decedent's family, and any information pertaining to the fatality.

H. “Department” or “DOH” means the New Mexico department of health.

I. “Department designee for MCH death review” means the department staff person, usually an epidemiologist, authorized to receive information regarding deaths that fit the criteria for MMR, FIMR and CFR.

J. “Death investigation” means the investigation of a death by appropriate authorities for the purpose of establishing the manner and cause of death.

K. “Expert” means a person by whose training and present work-related activities or professional licensure has the requisite knowledge to review case information and contribute to an assessment of prevention factors, risk reduction factors and/or systems failure factors. The expert is bound by confidentiality policies and statute, and must be recognized by the department.

L. “Fetal and infant mortality review” or “FIMR” means a review including all reported deaths of fetuses (death prior to the complete expulsion or extraction from the mother of a product of human conception, fetus and placenta, irrespective of the duration of pregnancy), and infants (any death at any time from birth through one year).

M. “MCH” means public health practice concerned with maternal and child health.

N. “Maternal mortality review” or “MMR” means the review of all reported deaths of the following: pregnant women who die from any cause during pregnancy, or who die within one calendar year of pregnancy termination.

O. “Multidisciplinary team” means a team of experts comprising, but not limited to, the disciplines essential to death review, such as medicine, nursing, social work, law enforcement, mental health, public health, education, domestic violence, and child advocacy.

P. “OMI” means the New Mexico office of medical investigator.

Q. “PHD” means the public health division of the department.

R. “Prevention factors” means the circumstances, events, exposures or products that are identified by the death review team as potential contributors to the death and about which providers, communities and/or the public need to be informed and/or educated for the prevention of future such death(s).

S. “Retrospective case review” means the gathering of case information and analysis of information after the manner and cause of death have been registered with vital records and health statistics. Retrospective case review is not a death investigation process. It is a public health function concerned with assessment, prevention, risk reduction and/or systems improvements.

T. “Risk reduction factors” means the circumstances, events, exposures or products that are identified by the death review team as potential contributors to the death and about which providers, communities and/or the public need to be informed and/or educated for the prevention of future such death(s).

U. “Secretary” means the secretary of the department or his/her designee.

V. “Special panel” means a group convened on a permanent or temporary basis for the MMR, FIMR or CFR Team, to review an aggregation of deaths by selected categories to increase the power of analysis and interpretation by reviewing several cases of a similar manner or cause of death.

W. “State level review” means the process whereby statewide quantitative and qualitative data, gathered either at the state level or by a local community death review team, are analyzed and used for development of public policy, public health recommendations, and/or implementation of prevention measures.

X. “System failure factors” means the community-based circumstances, events, resources including the lack thereof, and provider policies that are identified by the death review team as potential contributors to the death and about which providers, communities and/or the public need to be informed and or educated for the prevention of future such death(s).

Y. “Team” means one of the state or community level MMR, FIMR or CFR teams.

Z. “UNM” means the university of New Mexico.

AA. “VRHS/NM” means the department entity responsible for vital records and health statistics in New Mexico.

[01/01/98; Recompiled 10/31/01]

N.M. STAT. ANN. § 7.4.5.8 (2011). PROGRAM ADMINISTRATION:

MMR, FIMR, and CFR are administered by the public health division in the department in collaboration with the OMI of UNM. MMR, FIMR and CFR are coordinated by the MCH death review coordinator in the office of MCH epidemiology.

[01/01/98; Recompiled 10/31/01]

N.M. STAT. ANN. § 7.4.5.9 (2011). EXECUTIVE OVERSIGHT BOARD:

An executive oversight board will comprise department representatives designated by the secretary including but not limited to the office of the DOH chief medical officer, office of general counsel, offices of the PHD director, VRHS/NM, family health, MCH epidemiology; and a designated representative of OMI, ACOG and CYFD.

[01/01/98; Recompiled 10/31/01]

N.M. STAT. ANN. § 7.4.5.10 (2011). MEMBERSHIP:

The members of maternal mortality review team, the fetal and Infant mortality review team and child fatality review team will be state or local experts in their field and appointed by the department. Members are selected to achieve a culturally diverse, multidisciplinary team that may include but is not limited to representatives of the following disciplines: medicine and selected subspecialties, nursing, nurse-midwifery, forensic medicine, mental health, social work, specialists in child abuse and neglect, public health epidemiology, law enforcement, the judiciary, prosecution, traffic safety, education, child advocacy, grief intervention and support, domestic violence, health education, survivor or parent support groups. Membership will include representation from federal (military and Indian), state and local entities. Membership is voluntary and team members or special panel members shall not be remunerated by the department.

A. State level teams are organized for MMR, FIMR and CFR and are responsible for initial and/or final review of all cases, aggregate analysis of statewide data, and the identification and preparation of reports or other documents to address statewide and or local systems improvements, prevention, and risk reduction factors. State level teams are responsible for training, support and consultation to community level teams.

B. Community level teams shall be organized with training and support of state level teams, and shall abide by state level regulations, protocols and policies. The formation of community level teams shall be contingent upon available resources including consultation by specialists in appropriate disciplines. The purpose of a community team is to bring case review to the local level where identification of problems and development of interventions for systems improvements, risk reduction or prevention can take place

C. Special panels: Special ad hoc panels may be organized in response to any identified profile or cluster of fatalities that are identified by a team and the department, the OMI, or other appropriate entities as approved by the executive committee.

D. Maternal mortality review: The organizational membership of MMR shall seek to include, but not be limited to, representatives of the New Mexico section of ACOG; the New Mexico academy of family practice; the New Mexico hospital and health service association; the New Mexico association for women's health, obstetrics, and neonatal

nursing; the New Mexico department of health, public health division; the New Mexico chapter of the American college of nurse midwives; the New Mexico vital records and health statistics entity; the Indian health service; the New Mexico office of the medical investigator; tertiary center perinatologists (institutions designated as level III neonatal intensive care unit); and community obstetricians and family practitioners.

E. Fetal and infant mortality review: The organizational membership of FIMR shall seek to include but not be limited to representatives from New Mexico units of the American academy of family physicians; the American academy of pediatrics; the American anthropological association; ACOG; the American college of nurse midwives; the New Mexico hospital and health service association; the MCH Title V entity of the department; the New Mexico vital records and health statistics entity; the association of state and territorial health officials; the college of American pathologists; the march of dimes birth defects foundation; the association for women's health, obstetric and neonatal nurses; and the society of perinatal obstetricians.

F. Child fatality review: The membership of CFR shall seek to include but not be limited to representatives of the following organizations and interest areas: law enforcement; prosecution; the medical and mental health communities; tribal governments; tribal social service agencies; military bases; a domestic violence program; a grief intervention program; the New Mexico traffic safety bureau; the New Mexico sudden infant death syndrome program; a child advocacy group; the unit responsible for the investigation and prevention of child abuse and neglect in CYFD; public health epidemiology, the New Mexico vital records and health statistics entity; the MCH Title V entity in the department; a representative from OMI; a representative of the New Mexico not even one project, and a representative from the public school system.

[01/01/98; Recompiled 10/31/01]

N.M. STAT. ANN. § 7.4.5.11 (2011). CASE IDENTIFICATION:

Deaths of New Mexico residents which are registered with VRHS/NM will serve as the denominator or source file for MMR, FIMR and CFR. Deaths of non-residents which have occurred in New Mexico may not always be included.

A. MMR case identification: Deaths that meet criteria for maternal mortality review will be reported by OMI to the department designee on a monthly basis. At the closing of the VRHS/NM file for a calendar year, all deaths meeting criteria for MMR including a linked birth, death and fetal death file, will be reported by VRHS/NM to the department designee.

B. FIMR case identification: Deaths that meet criteria for fetal or infant mortality review will be reported by VRHS/NM to the department designee on a monthly basis. At the closing of the VRHS/NM file for a calendar year, all deaths meeting criteria for FIMR will be reported by VRHS/NM to the department designee.

C. CFR case identification: Deaths that meet criteria for child fatality review will be reported by OMI to the department designee on a monthly basis. At the closing of the VRHS/NM file for a calendar year, all deaths meeting criteria for child fatality review will be reported by VRHS/NM to the department designee for MCH death review.

[01/01/98; Recompiled 10/31/01]

N.M. STAT. ANN. § 7.4.5.12 (2011). DATA COLLECTION:

The department designee shall receive case identifiers from OMI and VRHS/NM and shall prepare the file for review by ascertaining what supplementary records are needed for a comprehensive case review. Case data and information are then requested from the relevant sources.

A. Non-federal sources: Relevant sources for FIMR, MMR, CFR review include but are not limited to: OMI records; providers of medical, health, nutrition and mental health care; emergency department records; emergency transport records; hospital records; records of applicable law enforcement agencies; other public safety service records such as those maintained by fire departments; records of providers of social work care including child protective services; day care records; school-based records; motor vehicle crash reports.

B. Federal sources: Deaths meeting criteria for MMR, FIMR and CFR which have occurred on military reserves or Indian reservations will require collection of case information from relevant federal agencies including but not limited to the federal bureau of investigation (FBI); the bureau of Indian affairs (BIA), the Indian health service (IHS), military and tribal police, and military and tribal social services.

C. Forms: A standard form to request information of private or public entities shall be used and which states the authority of the department with the signature of the chief medical officer of the department. The form shall be prepared, signed and dated by the department designee or the coordinator.

D. Collection of information by interview: Case review may include interviews with the decedent's family, care providers, and other relevant persons. These interviews will be conducted only with the informed consent of the interviewee.

E. Partial collection of information: In death review data collection where case information is sequestered, privileged, or confidential, the department will request information as required on the data form from appropriate agencies. Such deaths may be deferred for review until such time as the case file may be available for review.

[01/01/98; Recompiled 10/31/01]

N.M. STAT. ANN. § 7.4.5.13 (2011). CONFIDENTIALITY OF RECORDS, PROCEEDINGS AND FINDINGS:

MMR, FIMR and CFR involve the use of highly confidential case files which are protected by statute(s), regulation(s), departmental protocol, and policy.

A. Confidentiality of Information from VRHS/NM: Access to data constituting vital statistics as defined in the New Mexico Vital Statistics Act, Section 24-14-1, et seq. NMSA 1978, shall be in accordance with the Act and applicable department regulations.

B. Open records: All information and records accessed or in the possession of the MMR team, FIMR team, CFR team, or a special panel are confidential in accordance with the New Mexico Inspection of Public Records Act, Sections 14-2-1, et seq. NMSA 1978 and applicable law.

C. Member confidentiality statement: All members shall receive a training orientation regarding applicable statutes, protocols, and the rules for confidentiality. Each member is required to sign a confidentiality statement, the intent of which is to protect the confidentiality and privacy of the decedent, the decedent's family, and other individuals, agencies or providers cited in the case file. The confidentiality statement shall be signed by a team member prior to participation in case review and signed annually thereafter on July 1st or the first review session held for the state fiscal year. Experts invited for a special panel are to sign the confidentiality statement prior to participation in a case review.

D. Breach of confidentiality: Anyone who breaches confidentiality shall be subject to legal liability including, but not limited to, the provisions of the Vital Statistics Act at Sections 24-14-27 NMSA 1978 and 24-14-31 NMSA 1978.

E. Review team findings: The findings and recommendations of the MMR, FIMR, and CFR teams with respect to prevention, risk reduction or systems failures are the property of the department. They are based on retrospective case review. The process by which findings are derived is different from the understanding and judgment of a provider or any other person present at the time of caring for the decedent prior to the death. Findings and recommendations are prevention-oriented rather than investigatory. The opinions expressed are based upon an aggregate of information which has been compiled from a variety of sources post-mortem, and which was not available to any single provider at the time of death.

F. Closed meetings: Team meetings are not subject to the Open Meetings Act, Sections 10-15-1 through 10-15-4 NMSA 1978. Records of the team shall be confidential pursuant to the provisions of the Inspection of Public Records Act and Section 24-1-20 NMSA 1978 of the Public Health Act. Individuals who are not members of the team or special panel will not be allowed to be present at case reviews unless the individual is approved

by the presiding chair with the consent of the panel or team, and that individual signs the confidentiality agreement.

G. Reports of findings: Statistical studies and research reports based upon the confidential information may be published, but they will not identify decedents, their families, or provide any other information that can be extrapolated to ultimately identify these individuals. Data will be published in the aggregate.

H. Follow-up to at-risk circumstances: In the event that a team or special panel finds that there are circumstances that may place others at risk for injury or untoward exposure, the department on behalf of the team or special panel shall inform the appropriate federal, state and/or community entity in accordance with procedures and protocols established by the department.

[01/01/98; Recompiled 10/31/01]

N.M. STAT. ANN. § 7.4.5.14 (2011). SECURITY OF RECORDS:

A. Statistical information: Information from forms completed by any of the teams or its special panels will be entered without personal identifiers into a data base dedicated solely to MMR, FIMR and CFR, and will be accessed only by the team coordinator, the department designee for MCH death review, and the individual who is responsible for data base management and data entry. Personal identifiers include first, middle, and last name, and the street address of decedent or other persons, including providers.

B. Administrative information: The review forms with personal identifiers will be kept in a secure, locked location which can be accessed only by the department designee for MCH death review, the coordinator, and the individual responsible for data base management and entry.

C. Management of case documentation during review session: Team members are prohibited from leaving case reviews with any identifiable written review information that is related to cases under review, those cases which have been reviewed, and those cases which will be reviewed. All materials held by anyone other than the coordinator of the review team, the department designee for MCH death review, an OMI representative, or the designee of any of the aforementioned individuals will be collected and destroyed by the presiding chair of the team reviewing the case.

[01/01/98; Recompiled 10/31/01]

N.M. STAT. ANN. § 7.4.5.15 (2011). DISSEMINATION OF INFORMATION:

Non-identified, aggregate data and descriptive risk information will be disseminated by the MMR, FIMR or CFR team in annual reports, epidemiological bulletins to providers,

informational releases to the public regarding preventable risk, and special reports to the New Mexico legislature and other appropriate groups.

[01/01/98; Recompiled 10/31/01]

NEW YORK

N.Y. Penal Law §422-b (2011). Local and regional fatality review teams

1. A fatality review team may be established at a local or regional level, with the approval of the office of children and family services, for the purpose of investigating the death of any child whose care and custody or custody and guardianship has been transferred to an authorized agency, any child for whom child protective services has an open case, any child for whom the local department of social services has an open preventive services case, and in the case of a report made to the central register involving the death of a child. A fatality review team may also investigate any unexplained or unexpected death of any child under the age of eighteen.

2. A local or regional fatality review team may exercise the same authority as the office of children and family services with regard to the preparation of a fatality report as set forth in paragraphs (b) and (c) of subdivision five of section twenty of this chapter. Notwithstanding any other provision of law to the contrary and to the extent consistent with federal law, such local or regional fatality review team shall have access to those client-identifiable records necessary for the preparation of the report, as authorized in accordance with paragraph (d) of subdivision five of section twenty of this chapter. A fatality report prepared by a local or regional fatality review team and approved by the office of children and family services satisfies the obligation to prepare a fatality report as set forth in subdivision five of section twenty of this chapter. Such report shall be subject to the same redisclosure provisions applicable to fatality reports prepared by the office of children and family services.

3. For the purposes of this section, a local or regional fatality review team must include, but need not be limited to, representatives from the child protective service, office of children and family services, county department of health, or, should the locality not have a county department of health, the local health commissioner or his or her designee or the local public health director or his or her designee, office of the medical examiner, or, should the locality not have a medical examiner, office of the coroner, office of the district attorney, office of the county attorney, local and state law enforcement, emergency medical services and a pediatrician or comparable medical professional, preferably with expertise in the area of child abuse and maltreatment or forensic

pediatrics. A local or regional fatality review team may also include representatives from local departments of social services, mental health agencies, domestic violence agencies, substance abuse programs, hospitals, local schools, and family court.

4. A local or regional fatality review team established pursuant to this section shall have access to all records, except those protected by statutory privilege, within twenty-one days of receipt of a request.

5. Members of a local or regional fatality review team, persons attending a meeting of a local or regional fatality review team, and persons who present information to a local or regional fatality review team shall have immunity from civil and criminal liability for all reasonable and good faith actions taken pursuant to this section, and shall not be questioned in any civil or criminal proceeding regarding any opinions formed as a result of a meeting of a local or regional fatality review team. Nothing in this section shall be construed to prevent a person from testifying as to information obtained independently of a local or regional fatality review team or which is public information.

6. All meetings conducted and all reports and records made and maintained, and books and papers obtained, by a local or regional fatality review team shall be confidential and not open to the general public except by court order and except for an annual report or a fatality report, if the fatality review team chooses to complete such an annual report or fatality report. The release of any fatality report prepared by a local or regional fatality review team shall be governed by the provisions of subdivision five of section twenty of this chapter. Any such annual report or fatality report shall not contain any individually identifiable information and shall be provided to the office of children and family services upon completion. The office of children and family services shall forward copies of any such report to all other local or regional fatality review teams established pursuant to this section, to all citizen review panels established pursuant to section three hundred seventy-one-b of this chapter, and to the governor, the temporary president of the senate and the speaker of the assembly

NORTH CAROLINA

N.C. GEN. STAT. § 7B-1400 (2011). DECLARATION OF PUBLIC POLICY

The General Assembly finds that it is the public policy of this State to prevent the abuse, neglect, and death of juveniles. The General Assembly further finds that the prevention of the abuse, neglect, and death of juveniles is a community responsibility; that professionals from disparate disciplines have responsibilities for children or juveniles and have expertise that can promote their safety and well-being; and that multidisciplinary reviews of the abuse, neglect, and death of juveniles can lead to a greater understanding of the causes and methods of preventing these deaths. It is, therefore, the intent of the General Assembly, through this Article, to establish a statewide multidisciplinary,

multiagency child fatality prevention system consisting of the State Team established in G.S. 7B-1404 and the Local Teams established in G.S. 7B-1406. The purpose of the system is to assess the records of selected cases in which children are being served by child protective services and the records of all deaths of children in North Carolina from birth to age 18 in order to (i) develop a communitywide approach to the problem of child abuse and neglect, (ii) understand the causes of childhood deaths, (iii) identify any gaps or deficiencies that may exist in the delivery of services to children and their families by public agencies that are designed to prevent future child abuse, neglect, or death, and (iv) make and implement recommendations for changes to laws, rules, and policies that will support the safe and healthy development of our children and prevent future child abuse, neglect, and death.

N.C. Gen. Stat. § 7B-1401 (2011). Definitions

The following definitions apply in this Article:

(1) Additional Child Fatality. --Any death of a child that did not result from suspected abuse or neglect and about which no report of abuse or neglect had been made to the county department of social services within the previous 12 months.

(2) Local Team. --A Community Child Protection Team or a Child Fatality Prevention Team.

(3) State Team. --The North Carolina Child Fatality Prevention Team.

(4) Task Force. --The North Carolina Child Fatality Task Force.

(5) Team Coordinator. --The Child Fatality Prevention Team Coordinator.

N.C. Gen. Stat. § 7B-1402 (2011). Task Force --creation; membership; vacancies.

(a) There is created the North Carolina Child Fatality Task Force within the Department of Health and Human Services for budgetary purposes only.

(b) The Task Force shall be composed of 35 members, 11 of whom shall be ex officio members, four of whom shall be appointed by the Governor, 10 of whom shall be appointed by the Speaker of the House of Representatives, and 10 of whom shall be appointed by the President Pro Tempore of the Senate. The ex officio members other than the Chief Medical Examiner shall be nonvoting members and may designate representatives from their particular departments, divisions, or offices to represent them on the Task Force. The members shall be as follows:

- (1) The Chief Medical Examiner;
- (2) The Attorney General;
- (3) The Director of the Division of Social Services;
- (4) The Director of the State Bureau of Investigation;
- (5) The Director of the Division of Maternal and Child Health of the Department of Health and Human Services;
- (6) The Director of the Governor's Youth Advocacy and Involvement Office;
- (7) The Superintendent of Public Instruction;
- (8) The Chairman of the State Board of Education;
- (9) The Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services;
- (10) The Secretary of the Department of Health and Human Services;
- (11) The Director of the Administrative Office of the Courts;
- (12) A director of a county department of social services, appointed by the Governor upon recommendation of the President of the North Carolina Association of County Directors of Social Services;
- (13) A representative from a Sudden Infant Death Syndrome counseling and education program, appointed by the Governor upon recommendation of the Director of the Division of Maternal and Child Health of the Department of Health and Human Services;
- (14) A representative from the North Carolina Child Advocacy Institute, appointed by the Governor upon recommendation of the President of the Institute;
- (15) A director of a local department of health, appointed by the Governor upon the recommendation of the President of the North Carolina Association of Local Health Directors;
- (16) A representative from a private group, other than the North Carolina Child Advocacy Institute, that advocates for children, appointed by the Speaker of the House of Representatives upon recommendation of private child advocacy organizations;

- (17) A pediatrician, licensed to practice medicine in North Carolina, appointed by the Speaker of the House of Representatives upon recommendation of the North Carolina Pediatric Society;
- (18) A representative from the North Carolina League of Municipalities, appointed by the Speaker of the House of Representatives upon recommendation of the League;
- (18a) A representative from the North Carolina Domestic Violence Commission, appointed by the Speaker of the House of Representatives upon recommendation of the Director of the Commission;
- (19) One public member, appointed by the Speaker of the House of Representatives;
- (20) A county or municipal law enforcement officer, appointed by the President Pro Tempore of the Senate upon recommendation of organizations that represent local law enforcement officers;
- (21) A district attorney, appointed by the President Pro Tempore of the Senate upon recommendation of the President of the North Carolina Conference of District Attorneys;
- (22) A representative from the North Carolina Association of County Commissioners, appointed by the President Pro Tempore of the Senate upon recommendation of the Association;
- (22a) A representative from the North Carolina Coalition Against Domestic Violence, appointed by the President Pro Tempore of the Senate upon recommendation of the Executive Director of the Coalition;
- (23) One public member, appointed by the President Pro Tempore of the Senate; and
- (24) Five members of the Senate, appointed by the President Pro Tempore of the Senate, and five members of the House of Representatives, appointed by the Speaker of the House of Representatives.
- (c) All members of the Task Force are voting members. Vacancies in the appointed membership shall be filled by the appointing officer who made the initial appointment. Terms shall be two years. The members shall elect a chair who shall preside for the duration of the chair's term as member. In the event a vacancy occurs in the chair before the expiration of the chair's term, the members shall elect an acting chair to serve for the remainder of the unexpired term.

N.C. Gen. Stat. § 7B-1403 (2011). Task Force --duties

The Task Force shall:

- (1) Undertake a statistical study of the incidences and causes of child deaths in this State and establish a profile of child deaths. The study shall include (i) an analysis of all community and private and public agency involvement with the decedents and their families prior to death, and (ii) an analysis of child deaths by age, cause, and geographic distribution;
- (2) Develop a system for multidisciplinary review of child deaths. In developing such a system, the Task Force shall study the operation of existing Local Teams. The Task Force shall also consider the feasibility and desirability of local or regional review teams and, should it determine such teams to be feasible and desirable, develop guidelines for the operation of the teams. The Task Force shall also examine the laws, rules, and policies relating to confidentiality of and access to information that affect those agencies with responsibilities for children, including State and local health, mental health, social services, education, and law enforcement agencies, to determine whether those laws, rules, and policies inappropriately impede the exchange of information necessary to protect children from preventable deaths, and, if so, recommend changes to them;
- (3) Receive and consider reports from the State Team; and
- (4) Perform any other studies, evaluations, or determinations the Task Force considers necessary to carry out its mandate.

N.C. Gen. Stat. § 7B-1404 (2011). State Team --creation; membership; vacancies

- (a) There is created the North Carolina Child Fatality Prevention Team within the Department of Health and Human Services for budgetary purposes only.
- (b) The State Team shall be composed of the following 11 members of whom nine members are ex officio and two are appointed:
 - (1) The Chief Medical Examiner, who shall chair the State Team;
 - (2) The Attorney General;
 - (3) The Director of the Division of Social Services, Department of Health and Human Services;
 - (4) The Director of the State Bureau of Investigation;
 - (5) The Director of the Division of Maternal and Child Health of the Department of Health and Human Services;

- (6) The Superintendent of Public Instruction;
- (7) The Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services;
- (8) The Director of the Administrative Office of the Courts;
- (9) The pediatrician appointed pursuant to G.S. 7B-1402(b) to the Task Force;
- (10) A public member, appointed by the Governor; and
- (11) The Team Coordinator.

The ex officio members other than the Chief Medical Examiner may designate a representative from their departments, divisions, or offices to represent them on the State Team.

(c) All members of the State Team are voting members. Vacancies in the appointed membership shall be filled by the appointing officer who made the initial appointment.

N.C. Gen. Stat. § 7B-1405 (2011). State Team --duties

The State Team shall:

- (1) Review current deaths of children when those deaths are attributed to child abuse or neglect or when the decedent was reported as an abused or neglected juvenile pursuant to G.S. 7B-301 at any time before death;
- (2) Report to the Task Force during the existence of the Task Force, in the format and at the time required by the Task Force, on the State Team's activities and its recommendations for changes to any law, rule, and policy that would promote the safety and well-being of children;
- (3) Upon request of a Local Team, provide technical assistance to the Team;
- (4) Periodically assess the operations of the multidisciplinary child fatality prevention system and make recommendations for changes as needed;
- (5) Work with the Team Coordinator to develop guidelines for selecting child deaths to receive detailed, multidisciplinary death reviews by Local Teams that review cases of additional child fatalities; and

(6) Receive reports of findings and recommendations from Local Teams that review cases of additional child fatalities and work with the Team Coordinator to implement recommendations.

N.C. Gen. Stat. § 7B-1406 (2011). Community Child Protection Teams; Child Fatality Prevention Teams; creation and duties

(a) Community Child Protection Teams are established in every county of the State. Each Community Child Protection Team shall:

(1) Review, in accordance with the procedures established by the director of the county department of social services under G.S. 7B-1409:

a. Selected active cases in which children are being served by child protective services; and

b. Cases in which a child died as a result of suspected abuse or neglect, and

1. A report of abuse or neglect has been made about the child or the child's family to the county department of social services within the previous 12 months, or

2. The child or the child's family was a recipient of child protective services within the previous 12 months.

(2) Submit annually to the board of county commissioners recommendations, if any, and advocate for system improvements and needed resources where gaps and deficiencies may exist.

In addition, each Community Child Protection Team may review the records of all additional child fatalities and report findings in connection with these reviews to the Team Coordinator.

(b) Any Community Child Protection Team that determines it will not review additional child fatalities shall notify the Team Coordinator. In accordance with the plan established under G.S. 7B-1408(1), a separate Child Fatality Prevention Team shall be established in that county to conduct these reviews. Each Child Fatality Prevention Team shall:

(1) Review the records of all cases of additional child fatalities.

(2) Submit annually to the board of county commissioners recommendations, if any, and advocate for system improvements and needed resources where gaps and deficiencies may exist.

(3) Report findings in connection with these reviews to the Team Coordinator.

(c) All reports to the Team Coordinator under this section shall include:

(1) A listing of the system problems identified through the review process and recommendations for preventive actions;

(2) Any changes that resulted from the recommendations made by the Local Team;

(3) Information about each death reviewed; and

(4) Any additional information requested by the Team Coordinator.

N.C. Gen. Stat. § 7B-1407 (2011). Local Teams; composition

(a) Each Local Team shall consist of representatives of public and nonpublic agencies in the community that provide services to children and their families and other individuals who represent the community. No single team shall encompass a geographic or governmental area larger than one county.

(b) Each Local Team shall consist of the following persons:

(1) The director of the county department of social services and a member of the director's staff;

(2) A local law enforcement officer, appointed by the board of county commissioners;

(3) An attorney from the district attorney's office, appointed by the district attorney;

(4) The executive director of the local community action agency, as defined by the Department of Health and Human Services, or the executive director's designee;

(5) The superintendent of each local school administrative unit located in the county, or the superintendent's designee;

(6) A member of the county board of social services, appointed by the chair of that board;

(7) A local mental health professional, appointed by the director of the area authority established under Chapter 122C of the General Statutes;

(8) The local guardian ad litem coordinator, or the coordinator's designee;

(9) The director of the local department of public health; and

(10) A local health care provider, appointed by the local board of health.

(c) In addition, a Local Team that reviews the records of additional child fatalities shall include the following five additional members:

(1) An emergency medical services provider or firefighter, appointed by the board of county commissioners;

(2) A district court judge, appointed by the chief district court judge in that district;

(3) A county medical examiner, appointed by the Chief Medical Examiner;

(4) A representative of a local child care facility or Head Start program, appointed by the director of the county department of social services; and

(5) A parent of a child who died before reaching the child's eighteenth birthday, to be appointed by the board of county commissioners.

(d) The Team Coordinator shall serve as an ex officio member of each Local Team that reviews the records of additional child fatalities. The board of county commissioners may appoint a maximum of five additional members to represent county agencies or the community at large to serve on any Local Team. Vacancies on a Local Team shall be filled by the original appointing authority.

(e) Each Local Team shall elect a member to serve as chair at the Team's pleasure.

(f) Each Local Team shall meet at least four times each year.

(g) The director of the local department of social services shall call the first meeting of the Community Child Protection Team. The director of the local department of health, upon consultation with the Team Coordinator, shall call the first meeting of the Child Fatality Prevention Team. Thereafter, the chair of each Local Team shall schedule the time and place of meetings, in consultation with these directors, and shall prepare the agenda. The chair shall schedule Team meetings no less often than once per quarter and often enough to allow adequate review of the cases selected for review. Within three months of election, the chair shall participate in the appropriate training developed under this Article.

N.C. Gen. Stat. § 7B-1408 (2011). Child Fatality Prevention Team Coordinator; duties

The Child Fatality Prevention Team Coordinator shall serve as liaison between the State Team and the Local Teams that review records of additional child fatalities and shall provide technical assistance to these Local Teams. The Team Coordinator shall:

- (1) Develop a plan to establish Local Teams that review the records of additional child fatalities in each county.
- (2) Develop model operating procedures for these Local Teams that address when public meetings should be held, what items should be addressed in public meetings, what information may be released in written reports, and any other information the Team Coordinator considers necessary.
- (3) Provide structured training for these Local Teams at the time of their establishment, and continuing technical assistance thereafter.
- (4) Provide statistical information on all child deaths occurring in each county to the appropriate Local Team, and assure that all child deaths in a county are assessed through the multidisciplinary system.
- (5) Monitor the work of these Local Teams.
- (6) Receive reports of findings, and other reports that the Team Coordinator may require, from these Local Teams.
- (7) Report the aggregated findings of these Local Teams to each Local Team that reviews the records of additional child fatalities and to the State Team.
- (8) Evaluate the impact of local efforts to identify problems and make changes.

N.C. Gen. Stat. § 7B-1409 (2011). Community Child Protection Teams; duties of the director of the county department of social services

In addition to any other duties as a member of the Community Child Protection Team, and in connection with the reviews under G.S. 7B-1406(a)(1), the director of the county department of social services shall:

- (1) Assure the development of written operating procedures in connection with these reviews, including frequency of meetings, confidentiality policies, training of members, and duties and responsibilities of members;
- (2) Assure that the Team defines the categories of cases that are subject to its review;
- (3) Determine and initiate the cases for review;

- (4) Bring for review any case requested by a Team member;
- (5) Provide staff support for these reviews;
- (6) Maintain records, including minutes of all official meetings, lists of participants for each meeting of the Team, and signed confidentiality statements required under G.S. 7B-1413, in compliance with applicable rules and law; and
- (7) Report quarterly to the county board of social services, or as required by the board, on the activities of the Team.

N.C. Gen. Stat. § 7B-1410 (2011). Local Teams; duties of the director of the local department of health

In addition to any other duties as a member of the Local Team and in connection with reviews of additional child fatalities, the director of the local department of health shall:

- (1) Distribute copies of the written procedures developed by the Team Coordinator under G.S. 7B-1408 to the administrators of all agencies represented on the Local Team and to all members of the Local Team;
- (2) Maintain records, including minutes of all official meetings, lists of participants for each meeting of the Local Team, and signed confidentiality statements required under G.S. 7B-1413, in compliance with applicable rules and law;
- (3) Provide staff support for these reviews; and
- (4) Report quarterly to the local board of health, or as required by the board, on the activities of the Local Team.

N.C. Gen. Stat. § 7B-1411 (2011). Community Child Protection Teams; responsibility for training of team members

The Division of Social Services, Department of Health and Human Services, shall develop and make available, on an ongoing basis, for the members of Local Teams that review active cases in which children are being served by child protective services, training materials that address the role and function of the Local Team, confidentiality requirements, an overview of child protective services law and policy, and Team record keeping.

N.C. Gen. Stat. § 7B-1412 (2011). Task Force --reports

The Task Force shall report annually to the Governor and General Assembly, within the first week of the convening or reconvening of the General Assembly. The report shall contain at least a summary of the conclusions and recommendations for each of the Task Force's duties, as well as any other recommendations for changes to any law, rule, or policy that it has determined will promote the safety and well-being of children. Any recommendations of changes to law, rule, or policy shall be accompanied by specific legislative or policy proposals and detailed fiscal notes setting forth the costs to the State.

N.C. Gen. Stat. § 7B-1413 (2011). Access to records

(a) The State Team, the Local Teams, and the Task Force during its existence, shall have access to all medical records, hospital records, and records maintained by this State, any county, or any local agency as necessary to carry out the purposes of this Article, including police investigations data, medical examiner investigative data, health records, mental health records, and social services records. The State Team, the Task Force, and the Local Teams shall not, as part of the reviews authorized under this Article, contact, question, or interview the child, the parent of the child, or any other family member of the child whose record is being reviewed. Any member of a Local Team may share, only in an official meeting of that Local Team, any information available to that member that the Local Team needs to carry out its duties.

(b) Meetings of the State Team and the Local Teams are not subject to the provisions of Article 33C of Chapter 143 of the General Statutes. However, the Local Teams may hold periodic public meetings to discuss, in a general manner not revealing confidential information about children and families, the findings of their reviews and their recommendations for preventive actions. Minutes of all public meetings, excluding those of executive sessions, shall be kept in compliance with Article 33C of Chapter 143 of the General Statutes. Any minutes or any other information generated during any closed session shall be sealed from public inspection.

(c) All otherwise confidential information and records acquired by the State Team, the Local Teams, and the Task Force during its existence, in the exercise of their duties are confidential; are not subject to discovery or introduction into evidence in any proceedings; and may only be disclosed as necessary to carry out the purposes of the State Team, the Local Teams, and the Task Force. In addition, all otherwise confidential information and records created by a Local Team in the exercise of its duties are confidential; are not subject to discovery or introduction into evidence in any proceedings; and may only be disclosed as necessary to carry out the purposes of the Local Team. No member of the State Team, a Local Team, nor any person who attends a meeting of the State Team or a Local Team, may testify in any proceeding about what transpired at the meeting, about information presented at the meeting, or about opinions

formed by the person as a result of the meetings. This subsection shall not, however, prohibit a person from testifying in a civil or criminal action about matters within that person's independent knowledge.

(d) Each member of a Local Team and invited participant shall sign a statement indicating an understanding of and adherence to confidentiality requirements, including the possible civil or criminal consequences of any breach of confidentiality.

(e) Cases receiving child protective services at the time of review by a Local Team shall have an entry in the child's protective services record to indicate that the case was received by that Team. Additional entry into the record shall be at the discretion of the director of the county department of social services.

(f) The Social Services Commission shall adopt rules to implement this section in connection with reviews conducted by Community Child Protection Teams. The Commission for Public Health shall adopt rules to implement this section in connection with Local Teams that review additional child fatalities. In particular, these rules shall allow information generated by an executive session of a Local Team to be accessible for administrative or research purposes only.

N.C. Gen. Stat. § 7B-1414 (2011). Administration; funding

(a) To the extent of funds available, the chairs of the Task Force and State Team may hire staff or consultants to assist the Task Force and the State Team in completing their duties.

(b) Members, staff, and consultants of the Task Force or State Team shall receive travel and subsistence expenses in accordance with the provisions of G.S. 138-5 or G.S. 138-6, as the case may be, paid from funds appropriated to implement this Article and within the limits of those funds.

(c) With the approval of the Legislative Services Commission, legislative staff and space in the Legislative Building and the Legislative Office Building may be made available to the Task Force.

NORTH DAKOTA

N.D. Cent. Code § 50-25.1-04.2 (2011). Child fatality review panel

The state child protection team shall serve as a child fatality review panel. The department shall appoint a peace officer licensed in the state, a mental health professional, and any other person as appropriate to assist the panel in the performance of its duties. The department, in coordination with the state department of health, shall adopt

rules for the operation of the panel. Panel members are not entitled to compensation or reimbursement of expenses for service on the panel.

N.D. Cent. Code § 50-25.1-04.3 (2011). Child fatality review panel--Duties

The child fatality review panel shall meet at least semiannually to review the deaths of all minors which occurred in the state during the preceding six months and to identify trends or patterns in the deaths of minors. The panel shall promote:

1. Interagency communication for the management of child death cases and for the management of future nonfatal cases.
2. Effective criminal, civil, and social intervention for families with fatalities.
3. Intervention and counseling of surviving and at-risk siblings, and offer the same.
4. Interagency use of cases to audit the total health and social service systems and to minimize misclassification of cause of death.
5. Evaluation of the impact of specific risk factors including substance abuse, domestic violence, and prior child abuse.
6. Interagency services to high-risk families.
7. Data collection for surveillance of deaths and the study of categories of causes of death.
8. The use of media to educate the public about child abuse prevention.
9. Intercounty and interstate communications regarding child death.
10. Use of local child protection team members as local child fatality review panelists.
11. Information that apprises a parent or guardian of the parent's or guardian's rights and the procedures taken after the death of a child.

N.D. Cent. Code § 50-25.1-04.4 (2011). Child fatality review panel--Access to records

Upon the request of a coroner or the presiding officer of a child fatality review panel, any hospital, physician, medical professional, medical facility, mental health professional, mental health facility, school counselor, or division of juvenile services employee shall disclose all records of that entity with respect to any child who has or is eligible to receive a certificate of live birth and who has died. The person submitting the request

shall reimburse the disclosing entity for the actual costs of assembling and disclosing the information.

N.D. Cent. Code § 50-25.1-04.5 (2011). Child fatality review panel--Confidentiality of meetings, documentation, and reports

Notwithstanding section 44-04-19, all meetings of the panel are closed to the public.

Notwithstanding section 44-04-18, all documentation and reports, except for an annual report, of the panel are confidential. The panel shall make available to the persons designated in section 50-25.1-11 the documentation and reports of the panel.

OHIO

OHIO REV. CODE ANN. § 307.621 (2011). Child fatality review board; regional child fatality review board

A board of county commissioners shall appoint a health commissioner of the board of health of a city or general health district that is entirely or partially located in the county in which the board of county commissioners is located to establish a child fatality review board to review the deaths of children under eighteen years of age. The boards of county commissioners of two or more counties may, by adopting a joint resolution passed by a majority of the members of each participating board of county commissioners, create a regional child fatality review board to serve all participating counties. The joint resolution shall appoint, for each county participating as part of the regional review board, one health commissioner from a board of health of a city or general health district located at least in part in each county. The health commissioners appointed shall select one of their number as the health commissioner to establish the regional review board. The regional review board shall be established in the same manner as provided for single county review boards.

In any county that has a body acting as a child fatality review board on the effective date of this section, the board of county commissioners of that county, in lieu of having a health commissioner establish a child fatality review board, shall appoint that body to function as the child fatality review board for the county. The body shall have the same duties, obligations, and protections as a child fatality review board appointed by a health commissioner. The board of county commissioners or an individual designated by the board shall convene the body as required by section 307.624 of the Revised Code.

OHIO REV. CODE ANN. § 307.622 (2011). Members

(A) The health commissioner of the board of health of a city or a general health district who is appointed under section 307.621 of the Revised Code to establish the child fatality review board shall select six members to serve on the child fatality review board along with the commissioner. The review board shall consist of the following:

National Center for Prosecution of Child Abuse
National District Attorney Association

- (1) A county coroner or designee;
 - (2) The chief of police of a police department or the sheriff that serves the greatest population in the county or region or a designee of the chief or sheriff;
 - (3) The executive director of a public children services agency or designee;
 - (4) A public health official or designee;
 - (5) The executive director of a board of alcohol, drug addiction, and mental health services or designee;
 - (6) A physician who holds a certificate issued pursuant to Chapter 4731. of the Revised Code authorizing the practice of medicine and surgery or osteopathic medicine and surgery, specializes in pediatric or family medicine, and currently practices pediatric or family medicine.
- (B) The majority of the members of a review board may invite additional members to serve on the board. The additional members invited under this division shall serve for a period of time determined by a majority of the members described in division (A) of this section. An additional member shall have the same authority, duties, and responsibilities as members described in division (A) of this section.
- (C) A vacancy in a child fatality review board shall be filled in the same manner as the original appointment.
- (D) A child fatality review board member shall not receive any compensation for, and shall not be paid for any expenses incurred pursuant to, fulfilling the member's duties on the board unless compensation for, or payment for expenses incurred pursuant to, those duties is received pursuant to a member's regular employment.

OHIO REV. CODE ANN. § 307.623 (2011). Purpose of child fatality review board

The purpose of the child fatality review board is to decrease the incidence of preventable child deaths by doing all of the following:

- (A) Promoting cooperation, collaboration, and communication between all groups, professions, agencies, or entities that serve families and children;
- (B) Maintaining a comprehensive database of all child deaths that occur in the county or region served by the child fatality review board in order to develop an understanding of the causes and incidence of those deaths;

(C) Recommending and developing plans for implementing local service and program changes and changes to the groups, professions, agencies, or entities that serve families and children that might prevent child deaths;

(D) Advising the department of health of aggregate data, trends, and patterns concerning child deaths.

OHIO REV. CODE ANN. § 307.624 (2011). Chairperson

The board of county commissioners, or if a regional child fatality review board is established, the group of health commissioners appointed to select the health commissioner to establish the regional review board, shall designate either the health commissioner that establishes the review board or a representative of the health commissioner to convene meetings and be the chairperson of the review board. If a regional review board includes a county with more than one health district, the regional review board meeting shall be convened in that county. If more than one of the counties participating on the regional review board has more than one health district, the person convening the meeting shall select one of the counties with more than one health district as the county in which to convene the meeting. The person designated to convene the review board shall convene it at least once a year to review, in accordance with this section and the rules adopted by the department of health under section 3701.045 of the Revised Code, the deaths of all children under eighteen years of age who, at the time of death, were residents of the county or, if a regional review board, one of the participating counties.

OHIO REV. CODE ANN. § 307.625 (2011). Review of death of child prohibited while investigation or prosecution pending

A child fatality review board may not conduct a review of the death of a child described in section 307.624 of the Revised Code while an investigation of the death or prosecution of a person for causing the death is pending unless the prosecuting attorney agrees to allow the review. The law enforcement agency conducting the criminal investigation, on the conclusion of the investigation, and the prosecuting attorney prosecuting the case, on the conclusion of the prosecution, shall notify the chairperson of the review board of the conclusion.

OHIO REV. CODE ANN. § 307.626 (2011). Report

(A) By the first day of April of each year, the person convening the child fatality review board shall prepare and submit to the Ohio department of health a report that summarizes the following information with respect to the child deaths that were reviewed by the review board in the previous calendar year:

(1) The cause of death;

- (2) Factors contributing to death;
- (3) Age;
- (4) Sex;
- (5) Race;
- (6) The geographic location of death;
- (7) The year of death.

The report shall specify the number of child deaths that were not reviewed during the previous calendar year.

The report may include recommendations for actions that might prevent other deaths, as well as any other information the review board determines should be included.

(B) Reports prepared under division (A) of this section shall be considered public records under section 149.43 of the Revised Code.

(C) The child fatality review board shall submit individual data with respect to each child death review into the Ohio department of health child death review database or the national child death review database. The individual data shall include the information specified in division (A) of this section and any other information the board considers relevant to the review. Individual data related to a child death review that is contained in the Ohio department of health child death review database is not a public record under section 149.43 of the Revised Code.

OHIO REV. CODE ANN. § 307.627 (2011). Summary sheet of information

(A) Notwithstanding section 3701.243 and any other section of the Revised Code pertaining to confidentiality, any individual; public children services agency, private child placing agency, or agency that provides services specifically to individuals or families; law enforcement agency; or other public or private entity that provided services to a child whose death is being reviewed by a child fatality review board, on the request of the review board, shall submit to the review board a summary sheet of information. With respect to a request made to a health care entity, the summary sheet shall contain only information available and reasonably drawn from the child's medical record created by the health care entity. With respect to a request made to any other individual or entity, the summary shall contain only information available and reasonably drawn from any record involving the child that the individual or entity develops in the normal course of business. On the request of the review board, an individual or entity may, at the

individual or entity's discretion, make any additional information, documents, or reports available to the review board. For purposes of the review, the review board shall have access to confidential information provided to the review board under this division or division (H)(4) of section 2151.421 of the Revised Code, and each member of the review board shall preserve the confidentiality of that information.

(B) Notwithstanding division (A) of this section, no person, entity, law enforcement agency, or prosecuting attorney shall provide any information regarding the death of a child to a child fatality review board while an investigation of the death or prosecution of a person for causing the death is pending unless the prosecuting attorney has agreed pursuant to section 307.625 of the Revised Code to allow review of the death.

OHIO REV. CODE ANN. § 307.628 (2011). Immunity from liability

(A) An individual or public or private entity providing information, documents, or reports to a child fatality review board is immune from any civil liability for injury, death, or loss to person or property that otherwise might be incurred or imposed as a result of providing the information, documents, or reports to the review board.

(B) Each member of a review board is immune from any civil liability for injury, death, or loss to person or property that might otherwise be incurred or imposed as a result of the member's participation on the review board.

OHIO REV. CODE ANN. § 307.629 (2011). Confidentiality

(A) Except as provided in sections 5153.171 to 5153.173 of the Revised Code, any information, document, or report presented to a child fatality review board, all statements made by review board members during meetings of the review board, all work products of the review board, and child fatality review data submitted by the child fatality review board to the department of health or a national child death review database, other than the report prepared pursuant to division (A) of section 307.626 of the Revised Code, are confidential and shall be used by the review board, its members, and the department of health only in the exercise of the proper functions of the review board and the department.

(B) No person shall permit or encourage the unauthorized dissemination of the confidential information described in division (A) of this section.

(C) Whoever violates division (B) of this section is guilty of a misdemeanor of the second degree.

OKLAHOMA

OKLA. STAT. ANN. TIT. 10, § 1150 (2011). Child Death Review Board Act

Short title Sections 1 through 6 of this act [FN1] shall be known and may be cited as the “Child Death Review Board Act”.

[FN1] Title 10, § 1150 et seq.

OKLA. STAT. ANN. TIT. 10, § 1150.1 (2011). Definitions

As used in the Child Death Review Board Act: [FN1]

1. “Board” means the Child Death Review Board;
2. “Child protection system” means public and private agencies, medical personnel, courts, law enforcement agencies and legal, education and social service professionals with responsibilities related to child abuse and neglect; and
3. “Commission” means the Oklahoma Commission on Children and Youth.

[FN1] Title 10, § 1150 et seq.

OKLA. STAT. ANN. TIT. 10, § 1150.2 (2011). Child Death Review Board--Creation--Powers and duties--Meetings and discussions--Annual report

A. There is hereby re-created until July 1, 2012, in accordance with the Oklahoma Sunset Law, [FN1] the Child Death Review Board within the Oklahoma Commission on Children and Youth. The Board shall have the power and duty to:

1. Conduct case reviews of deaths and near deaths of children in this state;
2. Develop accurate statistical information and identification of deaths of children due to abuse and neglect;
3. Improve the ability to provide protective services to the surviving siblings of a child or children who die of abuse or neglect and who may be living in a dangerous environment;
4. Improve policies, procedures and practices within the agencies that serve children, including the child protection system;

5. Enter into agreements with local teams established by the Child Death Review Board to carry out such duties and responsibilities as the Child Death Review Board shall designate, including reviewing cases assigned by the Board in the geographical area for that local team. The Oklahoma Commission on Children and Youth, with the advice of the Child Death Review Board, shall promulgate rules as necessary for the implementation and administration of the provisions of this paragraph; and
6. Enter into agreements with other state, local, or private entities as necessary to carry out the duties of the Child Death Review Board including, but not limited to, conducting joint reviews with the Domestic Violence Fatality Review Board on domestic violence cases involving child death or child near-death incidents.

B. In carrying out its duties and responsibilities the Board shall:

1. Establish criteria for cases involving the death or near death of a child subject to specific, in-depth review by the Board. As used in this section, the term “near death” means a child is in serious or critical condition, as certified by a physician, as a result of abuse or neglect;
2. Conduct a specific case review of those cases where the cause of death or near death is or may be related to abuse or neglect of a child;
3. Establish and maintain statistical information related to the deaths and near deaths of children including, but not limited to, demographic and medical diagnostic information;
4. Establish procedures for obtaining initial information regarding near deaths of children from the Department of Human Services and law enforcement agencies;
5. Review the policies, practices, and procedures of the child protection system and make specific recommendations to the entities comprising the child protection system for actions necessary for the improvement of the system;
6. Review the extent to which the state child protection system is coordinated with foster care and adoption programs and evaluate whether the state is efficiently discharging its child protection responsibilities under the federal Child Abuse Prevention and Treatment Act [FN2] state plan;
7. As necessary and appropriate, for the protection of the siblings of a child who dies and whose siblings are deemed to be living in a dangerous environment, refer specific cases to the Department of Human Services or the appropriate district attorney for further investigation;
8. Request and obtain a copy of all records and reports pertaining to a child whose case is under review including, but not limited to:

- a. the report of the medical examiner,
- b. hospital records,
- c. school records,
- d. court records,
- e. prosecutorial records,
- f. local, state, and federal law enforcement records including, but not limited to, the Oklahoma State Bureau of Investigation (OSBI),
- g. fire department records,
- h. State Department of Health records, including birth certificate records,
- i. medical and dental records,
- j. Department of Mental Health and Substance Abuse Services and other mental health records,
- k. emergency medical service records,
- l. files of the Department of Human Services, and
- m. records in the possession of the Domestic Violence Fatality Review Board when conducting a joint review pursuant to paragraph 6 of subsection A of this section.

Confidential information provided to the Board shall be maintained by the Board in a confidential manner as otherwise required by state and federal law. Any person damaged by disclosure of such confidential information by the Board, its local boards or their members, not authorized by law, may maintain an action for damages, costs and attorney fees;

9. Maintain all confidential information, documents and records in possession of the Board as confidential and not subject to subpoena or discovery in any civil or criminal proceedings; provided, however, information, documents and records otherwise available from other sources shall not be exempt from subpoena or discovery through those sources solely because such information, documents and records were presented to or reviewed by the Board;

10. Conduct reviews of specific cases of deaths and near deaths of children and request the preparation of additional information and reports as determined to be necessary by the Board including, but not limited to, clinical summaries from treating physicians, chronologies of contact, and second opinion autopsies;

11. Report, if recommended by a majority vote of the Board, to the President Pro Tempore of the Senate and the Speaker of the House of Representatives any gross neglect of duty by any state officer or state employee, or any problem within the child protective services system discovered by the Board while performing its duties;

12. Recommend, when appropriate, amendment of the cause or manner of death listed on the death certificate; and

13. Subject to the approval of the Oklahoma Commission on Children and Youth, exercise all incidental powers necessary and proper for the implementation and administration of the Child Death Review Board Act.

C. The review and discussion of individual cases of death or near death of a child shall be conducted in executive session and in compliance with the confidentiality requirements of Section 7005-1.2 of this title. All other business shall be conducted in accordance with the provisions of the Oklahoma Open Meeting Act. [FN3] All discussions of individual cases and any writings produced by or created for the Board in the course of its remedial measure and recommended by the Board, as the result of a review of an individual case of the death or near death of a child, shall be privileged and shall not be admissible in evidence in any proceeding. The Board shall periodically conduct meetings to discuss organization and business matters and any actions or recommendations aimed at improvement of the child protection system which shall be subject to the Oklahoma Open Meeting Act. Part of any meeting of the Board may be specifically designated as a business meeting of the Board subject to the Oklahoma Open Meeting Act.

D. 1. The Board shall submit an annual statistical report on the incidence and causes of death and near death of children in this state for which the Board has completed its review during the past calendar year, including its recommendations, to the Oklahoma Commission on Children and Youth on or before May 1 of each year. The Board shall also prepare and make available to the public, on an annual basis, a report containing a summary of the activities of the Board relating to the review of deaths and near deaths of children, the extent to which the state child protection system is coordinated with foster care and adoption programs, and an evaluation of whether the state is efficiently discharging its child protection responsibilities. The report shall be completed no later than December 31 of each year.

2. The Oklahoma Commission on Children and Youth shall review the report of the Board and, as appropriate, incorporate the findings and recommendations into the annual Commission report and the State Plan for Services to Children and Youth.

[FN1] Title 74, § 3901 et seq.

[FN2] 42 U.S.C.A. § 5101 et seq.

[FN3] Title 25, § 301 et seq.

OKLA. STAT. ANN. TIT. 10, § 1150.2A (2011). Production of documents--Subpoena

A. In any investigation relating to the functions of the Child Death Review Board pursuant to Section 1150.2 of Title 10 of the Oklahoma Statutes, the Director of the Oklahoma Commission on Children and Youth, if recommended and approved by the Child Death Review Board and the legal counsel for the Governor, may require the production of, by subpoena, any records, including books, papers, documents, and other tangible things which constitute or contain evidence which the Board finds relevant or material to the investigation, if the Board has been unable to obtain the necessary information by requesting it. The production of records may be required from any place in the state to be forwarded to the Child Death Review Board. Reasonable copying fees shall be paid upon request.

B. Compliance with the subpoena may be accomplished by:

1. Producing documents, as requested; or
2. Notifying the Board, in writing, of refusal to produce documents, within ten (10) days of the date of service.

The subpoena form shall clearly set forth the optional means of compliance including instructions for sending written notice of refusal.

C. A subpoena issued pursuant to this section may be served by any person designated in the subpoena to serve it. Service upon a natural person may be made by personal delivery of the subpoena to the person. Service may be made upon a domestic or foreign corporation or upon a partnership or other unincorporated association which is subject to suit under a common name, by delivering the subpoena to an officer, to a managing or general agent, or to any other agent authorized by appointment or by law to receive service of process. The affidavit of the person serving the subpoena entered on a true copy thereof by the person serving it shall be proof of service.

D. In the case of refusal to obey a subpoena issued to any person, the Director of the Oklahoma Commission on Children and Youth may invoke the aid of any district court of the state within the jurisdiction of which the investigation is carried on or of which the subpoenaed person is an inhabitant, or in which such person conducts business or may be

found, to compel compliance with the subpoena. The court may issue an order requiring the subpoenaed person to appear before the Director to produce records, if so ordered. Any failure to obey the order of the court may be punished by the court as an indirect contempt thereof. All process in any such case may be served in any judicial district in which such person may be found.

E. The district court of the county wherein the subpoena is served may quash a subpoena issued pursuant to this section upon a motion to quash the subpoena filed with the court by the party to whom the subpoena is issued.

OKLA. STAT. ANN. TIT. 10, § 1150.3(2011). Board--Membership--Officers--Meetings--Compensation--Administrative assistance and services

A. The Child Death Review Board shall be composed of twenty-seven (27) members, or their designees, as follows:

1. Fourteen of the members shall be:

- a. the Chief Medical Examiner,
- b. the Director of the Department of Human Services, or a designee, provided the designee shall be a person assigned to the Child Welfare Division of the Department,
- c. the State Commissioner of Health,
- d. the Director of the Office of Child Abuse Prevention,
- e. the Director of the Oklahoma Commission on Children and Youth,
- f. the Chief Child Abuse Medical Examiner,
- g. the Chief of Maternal and Child Health Services of the State Department of Health,
- h. the Commissioner of Mental Health and Substance Abuse Services,
- i. the Chair of the Child Protection Committee of the Children's Hospital of Oklahoma,
- j. the Director of the Office of Juvenile Affairs,
- k. the Chief of Injury Prevention Services of the State Department of Health,
- l. the State Epidemiologist of the State Department of Health,

- m. the Director of the Oklahoma State Bureau of Investigation, and
 - n. the Chief Executive Officer of the Oklahoma Health Care Authority; and
2. Thirteen of the members shall be appointed by the Director of the Oklahoma Commission on Children and Youth, shall serve for terms of two (2) years, and shall be eligible for reappointment. The members shall be persons having training and experience in matters related to the abuse or neglect of a child. The appointed members shall include:
- a. a law enforcement officer selected from lists submitted by the executive boards of organizations representing sheriffs and peace officers in this state,
 - b. an attorney licensed in this state who is in private practice selected from a list submitted by the executive board of the Oklahoma Bar Association,
 - c. a district attorney selected from a list submitted by the District Attorney's Council,
 - d. a physician selected from lists submitted by statewide organizations representing physicians in this state,
 - e. a physician selected from lists submitted by statewide organizations representing osteopathic physicians in this state,
 - f. a member of the State Post-Adjudication Review Advisory Board,
 - g. a social worker selected from a list submitted by each organization representing social workers,
 - h. an individual selected from lists submitted by Oklahoma court-appointed special advocate associations,
 - i. a psychologist selected from lists submitted by Oklahoma psychological associations,
 - j. a member of a Native American Tribe involved in the area of protection of Native American children selected from a list submitted by the Oklahoma Indian Affairs Commission,
 - k. an individual selected from lists submitted by Oklahoma coalitions or associations against domestic violence and sexual assault,
 - l. a pediatric physician selected from lists submitted by organizations of pediatric physicians or osteopaths, and
 - m. a member of an emergency medical technicians association.

B. Every two (2) years the Board shall elect from among its membership a chair and a vice-chair. The Board shall meet at least quarterly and may meet more frequently as necessary as determined by the chair. Members shall serve without compensation but may be reimbursed for necessary travel out of funds available to the Commission pursuant to the State Travel Reimbursement Act [FN1]; provided, that the reimbursement shall be paid in the case of state employee members by the agency employing the member.

C. With funds appropriated or otherwise available for that purpose, the Commission shall provide administrative assistance and services to the Child Death Review Board.

[FN1] Title 74, § 500.1 et seq.

OKLA. STAT. ANN. TIT. 10, § 1150.4(2011). Chief Medical Examiner--Monthly death reports--Review of child death certificates--Requests for information

A. Beginning November 1, 1991, the Director of the Bureau of Vital Statistics shall forward to the Office of the Chief Medical Examiner on a monthly basis copies of all death certificates of persons under eighteen (18) years of age received by the Bureau of Vital Statistics during the preceding month.

B. The Office of Chief Medical Examiner shall conduct an initial review of child death certificates in accordance with the criteria established by the Child Death Review Board and refer to the Board those cases that meet the criteria established by the Board for specific case review.

C. Upon the request of the Board, every entity within the child protection system shall provide to the Board any information requested by the Board.

§ 1150.5. Repealed by Laws 1993, c. 195, § 5, eff. July 1, 1993

OREGON

OR. REV. STAT. § 418.785 (2011). Child fatality review teams; creation; duties

(1) Each county multidisciplinary child abuse team shall establish a child fatality review team to conduct child fatality reviews. The purpose of the review process is to help prevent severe and fatal child abuse and neglect by:

- (a) Identifying local and state issues related to preventable child fatalities; and
 - (b) Promoting implementation of recommendations at the county level.
- (2) In establishing the review process and carrying out reviews, the child fatality review team shall be assisted by the county medical examiner or county health officer as well as other professionals who are specially trained in areas relevant to the purpose of the team.
- (3) The categories of fatalities reviewed by the child fatality review team include:
- (a) Child fatalities in which child abuse or neglect may have occurred at any time prior to death or may have been a factor in the fatality;
 - (b) Any category established by the county multidisciplinary child abuse team;
 - (c) All child fatalities where the child is less than 18 years of age and there is an autopsy performed by the medical examiner; and
 - (d) Any specific cases recommended for local review by the statewide interdisciplinary team established under ORS 418.748.
- (4) A child fatality review team shall develop a written protocol for review of child fatalities. The protocol shall be designed to facilitate communication and the exchange of information between persons who perform autopsies and those professionals and agencies concerned with the prevention, investigation and treatment of child abuse and neglect.
- (5) Within the guidelines, and in a format, established by the statewide interdisciplinary team established under ORS 418.748, the child fatality review team shall provide the statewide interdisciplinary team with information regarding the categories of child fatalities described under subsection (3) of this section.
- (6) Upon the conclusion of a criminal case involving a child fatality, or upon the conclusion of a direct appeal if one is taken, the district attorney may submit a letter to the Governor and the Director of Human Services outlining recommendations for the systemic improvement of child abuse investigations.

PENNSYLVANIA

11 PA. CONS. STAT. ANN. § 2150.1 (2011). Public Health Child Death Review Act.

This act shall be known and may be cited as the Public Health Child Death Review Act.

11 PA. CONS. STAT. ANN. § 2150.2 (2011). . Definitions

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

“Child.” An individual 21 years of age and under.

“Child death review data collection system.” A data collection system approved by the National MCH Center for Child Death Review or a similar national organization.

“Department.” The Department of Health of the Commonwealth.

“Local public health child death review team.” A team representing a county or two or more counties comprised of professionals from organizations and local agencies who review cases of child deaths in accordance with protocols established by the State public health child death review team.

“Person in interest.” A person authorized to permit the release of the medical records of a deceased child.

“Program.” The Public Health Child Death Review Program established in section 3.
[FN1]

“State public health child death review team.” A State multidisciplinary team comprised of local professionals and representatives of State agencies who review data submitted by local public health child death review teams, develop protocols for child death reviews and develop child death prevention strategies.

[FN1] 11 P.S. § 2150.3.

11 PA. CONS. STAT. ANN. § 2150.3 (2011). . Public Health Child Death Review Program

(a) Establishment.--The department shall establish the Public Health Child Death Review Program which shall facilitate State and local multiagency, multidisciplinary teams to examine the circumstances surrounding deaths in this Commonwealth for the purpose of promoting safety and reducing child fatalities.

(b) Powers and duties.--The department, in cooperation with the State public health child death review team, shall have the following powers and duties in relation to the program:

(1) Assist in the establishment and coordination of local public health child death review teams.

- (2) Coordinate the collection of child death data, including the development and distribution of a form to be used by local public health child death review teams to report information and procedures for sharing the data with State and local agencies as appropriate.
- (3) Develop protocols to be used in the review of child deaths. These protocols shall not conflict with requirements set forth in 23 Pa.C.S. Ch. 63 (relating to child protective services), including, but not limited to, provisions relating to the review of child fatalities and near fatalities.
- (4) Provide training and technical assistance to local public health child death review teams, local agencies and individuals relating to child deaths.
- (5) Review reports from local public health child death review teams.
- (6) Identify best prevention strategies and activities, including an assessment of the following:
 - (i) Effectiveness.
 - (ii) Ease of implementation.
 - (iii) Cost.
 - (iv) Sustainability.
 - (v) Potential community support.
 - (vi) Unintended consequences.
- (7) Adopt programs, policies, recommendations and strategies based on collected data to prevent child deaths.
- (8) Review statutes and regulations relating to confidentiality and access to information relating to children from agencies responsible for the health and safety of children and propose recommended changes to appropriate Commonwealth agencies and the General Assembly.
- (9) Provide public information and education regarding the incidence and causes of child injury and death and the reduction of risks to children to agencies, health care professionals, child care professionals and the public.
- (10) Submit an annual report to the Governor and the General Assembly by September of each year relating to the activities of the State child death review team, a summary of

reports received from local child death review teams and recommendations relating to the reduction of risk of child injury or death.

11 PA. CONS. STAT. ANN. § 2150.4 (2011). State public health child death review team

(a) Composition.--A State public health child death review team shall be established by the department. The team shall consist of:

(1) The following individuals or their designees:

(i) The Secretary of Health, who shall serve as chairman.

(ii) The Secretary of Public Welfare.

(iii) The Director of the Office of Children, Youth and Families within the Department of Public Welfare.

(iv) The Commissioner of the Pennsylvania State Police.

(v) The Attorney General.

(vi) The Pennsylvania State Fire Commissioner.

(vii) The Director of the Bureau of Emergency Medical Services of the Department of Health.

(2) The following individuals who shall be appointed by the Secretary of Health:

(i) A physician who specializes in pediatric medicine.

(ii) A physician who specializes in family medicine.

(iii) A representative of local law enforcement.

(iv) A medical examiner.

(v) A district attorney.

(vi) A coroner.

(3) Representatives from local public health child death review teams.

(4) Any other individual deemed appropriate by the Secretary of Health.

(b) Powers and duties of the State public health child death review team.--The State public health child death review team shall:

(1) Review data submitted by local public health child death review teams.

(2) Develop protocols for child death reviews.

(3) Develop child death prevention strategies.

(4) Assist the department in implementing the program.

(c) Initial meeting.--The initial meeting of the State public health child death review team shall be held within 90 days of the effective date of this section.

(d) Additional meetings.--The department, in conjunction with the team, shall arrange for additional meetings to fulfill the duties of the team and goals of the program.

11 PA. CONS. STAT. ANN. § 2150.5 (2011). Local public health child death review teams

(a) Establishment.--Each county in this Commonwealth shall establish a local public health child death review team. Two or more counties may establish a local public health child death review team to operate on a regional basis to satisfy the requirements of this section.

(b) Local public health child death review team.--Local teams shall be comprised of the following:

(1) The director of the county children and youth agency or a designee.

(2) The district attorney or a designee.

(3) A representative of local law enforcement appointed by the county commissioners.

(4) A representative of the court of common pleas appointed by the president judge.

(5) A physician who specializes in pediatric or family medicine appointed by the county commissioners.

(6) The county coroner or medical examiner.

(7) A representative of emergency medical services selected jointly by the supervisors of all emergency medical organizations in the county.

(8) The director of a local public health agency or a designee.

(9) Any other person deemed appropriate by a majority of the local public health child death review team.

(c) Chairman.--The members of the local public health child death review team shall elect a chairman annually.

11 PA. CONS. STAT. ANN. § 2150.6 (2011). Powers and duties of local public health child death review teams

(a) Review.--A local public health child death review team shall review all deaths of children and may review the following information:

(1) Coroner's reports or postmortem examination records.

(2) Death certificates and birth certificates.

(3) Law enforcement records and interviews with law enforcement officials as long as the release of such records will not jeopardize an ongoing criminal investigation or proceeding.

(4) Medical records from hospitals and other health care providers.

(5) Information and reports made available by the county children and youth agency in accordance with 23 Pa.C.S. Ch. 63 (relating to child protective services).

(6) Information made available by firefighters or emergency services personnel.

(7) Reports and records made available by the court to the extent permitted by law or court rule.

(8) Reports to animal control.

(9) EMS records.

(10) Traffic fatality reports.

(11) Any other records necessary to conduct the review.

(b) Data collection.--The local public health child death review team shall utilize the child death review data collection system to report its findings in accordance with protocols established by the State public health child death review team. The name and home address of the deceased child shall not be reported to the child death review data collection system.

(c) Reports.--A local public health child death review team shall submit annual reports on deaths reviewed to the State public health child death review team. The report shall include the following:

(1) Identification of factors which cause a risk for injury and death, including modifiable risk factors.

(2) Recommendations regarding the following:

(i) The improvement of health and safety policies in this Commonwealth.

(ii) The coordination of services and investigations by child welfare agencies, medical officials, law enforcement and other agencies.

(3) Any other information required by the department.

(d) Recommendations.--A local public health child death review team shall make recommendations to local agencies relating to the procedures and other actions to reduce injury and death of children.

11 PA. CONS. STAT. ANN. § 2150.7 (2011). Access to records

(a) Juvenile records.--When deemed necessary for its review, a State or local public health child death review team may review and inspect all files and records of the court relating to a child pursuant to a proceeding under 42 Pa.C.S. Ch. 63 (relating to juvenile matters) in accordance with 42 Pa.C.S. § 6307 (relating to inspection of court files and records). However, this subsection shall not apply to files and records of the court subject to a child fatality or near fatality review pursuant to 23 Pa.C.S. Ch. 63 (relating to child protective services).

(b) Medical records.--Notwithstanding any other provision of law and consistent with the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), health care facilities and health care providers shall provide medical records of a child under review without the authorization of a person in interest to the State public

health child death review team and to a local public health child death review team for purposes of review under this act.

(c) Other records.--Other records pertaining to the child under review for the purposes of this act shall be open to inspection as permitted by law.

11 PA. CONS. STAT. ANN. § 2150.8 (2011). Confidentiality

(a) Maintenance.--State and local public health child death review teams shall maintain the confidentiality of any identifying information obtained relating to the death of a child, including the name of the child, guardians, family members, caretakers or alleged or suspected perpetrators of abuse, neglect or a criminal act.

(b) Agreement.--Each member of the State and local public health child death review team and any person appearing before the team shall sign a confidentiality agreement applicable to all proceedings and reviews conducted by the State or local public health child death review team.

(c) Liability.--An individual or agency that in good faith provides information or records to a State or local public health child death review team shall not be subject to civil or criminal liability as a result of providing the information or record.

(d) Discovery.--The proceedings, deliberations and records of a State or local public health child death review team are privileged and confidential and shall not be subject to discovery, subpoena or introduction into evidence in any civil or criminal action.

(e) Meetings.--Meetings of the State or local public health child death review team at which a specific child death is discussed shall be closed to the public and shall not be subject to the provisions of 65 Pa.C.S. Ch. 7 (relating to open meetings).

(f) Attendance.--Nothing in this act shall prevent a State or local public health child death review team from allowing the attendance of a person, including a parent, with information relevant to a review, at a child death review meeting.

(g) Penalty.--A person who violates the provisions of this section commits a misdemeanor of the third degree.

11 PA. CONS. STAT. ANN. § 2150.20 (2011). Regulations

The department shall promulgate regulations as necessary to carry out the purposes of this act.

RHODE ISLAND

R.I. GEN. LAWS § 23-4-3. (2011). Functions of Medical Examiner

The office of state medical examiners shall be responsible for:

- (1) The investigation of deaths within the state that in its judgment might reasonably be expected to involve causes of death enumerated in this chapter;
- (2) For the conduct of inquests when requested by the attorney general;
- (3) For the performance of autopsies, including the retention, examination and appropriate disposal of tissue, when appropriate, for deaths which in its judgment might reasonably be expected to involve causes of deaths enumerated in this chapter;
- (4) For the written determination of the causes of death investigated pursuant to this chapter;
- (5) For the presentation to the courts of Rhode Island of expert testimony relating to the cause of death;
- (6) For the keeping of complete records, including names, places, circumstances, and causes of deaths, of deaths investigated and reported, copies of which shall be delivered to the attorney general and of which written determinations of causes of death shall be made available for public inspection;
- (7) For the burial of bodies for which there is no other existing legal responsibility to do so; and
- (8) For the development and enforcement of procedures for the pronouncement of death and for the transplantation of organs from bodies of persons who have died within the state.
- (9) For a multi-disciplinary team review of child fatalities with the goal to decrease the prevalence of preventable child deaths and report recommendations for community and systems intervention strategies. A child death review team shall include, but is not limited to, representation from state agencies, health care, child welfare, and law enforcement.

SOUTH CAROLINA

S.C. CODE ANN. § 63-11-1900 (2011). POLICY.

It is the policy of this State that:

- (1) every child is entitled to live in safety and in health and to survive into adulthood;
- (2) responding to child deaths is a state and a community responsibility;
- (3) when a child dies, the response by the State and the community to the death must include an accurate and complete determination of the cause of death, the provision of services to surviving family members, and the development and implementation of measures to prevent future deaths from similar causes and may include court action, including prosecution of persons who may be responsible for the death and family court proceedings to protect other children in the care of the responsible person;
- (4) professionals from disparate disciplines and agencies who have responsibilities for children and expertise that can promote child safety and well-being should share their expertise and knowledge toward the goals of determining the causes of children's deaths, planning and providing services to surviving children and nonoffending family members, and preventing future child deaths;
- (5) a greater understanding of the incidence and causes of child deaths is necessary if the State is to prevent future child deaths;
- (6) multi-disciplinary and multi-agency reviews of child deaths can assist the State in the investigation of child deaths, in the development of a greater understanding of the incidence and causes of child deaths and the methods for preventing such deaths, and in identifying gaps in services to children and families;
- (7) access to information regarding deceased children and their families by the Department of Child Fatalities is necessary to achieve the department's purposes and duties; and
- (8) competent investigative services must be sensitive to the needs of South Carolina's children and their families and not unnecessarily intrusive and should be achieved through training, awareness, and technical assistance.

S.C. Code Ann. § 63-11-1910 (2011). Definitions.

For purposes of this article:

- (1) “Child” means a person under eighteen years of age.
- (2) “Committee” means the State Child Fatality Advisory Committee.
- (3) “Department” means the State Law Enforcement Division's Department of Child Fatalities.
- (4) “Local child protective services agency” means the county department of social services for the jurisdiction where a deceased child resided.
- (5) “Meeting” means both in-person meetings and meetings through telephone conferencing.
- (6) “Preventable death” means a death which reasonable medical, social, legal, psychological, or educational intervention may have prevented.
- (7) “Provider of medical care” means a licensed health care practitioner who provides, or a licensed health care facility through which is provided, medical evaluation or treatment, including dental and mental health evaluation or treatment.
- (8) “Working day” means Monday through Friday, excluding official state holidays.
- (9) “Unexpected death” includes all child deaths which, before investigation, appear possibly to have been caused by trauma, suspicious or obscure circumstances, or child abuse or neglect.

S.C. Code Ann. § 63-11-1920 (2011). Department established.

There is created within the State Law Enforcement Division (SLED) the Department of Child Fatalities which is under the supervision of the Chief of SLED.

S.C. Code Ann. § 63-11-1930 (2011). Committee established.

(A) There is created a multi-disciplinary State Child Fatality Advisory Committee composed of:

- (1) the director of the South Carolina Department of Social Services;
- (2) the director of the South Carolina Department of Health and Environmental Control;
- (3) the State Superintendent of Education;
- (4) the executive director of the South Carolina Criminal Justice Academy;

- (5) the chief of the State Law Enforcement Division;
- (6) the director of the Department of Alcohol and Other Drug Abuse Services;
- (7) the director of the State Department of Mental Health;
- (8) the director of the Department of Disabilities and Special Needs;
- (9) the director of the Department of Juvenile Justice;
- (10) an attorney with experience in prosecuting crimes against children;
- (11) a county coroner or medical examiner;
- (12) a pediatrician with experience in diagnosing and treating child abuse and neglect, appointed from recommendations submitted by the State Chapter of the American Academy of Pediatrics;
- (13) a solicitor;
- (14) a forensic pathologist; and
- (15) two members of the public at large, one of which must represent a private nonprofit organization that advocates children services.

(B) Those state agency members in items (1)-(9) shall serve ex officio and may appoint a designee to serve in their place from their particular departments or agencies who have administrative or program responsibilities for children and family services. The remaining members, including the coroner or medical examiner and solicitor who shall serve ex officio, must be appointed by the Governor for terms of four years and until their successors are appointed and qualify.

(C) A chairman and vice chairman of the committee must be elected from among the members by a majority vote of the membership for a term of two years.

(D) Meetings of the committee must be held at least quarterly. A majority of the committee constitutes a quorum.

(E) Each ex officio member shall provide sufficient staff and administrative support to carry out the responsibilities of this article.

S.C. Code Ann. § 63-11-1940 (2011). Purpose and duties of department.

(A) The purpose of the department is to expeditiously investigate child deaths in all counties of the State.

(B) To achieve its purpose, the department shall:

(1) upon receipt of a report of a child death from the county coroner or medical examiner, as required by Section 17-5-540, investigate and gather all information on the child fatality. The coroner or medical examiner immediately shall request an autopsy if SLED determines that an autopsy is necessary. The autopsy must be performed by a pathologist with forensic training as soon as possible. The pathologist shall inform the department of the findings within forty-eight hours of completion of the autopsy. If the autopsy reveals the cause of death to be pathological or an unavoidable accident, the case must be closed by the department. If the autopsy reveals physical or sexual trauma, suspicious markings, or other findings that are questionable or yields no conclusion to the cause of death, the department immediately must begin an investigation;

(2) request assistance of any other local, county, or state agency to aid in the investigation;

(3) upon receipt of additional investigative information, reopen a SLED case, and request in writing as soon as possible for the coroner to reopen a case for another coroner's inquest;

(4) upon receipt of the notification required by item (1), review agency records for information regarding the deceased child or family. Information available to the department pursuant to Section 63-11-1960 and information which is public under Chapter 4, Title 30, the Freedom of Information Act, must be available as needed to the county coroner or medical examiner and county department of social services;

(5) report the activities and findings related to a child fatality to the State Child Fatality Advisory Committee;

(6) develop a protocol for child fatality reviews;

(7) develop a protocol for the collection of data regarding child deaths as related to Section 17-5-540 and provide training to local professionals delivering services to children, county coroners and medical examiners, and law enforcement agencies on the use of the protocol;

(8) study the operations of local investigations of child fatalities, including the statutes, regulations, policies, and procedures of the agencies involved with children's services and child death investigations;

(9) examine confidentiality and access to information statutes, regulations, policies, and procedures for agencies with responsibilities for children, including, but not limited to, health, public welfare, education, social services, mental health, alcohol and other substance abuse, and law enforcement agencies and determine whether those statutes, regulations, policies, or procedures impede the exchange of information necessary to protect children from preventable deaths. If the department identifies a statute, regulation, policy, or procedure that impedes the necessary exchange of information, the department shall notify the committee and the agencies serving on the committee and the committee shall include proposals for changes to statutes, regulations, policies, or procedures in the committee's annual report;

(10) develop a Forensic Pathology Network available to coroners and medical examiners for prompt autopsy findings;

(11) submit to the Governor and the General Assembly, an annual report and any other reports prepared by the department, including, but not limited to, the department's findings and recommendations;

(12) promulgate regulations necessary to carry out its purposes and responsibilities under this article.

S.C. Code Ann. § 63-11-1950 (2011). Purpose and duties of committee.

(A) The purpose of the State Child Fatality Advisory Committee is to decrease the incidences of preventable child deaths by:

(1) developing an understanding of the causes and incidences of child deaths;

(2) developing plans for and implementing changes within the agencies represented on the committee which will prevent child deaths; and

(3) advising the Governor and the General Assembly on statutory, policy, and practice changes which will prevent child deaths.

(B) To achieve its purpose, the committee shall:

(1) meet with the department no later than one month after the department receives notification by the county coroner or medical examiner pursuant to Section 17-5-540 to review the investigation of the death;

(2) undertake annual statistical studies of the incidences and causes of child fatalities in this State. The studies shall include an analysis of community and public and private

agency involvement with the decedents and their families before and subsequent to the deaths;

(3) the committee shall consider training, including cross-agency training, consultation, technical assistance needs, and service gaps. If the committee determines that changes to any statute, regulation, policy, or procedure is needed to decrease the incidence of preventable child deaths, the committee shall include proposals for changes to statutes, regulations, policies, and procedures in the committee's annual report;

(4) educate the public regarding the incidences and causes of child deaths, the public role in preventing these deaths, and specific steps the public can undertake to prevent child deaths. The committee shall enlist the support of civic, philanthropic, and public service organizations in performing the committee's education duties;

(5) develop and implement policies and procedures for its own governance and operation;

(6) submit to the Governor and the General Assembly, an annual written report and any other reports prepared by the committee, including, but not limited to, the committee's findings and recommendations. Annual reports must be made available to the public.

S.C. Code Ann. § 63-11-1960 (2011). Access to information.

Upon request of the department and as necessary to carry out the department's purpose and duties, the department immediately must be provided:

(1) by a provider of medical care, access to information and records regarding a child whose death is being reviewed by the department, including information on prenatal care;

(2) access to all information and records maintained by any state, county, or local government agency, including, but not limited to, birth certificates, law enforcement investigation data, county coroner or medical examiner investigation data, parole and probation information and records, and information and records of social services and health agencies that provided services to the child or family, including information made strictly confidential in Section 63-7-940 concerning unfounded reports of abuse or neglect.

S.C. Code Ann. § 63-11-1970 (2011). Subpoena power.

When necessary in the discharge of the duties of the department and upon application of the department, the clerks of court shall issue a subpoena or subpoena duces tecum to any state, county, or local agency, board, or commission or to any representative of any state, county, or local agency, board, or commission or to a provider of medical care to compel the attendance of witnesses and production of documents, books, papers, correspondence, memoranda, and other relevant records to the discharge of the department's duties.

Failure to obey a subpoena or subpoena duces tecum issued pursuant to this section may be punished as contempt.

S.C. Code Ann. § 63-11-1980 (2011). Confidentiality of meetings.

(A) Meetings of the committee and department are closed to the public and are not subject to Chapter 4, Title 30, the Freedom of Information Act, when the committee and department are discussing individual cases of child deaths.

(B) Except as provided in subsection (C), meetings of the committee are open to the public and subject to the Freedom of Information Act when the committee is not discussing individual cases of child deaths.

(C) Information identifying a deceased child or a family member, guardian, or caretaker of a deceased child, or an alleged or suspected perpetrator of abuse or neglect upon a child may not be disclosed during a public meeting and information regarding the involvement of any agency with the deceased child or family may not be disclosed during a public meeting.

(D) Violation of this section is a misdemeanor and, upon conviction, a person must be fined not more than five hundred dollars or imprisoned not more than six months, or both.

S.C. Code Ann. § 63-11-1990 (2011). Confidentiality of information.

(A) All information and records acquired by the committee and by the department in the exercise of their purposes and duties pursuant to this article are confidential, exempt from disclosure under Chapter 4, Title 30, the Freedom of Information Act, and only may be disclosed as necessary to carry out the committee's and department's duties and purposes.

(B) Statistical compilations of data which do not contain information that would permit the identification of a person to be ascertained are public records.

(C) Reports of the committee and department which do not contain information that would permit the identification of a person to be ascertained are public information.

(D) Except as necessary to carry out the committee's and department's purposes and duties, members of the committee and department and persons attending their meeting may not disclose what transpired at a meeting which is not public under Section 63-11-1970 and may not disclose information, the disclosure of which is prohibited by this section.

(E) Members of the committee, persons attending a committee meeting, and persons who present information to the committee may not be required to disclose in any civil or

criminal proceeding information presented in or opinions formed as a result of a meeting, except that information available from other sources is not immune from introduction into evidence through those sources solely because it was presented during proceedings of the committee or department or because it is maintained by the committee or department. Nothing in this subsection may be construed to prevent a person from testifying to information obtained independently of the committee or which is public information.

(F) Information, documents, and records of the committee and department are not subject to subpoena, discovery, or the Freedom of Information Act, except that information, documents, and records otherwise available from other sources are not immune from subpoena, discovery, or the Freedom of Information Act through those sources solely because they were presented during proceedings of the committee or department or because they are maintained by the committee or department.

(G) Violation of this section is a misdemeanor and, upon conviction, a person must be fined not more than five hundred dollars or imprisoned for not more than six months, or both.

SOUTH DAKOTA

S.D. CODIFIED LAWS § 6-8A-14 (2011). Immunity from liability

Any person or party participating in good faith in the making of a report or the submitting of copies of medical examination, treatment, or hospitalization records pursuant to §§ 26-8A-3 to 26-8A-8, inclusive, or pursuant to any other provisions of this chapter, is immune from any liability, civil or criminal, that might otherwise be incurred or imposed, and has the same immunity for participation in any judicial proceeding resulting from the report. Immunity also extends in the same manner to persons requesting the taking of photographs and X rays pursuant to § 26-8A-16, to persons taking the photographs and X rays, to child protection teams established by the secretary of social services, to public officials or employees involved in the investigation and treatment of child abuse or neglect or making a temporary placement of the child pursuant to this chapter, or to any person who in good faith cooperates with a child protection team or the Department of Social Services in investigation, placement, or a treatment plan. The provisions of this section or any other section granting or allowing the grant of immunity do not extend to any person alleged to have committed an act or acts of child abuse or neglect.

S.D. CODIFIED LAWS § 6-8A-17 (2011). Child protection teams

The secretary of social services may appoint child protection teams to assist in the prevention and treatment of child abuse and neglect. A child protection team may include licensed or certified medical and health professionals, the court services officer recommended by the presiding judge of a judicial circuit in which the team is to operate, the secretaries of social services and health or their designees, a representative of a mental health center, a representative of a public school district in which the team is to operate, an attorney, a foster parent, and one or more representatives of the public. The Department of Social Services shall maintain a record of the membership of each child protection team.

S.D. CODIFIED LAWS § 6-16-1 (2011). Agreement to form county interdisciplinary child information team--Members

The following persons and agencies operating within a county may, by written agreement, form a county interdisciplinary child information team:

- (1) The state's attorney;
- (2) The county sheriff;
- (3) The chief of police of any municipality;
- (4) The superintendent or the chief executive officer of any school district;
- (5) The Department of Social Services;
- (6) The Department of Corrections; and
- (7) The administrator of the county teen court.

S.D. CODIFIED LAWS § 6-16-2 (2011). Team voting to allow additional persons to join team--Authorized members

The persons and agencies signing a written agreement to form a county interdisciplinary child information team may, from time to time, by majority vote, allow the following persons to sign the written agreement and join the team:

- (1) Any physician, psychologist, psychiatrist, nurse, or other provider of medical and mental health care;
- (2) Any administrator of any private elementary and secondary school;

(3) Any attorney practicing law in the county; and

(4) Any responsible person that has a legitimate interest in one or more of the children that the team is serving.

S.D. CODIFIED LAWS § 6-16-3 (2011). Auxiliary teams

The county interdisciplinary child information team may form one or more auxiliary teams for the purpose of providing service to a single child, a group of children, or specific children with a particular type of problem, or for any other purpose. Each auxiliary team is subject to the written agreement. Each member of an auxiliary team must be a person who has personal knowledge of or experience with some child serviced by the auxiliary team.

S.D. CODIFIED LAWS § 6-16-4 (2011). Information sharing in serving child for specified purposes--Confidentiality

The county interdisciplinary child information team and the written agreement shall facilitate the exchange and sharing of information that one or more team members may be able to use in serving a child in the course of their professions, specialities, interests, or occupations for the purpose of holding each child accountable, ensuring the safety of the child and the community, and providing early intervention to avert more serious problems. Information regarding any child that a team member supplies to other team members is confidential and may not be disseminated beyond the team.

S.D. CODIFIED LAWS § 6-16-5 (2011). Terms of written agreement--Filing

The terms of the written agreement shall provide for the rules under which the team will operate, the method by which information will be shared, distributed, and managed, the means by which the confidentiality of the information will be safeguarded, and any other matters necessary to the purpose and functions of the team. The terms of the written agreement shall also provide how the team will coordinate its efforts with child protection teams as provided in § 26-8A-17 and local interagency teams, if any, as provided in § 27A-15-54. The written agreement shall be filed with the county auditor.

S.D. CODIFIED LAWS § 6-16-6 (2011). Education records

To the extent that the county interdisciplinary child information team is involved in a proceeding that is held prior to adjudication by a court, the team satisfies the

requirements of 20 U.S.C. 1232g(b)(1)(E)(ii)(I) of the Family Educational Rights and Privacy Act of 1974. South Dakota school districts may release education records to the team. The terms of the written agreement, as provided for in § 26-16-5, shall include a requirement that the officials and authorities to whom the information is disclosed certify in writing to the school district that is releasing the education records that the education records or information from the education records will not be disclosed to any other party without the prior written consent of the parent or guardian of the student.

S.D. CODIFIED LAWS § 6-16-7 (2011). Immunity from civil liability for team members acting in good faith

Any person serving as a member of a county interdisciplinary child information team as provided in § 26-16-1 whose action in facilitating the exchange and sharing of information in serving any child in the course of their professions, specialities, interests, or occupations for the purpose of holding each child accountable, ensuring the safety of the child and the community, and providing early intervention to avert more serious problems, is immune from any civil liability, arising out of any good faith act relevant to participation on any county interdisciplinary child information team, that might otherwise be incurred or imposed.

S.D. CODIFIED LAWS § 6-16-8 (2011). Agreement to include requirement for notice to parent or guardian--Exception

Any agreement pursuant to this chapter shall include a requirement for notice to the parent or guardian unless the parent or guardian is the subject of an investigation by one of the participating agencies with respect to the child's conduct or welfare.

TENNESSEE

TENN. CODE ANN. § 68-142-101 (2011). Child Fatality Review and Prevention Act of 1995

This part shall be known as and may be cited as the “Child Fatality Review and Prevention Act of 1995.”

TENN. CODE ANN. § 68-142-102 (2011). Child fatality prevention team; creation

There is created the Tennessee child fatality prevention team, otherwise known as the state team. For administrative purposes only, the state team shall be attached to the department of health.

TENN. CODE ANN. § 68-142-103 (2011). Members

The state team shall be composed as provided in this section. Any ex officio member, other than the commissioner of health, may designate an agency representative to serve in such person's place. Members of the state team shall be as follows:

- (1) The commissioner of health, who shall chair the state team;
- (2) The attorney general and reporter;
- (3) The commissioner of children's services;
- (4) The director of the Tennessee bureau of investigation;
- (5) A physician nominated by the state chapter of the American Medical Association;
- (6) A physician to be appointed by the commissioner of health who is credentialed in forensic pathology, preferably with experience in pediatric forensic pathology;
- (7) The commissioner of mental health;
- (8) A member of the judiciary selected from a list submitted by the chief justice of the Tennessee supreme court;
- (9) The executive director of the commission on children and youth;
- (10) The president of the state professional society on the abuse of children;
- (11) A team coordinator, to be appointed by the commissioner of health;
- (12) Deleted by 2011 Pub.Acts, c. 410, § 3(hh), eff. July 1, 2011.
- (13) Two (2) members of the house of representatives to be appointed by the speaker of the house of representatives, at least one (1) of whom shall be a member of the health and human resources committee;
- (14) Two (2) senators to be appointed by the speaker of the senate, at least one (1) of whom shall be a member of the general welfare, health and human resources committee;

- (15) The commissioner of education or the commissioner's designee; and
- (16) The commissioner of intellectual and developmental disabilities.

TENN. CODE ANN. § 68-142-104 (2011). Voting members; vacancies

All members of the state team shall be voting members. All vacancies shall be filled by the appointing or designating authority in accordance with the requirements of § 68-142-103.

TENN. CODE ANN. § 68-142-105 (2011). Powers and duties

The state team shall:

- (1) Review reports from the local child fatality review teams;
- (2) Report to the governor and the general assembly concerning the state team's activities and its recommendations for changes to any law, rule, and policy that would promote the safety and well-being of children;
- (3) Undertake annual statistical studies of the incidence and causes of child fatalities in this state. The studies shall include an analysis of community and public and private agency involvement with the decedents and their families prior to and subsequent to the deaths;
- (4) Provide training and written materials to the local teams established by this part to assist them in carrying out their duties. Such written materials may include model protocols for the operation of local teams;
- (5) Develop a protocol for the collection of data regarding child deaths;
- (6) Upon request of a local team, provide technical assistance to such team, including the authorization of another medical or legal opinion on a particular death; and
- (7) Periodically assess the operations of child fatality prevention efforts and make recommendations for changes as needed.

TENN. CODE ANN. § 68-142-106 (2011). Local teams; members, meetings

- (a) There shall be a minimum of one (1) local team in each judicial district.
- (b) Each local team shall include the following statutory members or their designees:

National Center for Prosecution of Child Abuse
National District Attorney Association

(1) A supervisor of social services in the department of children's services within the area served by the team;

(2) The regional health officer in the department of health in the area served by the team, who shall serve as interim chair pending the election by the local team;

(3) A medical examiner who provides services in the area served by the team;

(4) A prosecuting attorney appointed by the district attorney general;

(5) An employee of the local education agency, to be appointed by the director of schools; and

(6) The interim chair of the local team shall appoint the following members to the local team:

(A) A local law enforcement officer;

(B) A mental health professional;

(C) A pediatrician or family practice physician;

(D) An emergency medical service provider or firefighter; and

(E) A representative from a juvenile court.

(c) Each local child fatality team may include representatives of public and nonpublic agencies in the community that provide services to children and their families.

(d) The local team may include non-statutory members to assist them in carrying out their duties. Vacancies on a local team shall be filled by the original appointing authority.

(e) A local team shall elect a member to serve as chair.

(f) The chair of each local team shall schedule the time and place of the first meeting, and shall prepare the agenda. Thereafter, the team shall meet no less often than once per quarter and often enough to allow adequate review of the cases meeting the criteria for review.

TENN. CODE ANN. § 68-142-107 (2011). Local teams; powers and duties

(a) The local child fatality review teams shall:

- (1) Be established to cover each judicial district in the state;
 - (2) Review, in accordance with the procedures established by the state team, all deaths of children seventeen (17) years of age or younger;
 - (3) Collect data according to the protocol developed by the state team;
 - (4) Submit data on child deaths quarterly to the state team;
 - (5) Submit annually to the state team recommendations, if any, and advocate for system improvements and resources where gaps and deficiencies may exist; and
 - (6) Participate in training provided by the state team.
- (b) Nothing in this part shall preclude a local team from providing consultation to any team member conducting an investigation.
- (c) Local child fatality review teams may request a second medical or legal opinion to be authorized by the state team in the event that a majority of the local team's statutory membership is in agreement that a second opinion is needed.

TENN. CODE ANN. § 68-142-108 (2011). Medical and agency records; access, subpoena powers; interviews, confidentiality, discovery, testimony, penalties

- (a) The department of health, state team and local teams are public health authorities conducting public health activities pursuant to the federal Health Insurance Portability and Accountability Act (HIPAA), compiled in 42 U.S.C. § 1320d et seq. Notwithstanding §§ 63-2-101(b) and 68-11-1502, and regardless of any express or implied contracts, agreements or covenants of confidentiality based upon those sections, the records of all health care facilities and providers shall be made available to the local team for inspection and copying as necessary to complete the review of a specific fatality and effectuate the intent of this part. The local team is authorized to inspect and copy any other records from any source as necessary to complete the review of a specific fatality and effectuate the intent of this part, including, but not limited to, police investigations data, medical examiner investigative data, vital records cause of death information, and social services records, including records of the department of children's services.
- (b) The local team shall not, as part of the review authorized under this part, contact, question or interview the parent of the deceased child or any other family member of the child whose death is being reviewed.

(c) The local team may request that persons with direct knowledge of circumstances surrounding a particular fatality provide the local team with information necessary to complete the review of the particular fatality; such persons may include the person or persons who first responded to a report concerning the child.

(d) Meetings of the state team and each local team shall not be subject to title 8, chapter 44, part 1. Any minutes or other information generated during official meetings of state or local teams shall be sealed from public inspection. However, the state and local teams may periodically make available, in a general manner not revealing confidential information about children and families, the aggregate findings of their reviews and their recommendations for preventive actions.

(e)(1) All otherwise confidential information and records acquired by the state team or any local child fatality review team in the exercise of the duties are confidential, are not subject to discovery or introduction into evidence in any proceedings, and may only be disclosed as necessary to carry out the purposes of the state team or local teams and for the purposes of the Sudden, Unexplained Child Death Act, pursuant to chapter 1, part 11 of this title.

(2) In addition, all otherwise confidential information and records created by a local team in the exercise of its duties are confidential, are not subject to discovery or introduction into evidence in any proceedings, and may only be disclosed as necessary to carry out the purposes of the state or local teams and for the purposes of the Sudden, Unexplained Child Death Act, pursuant to chapter 1, part 11 of this title. Release to the public or the news media of information discussed at official meetings is strictly prohibited. No member of the state team, a local team nor any person who attends an official meeting of the state team or a local team, may testify in any proceeding about what transpired at the meeting, about information presented at the meeting, or about opinions formed by the person as a result of the meeting.

(3) This subsection (e) shall not, however, prohibit a person from testifying in a civil or criminal action about matters within that person's independent knowledge.

(f) Each statutory member of a local child fatality review team and each non-statutory member of a local team and each person otherwise attending a meeting of a local child fatality review team shall sign a statement indicating an understanding of and adherence to confidentiality requirements, including the possible civil or criminal consequences of any breach of confidentiality.

TENN. CODE ANN. § 68-142-109 (2011). Staff; consultants

To the extent of funds available, the state team may hire staff or consultants to assist the state team and local teams in completing their duties.

TENN. CODE ANN. § 68-142-110 (2011). Immunity

Any person or facility acting in good faith in compliance with this part shall be immune from civil and criminal liability arising from such action.

TENN. CODE ANN. § 68-142-111 (2011). Child death investigations or reviews

Nothing in this part shall preclude any child death investigations or reviews to the extent authorized by other laws.

TEXAS

TEX. FAM. CODE ANN. § 264.501 (2011). Definitions

In this subchapter:

- (1) “Autopsy” and “inquest” have the meanings assigned by Article 49.01, Code of Criminal Procedure.
- (2) “Bureau of vital statistics” means the bureau of vital statistics of the Texas Department of Health.
- (3) “Child” means a person younger than 18 years of age.
- (4) “Committee” means the child fatality review team committee.
- (5) “Department” means the Department of Protective and Regulatory Services.
- (6) “Health care provider” means any health care practitioner or facility that provides medical evaluation or treatment, including dental and mental health evaluation or treatment.
- (7) “Meeting” means an in-person meeting or a meeting held by telephone or other electronic medium.

(8) “Preventable death” means a death that may have been prevented by reasonable medical, social, legal, psychological, or educational intervention. The term includes the death of a child from:

(A) intentional or unintentional injuries;

(B) medical neglect;

(C) lack of access to medical care;

(D) neglect and reckless conduct, including failure to supervise and failure to seek medical care; and

(E) premature birth associated with any factor described by Paragraphs (A) through (D).

(9) “Review” means a reexamination of information regarding a deceased child from relevant agencies, professionals, and health care providers.

(10) “Review team” means a child fatality review team established under this subchapter.

(11) “Unexpected death” includes a death of a child that, before investigation:

(A) appears to have occurred without anticipation or forewarning; and

(B) was caused by trauma, suspicious or obscure circumstances, sudden infant death syndrome, abuse or neglect, or an unknown cause.

TEX. FAM. CODE ANN. § 264.502 (2011). Committee

(a) The child fatality review team committee is composed of:

(1) a person appointed by and representing the state registrar of vital statistics;

(2) a person appointed by and representing the commissioner of the department;

(3) a person appointed by and representing the Title V director of the Department of State Health Services; and

(4) individuals selected under Subsection (b).

(b) The members of the committee who serve under Subsections (a)(1) through (3) shall select the following additional committee members:

- (1) a criminal prosecutor involved in prosecuting crimes against children;
 - (2) a sheriff;
 - (3) a justice of the peace;
 - (4) a medical examiner;
 - (5) a police chief;
 - (6) a pediatrician experienced in diagnosing and treating child abuse and neglect;
 - (7) a child educator;
 - (8) a child mental health provider;
 - (9) a public health professional;
 - (10) a child protective services specialist;
 - (11) a sudden infant death syndrome family service provider;
 - (12) a neonatologist;
 - (13) a child advocate;
 - (14) a chief juvenile probation officer;
 - (15) a child abuse prevention specialist;
 - (16) a representative of the Department of Public Safety; and
 - (17) a representative of the Texas Department of Transportation.
- (c) Members of the committee selected under Subsection (b) serve three-year terms with the terms of five or six members, as appropriate, expiring February 1 each year.
- (d) Members selected under Subsection (b) must reflect the geographical, cultural, racial, and ethnic diversity of the state.
- (e) An appointment to a vacancy on the committee shall be made in the same manner as the original appointment. A member is eligible for reappointment.

(f) Members of the committee shall select a presiding officer from the members of the committee.

(g) The presiding officer of the committee shall call the meetings of the committee, which shall be held at least quarterly.

(h) A member of the committee is not entitled to compensation for serving on the committee but is entitled to reimbursement for the member's travel expenses as provided in the General Appropriations Act. Reimbursement under this subsection for a person serving on the committee under Subsection (a)(2) shall be paid from funds appropriated to the department. Reimbursement for other persons serving on the committee shall be paid from funds appropriated to the Department of State Health Services.

TEX. FAM. CODE ANN. § 264.503 (2011). Purpose and Duties of Committee and Specified State Agencies

(a) The purpose of the committee is to:

(1) develop an understanding of the causes and incidence of child deaths in this state;

(2) identify procedures within the agencies represented on the committee to reduce the number of preventable child deaths; and

(3) promote public awareness and make recommendations to the governor and the legislature for changes in law, policy, and practice to reduce the number of preventable child deaths.

(b) To ensure that the committee achieves its purpose, the department and the Department of State Health Services shall perform the duties specified by this section.

(c) The department shall work cooperatively with:

(1) the Department of State Health Services;

(2) the committee; and

(3) individual child fatality review teams.

(d) The Department of State Health Services shall:

(1) recognize the creation and participation of review teams;

(2) promote and coordinate training to assist the review teams in carrying out their duties;

(3) assist the committee in developing model protocols for:

(A) the reporting and investigating of child fatalities for law enforcement agencies, child protective services, justices of the peace and medical examiners, and other professionals involved in the investigations of child deaths;

(B) the collection of data regarding child deaths; and

(C) the operation of the review teams;

(4) develop and implement procedures necessary for the operation of the committee; and

(5) promote education of the public regarding the incidence and causes of child deaths, the public role in preventing child deaths, and specific steps the public can undertake to prevent child deaths.

(d-1) The committee shall enlist the support and assistance of civic, philanthropic, and public service organizations in the performance of the duties imposed under Subsection (d).

(e) In addition to the duties under Subsection (d), the Department of State Health Services shall:

(1) collect data under this subchapter and coordinate the collection of data under this subchapter with other data collection activities; and

(2) perform annual statistical studies of the incidence and causes of child fatalities using the data collected under this subchapter.

(f) The committee shall issue a report for each preventable child death. The report must include findings related to the child's death, recommendations on how to prevent similar deaths, and details surrounding the department's involvement with the child prior to the child's death. Not later than April 1 of each year, the committee shall publish a compilation of the reports published under this subsection during the year, submit a copy of the compilation to the governor, lieutenant governor, speaker of the house of representatives, and department, and make the compilation available to the public. Not later than October 1 of each year, the department shall submit a written response on the compilation from the previous year to the committee, governor, lieutenant governor, and speaker of the house of representatives describing which of the committee's recommendations regarding the operation of the child protective services system the department will implement and the methods of implementation.

(g) The committee shall perform the functions and duties required of a citizen review panel under 42 U.S.C. Section 5106a(c)(4)(A).

TEX. FAM. CODE ANN. § 264.504 (2011). Meetings of Committee

(a) Except as provided by Subsections (b), (c), and (d), meetings of the committee are subject to the open meetings law, Chapter 551, Government Code, as if the committee were a governmental body under that chapter.

(b) Any portion of a meeting of the committee during which the committee discusses an individual child's death is closed to the public and is not subject to the open meetings law, Chapter 551, Government Code.

(c) Information identifying a deceased child, a member of the child's family, a guardian or caretaker of the child, or an alleged or suspected perpetrator of abuse or neglect of the child may not be disclosed during a public meeting. On a majority vote of the committee members, the members shall remove from the committee any member who discloses information described by this subsection in a public meeting.

(d) Information regarding the involvement of a state or local agency with the deceased child or another person described by Subsection (c) may not be disclosed during a public meeting.

(e) The committee may conduct an open or closed meeting by telephone conference call or other electronic medium. A meeting held under this subsection is subject to the notice requirements applicable to other meetings. The notice of the meeting must specify as the location of the meeting the location where meetings of the committee are usually held. Each part of the meeting by telephone conference call that is required to be open to the public shall be audible to the public at the location specified in the notice of the meeting as the location of the meeting and shall be tape-recorded. The tape recording shall be made available to the public.

(f) This section does not prohibit the committee from requesting the attendance at a closed meeting of a person who is not a member of the committee and who has information regarding a deceased child.

TEX. FAM. CODE ANN. § 264.505 (2011). Establishment of Review Team

(a) A multidisciplinary and multiagency child fatality review team may be established for a county to review child deaths in that county. A review team for a county with a population of less than 50,000 may join with an adjacent county or counties to establish a combined review team.

(b) Any person who may be a member of a review team under Subsection (c) may initiate the establishment of a review team and call the first organizational meeting of the team.

(c) A review team may include:

- (1) a criminal prosecutor involved in prosecuting crimes against children;
- (2) a sheriff;
- (3) a justice of the peace or medical examiner;
- (4) a police chief;
- (5) a pediatrician experienced in diagnosing and treating child abuse and neglect;
- (6) a child educator;
- (7) a child mental health provider;
- (8) a public health professional;
- (9) a child protective services specialist;
- (10) a sudden infant death syndrome family service provider;
- (11) a neonatologist;
- (12) a child advocate;
- (13) a chief juvenile probation officer; and
- (14) a child abuse prevention specialist.

(d) Members of a review team may select additional team members according to community resources and needs.

(e) A review team shall select a presiding officer from its members.

TEX. FAM. CODE ANN. § 264.506 (2011). Purpose and Duties of Review Team

(a) The purpose of a review team is to decrease the incidence of preventable child deaths by:

- (1) providing assistance, direction, and coordination to investigations of child deaths;
- (2) promoting cooperation, communication, and coordination among agencies involved in responding to child fatalities;
- (3) developing an understanding of the causes and incidence of child deaths in the county or counties in which the review team is located;
- (4) recommending changes to agencies, through the agency's representative member, that will reduce the number of preventable child deaths; and
- (5) advising the committee on changes to law, policy, or practice that will assist the team and the agencies represented on the team in fulfilling their duties.

(b) To achieve its purpose, a review team shall:

- (1) adapt and implement, according to local needs and resources, the model protocols developed by the department and the committee;
- (2) meet on a regular basis to review child fatality cases and recommend methods to improve coordination of services and investigations between agencies that are represented on the team;
- (3) collect and maintain data as required by the committee; and
- (4) submit to the bureau of vital statistics data reports on deaths reviewed as specified by the committee.

(c) A review team shall initiate prevention measures as indicated by the review team's findings.

TEX. FAM. CODE ANN. § 264.507 (2011). Duties of Presiding Officer

The presiding officer of a review team shall:

- (1) send notices to the review team members of a meeting to review a child fatality;
- (2) provide a list to the review team members of each child fatality to be reviewed at the meeting;
- (3) submit data reports to the bureau of vital statistics not later than the 30th day after the date on which the review took place; and

(4) ensure that the review team operates according to the protocols developed by the department and the committee, as adapted by the review team.

TEX. FAM. CODE ANN. § 264.508 (2011). Review Procedure

(a) The review team of the county in which the injury, illness, or event that was the cause of the death of the child occurred, as stated on the child's death certificate, shall review the death.

(b) On receipt of the list of child fatalities under Section 264.507, each review team member shall review the member's records and the records of the member's agency for information regarding each listed child.

TEX. FAM. CODE ANN. § 264.509 (2011). Access to Information

(a) A review team may request information and records regarding a deceased child as necessary to carry out the review team's purpose and duties. Records and information that may be requested under this section include:

(1) medical, dental, and mental health care information; and

(2) information and records maintained by any state or local government agency, including:

(A) a birth certificate;

(B) law enforcement investigative data;

(C) medical examiner investigative data;

(D) juvenile court records;

(E) parole and probation information and records; and

(F) child protective services information and records.

(b) On request of the presiding officer of a review team, the custodian of the relevant information and records relating to a deceased child shall provide those records to the review team at no cost to the review team.

(c) This subsection does not authorize the release of the original or copies of the mental health or medical records of any member of the child's family or the guardian or caretaker of the child or an alleged or suspected perpetrator of abuse or neglect of the child which are in the possession of any state or local government agency as provided in Subsection (a)(2). Information relating to the mental health or medical condition of a member of of [FN1] the child's family or the guardian or caretaker of the child or the alleged or suspected perpetrator of abuse or neglect of the child acquired as part of an investigation by a state or local government agency as provided in Subsection (a)(2) may be provided to the review team.

[FN1] So in enrolled bill.

TEX. FAM. CODE ANN. § 264.510 (2011). Meeting of Review Team

(a) A meeting of a review team is closed to the public and not subject to the open meetings law, Chapter 551, Government Code.

(b) This section does not prohibit a review team from requesting the attendance at a closed meeting of a person who is not a member of the review team and who has information regarding a deceased child.

(c) Except as necessary to carry out a review team's purpose and duties, members of a review team and persons attending a review team meeting may not disclose what occurred at the meeting.

(d) A member of a review team participating in the review of a child death is immune from civil or criminal liability arising from information presented in or opinions formed as a result of a meeting.

TEX. FAM. CODE ANN. § 264.511 (2011). Use of Information and Records; Confidentiality

(a) Information and records acquired by the committee or by a review team in the exercise of its purpose and duties under this subchapter are confidential and exempt from disclosure under the open records law, Chapter 552, Government Code, and may only be disclosed as necessary to carry out the committee's or review team's purpose and duties.

(b) A report of the committee or of a review team or a statistical compilation of data reports is a public record subject to the open records law, Chapter 552, Government Code, as if the committee or review team were a governmental body under that chapter, if the report or statistical compilation does not contain any information that would permit the identification of an individual.

(c) A member of a review team may not disclose any information that is confidential under this section.

(d) Information, documents, and records of the committee or of a review team that are confidential under this section are not subject to subpoena or discovery and may not be introduced into evidence in any civil or criminal proceeding, except that information, documents, and records otherwise available from other sources are not immune from subpoena, discovery, or introduction into evidence solely because they were presented during proceedings of the committee or a review team or are maintained by the committee or a review team.

TEX. FAM. CODE ANN. § 264.512 (2011). Governmental Units

The committee and a review team are governmental units for purposes of Chapter 101, Civil Practice and Remedies Code. A review team is a unit of local government under that chapter.

TEX. FAM. CODE ANN. § 264.513 (2011). Report of Death of Child

(a) A person who knows of the death of a child younger than six years of age shall immediately report the death to the medical examiner of the county in which the death occurs or, if the death occurs in a county that does not have a medical examiner's office or that is not part of a medical examiner's district, to a justice of the peace in that county.

(b) The requirement of this section is in addition to any other reporting requirement imposed by law, including any requirement that a person report child abuse or neglect under this code.

(c) A person is not required to report a death under this section that is the result of a motor vehicle accident. This subsection does not affect a duty imposed by another law to report a death that is the result of a motor vehicle accident.

TEX. FAM. CODE ANN. § 264.514 (2011). Procedure in the Event of Reportable Death

(a) A medical examiner or justice of the peace notified of a death of a child under Section 264.513 shall hold an inquest under Chapter 49, Code of Criminal Procedure, to determine whether the death is unexpected or the result of abuse or neglect. An inquest is not required under this subchapter if the child's death is expected and is due to a congenital or neoplastic disease. A death caused by an infectious disease may be considered an expected death if:

(1) the disease was not acquired as a result of trauma or poisoning;

(2) the infectious organism is identified using standard medical procedures; and

(3) the death is not reportable to the Texas Department of Health under Chapter 81, Health and Safety Code.

(b) The medical examiner or justice of the peace shall immediately notify an appropriate local law enforcement agency if the medical examiner or justice of the peace determines that the death is unexpected or the result of abuse or neglect, and that agency shall investigate the child's death.

(c) In this section, the terms “abuse” and “neglect” have the meaning assigned those terms by Section 261.001.

TEX. FAM. CODE ANN. § 264.515 (2011). Investigation

(a) The investigation required by Section 264.514 must include:

(1) an autopsy, unless an autopsy was conducted as part of the inquest;

(2) an inquiry into the circumstances of the death, including an investigation of the scene of the death and interviews with the parents of the child, any guardian or caretaker of the child, and the person who reported the child's death; and

(3) a review of relevant information regarding the child from an agency, professional, or health care provider.

(b) The review required by Subsection (a)(3) must include a review of any applicable medical record, child protective services record, record maintained by an emergency medical services provider, and law enforcement report.

(c) The committee shall develop a protocol relating to investigation of an unexpected death of a child under this section. In developing the protocol, the committee shall consult with individuals and organizations that have knowledge and experience in the issues of child abuse and child deaths.

UTAH

**UTAH CODE ANN. § 62A-16-302 (2011). REPORTING TO, AND REVIEW BY,
LEGISLATIVE COMMITTEES**

(1) The Office of Legislative Research and General Counsel shall provide a copy of the report described in Subsection 62A-16-301(1)(b), and the responses described in Subsections 62A-16-301(2) and (4)(c) to the chairs of:

(a) the Health and Human Services Interim Committee; or

(b) if the individual who is the subject of the report was, at the time of death, a person described in Subsection 62A-16-102(2)(c) or (d), the Child Welfare Legislative Oversight Panel.

(2)(a) The Health and Human Services Interim Committee may, in a closed meeting, review a report described in Subsection 62A-16-301(1)(b).

(b) The Child Welfare Legislative Oversight Panel shall, in a closed meeting, review a report described in Subsection (1)(b).

(3)(a) Neither the Health and Human Services Interim Committee nor the Child Welfare Legislative Oversight Panel may interfere with, or make recommendations regarding, the resolution of a particular case.

(b) The purpose of a review described in Subsection (2) is to assist a committee or panel described in Subsection (2) in determining whether to recommend a change in the law.

(c) Any recommendation, described in Subsection (3)(b), by a committee or panel for a change in the law shall be made in an open meeting.

(4)(a) On or before September 1 of each year, the department shall provide an executive summary of all fatality review reports for the preceding state fiscal year to the Office of Legislative Research and General Counsel.

(b) The Office of Legislative Research and General Counsel shall forward a copy of the executive summary described in Subsection(4)(a) to:

(i) the Health and Human Services Interim Committee; and

(ii) the Child Welfare Legislative Oversight Panel.

(5) The executive summary described in Subsection (4):

(a) may not include any names or identifying information;

(b) shall include:

- (i) all recommendations regarding changes to the law that were made during the preceding fiscal year under Subsection 62A-16-204 (6);
- (ii) all changes made, or in the process of being made, to a law, rule, policy, or procedure in response to a fatality review that occurred during the preceding fiscal year;
- (iii) a description of the training that has been completed in response to a fatality review that occurred during the preceding fiscal year;
- (iv) statistics for the preceding fiscal year regarding:
 - (A) the number and type of fatalities of qualified individuals that are known to the department;
 - (B) the number of formal fatality reviews conducted;
 - (C) the categories, described in Subsection 62A-16-102(2) of qualified individuals who died;
 - (D) the gender, age, race, and other significant categories of qualified individuals who died; and
 - (E) the number of fatalities of qualified individuals known to the department that are identified as suicides; and
- (v) action taken by the Office of Licensing and the Bureau of Internal Review and Audits in response to the fatality of a qualified individual; and
- (c) is a public document.

(6) The Division of Child and Family Services shall, to the extent required by the federal Child Abuse Prevention and Treatment Act, as amended, allow public disclosure of the findings or information relating to a case of child abuse or neglect that results in a child fatality or near fatality

Information from Utah Health Department

In 1992, the Utah Department of Health established the Utah Child Fatality Review Committee (CFRC). The CFRC was charged with the review of the circumstances and cause of all childhood deaths in the state. The purpose of the CRFC is to develop a better understanding of child deaths in order to reduce the number of intentional and unintentional deaths of Utah children. Often, this involves improving the response of various agencies in the investigation of child deaths to prevent future deaths.

Child death review teams are seen as a way to use a public health model of prevention through the review of child deaths. The American Academy of Pediatrics (AAP) recently issued a policy statement supporting federal and state legislation to enhance the child death review process. The AAP also recommended that pediatricians become involved in reviews in their local areas (1).

The committee published its first Child Fatality Review Report in 2003. A second report, Child Injury Deaths in Utah 2005-2007, was released in November 2011.

The goals of the CRFC are to:

- Identify and describe the prevalence of risk factors among deceased children by studying and reporting trends and patterns of child deaths in Utah.

- Maximize resources through interagency collaboration to identify and describe the service delivery of the involved systems (medical, human services, and law enforcement) to high-risk children, and make policy recommendations to improve the service systems to better meet the needs of all families involved with these systems.

- Promote effective prevention strategies to reduce the number of child deaths.

- Refer issues and propose strategies to appropriate organizations and agencies to promote education and prevention.

The CFRC meets once a month to review deaths of all Utah children (ages 0-18) who died within the three months prior, as well as any recent suspicious cases, and which were identified by the Office of the Medical Examiner (OME). These include homicides, suicides, suspicious or undetermined deaths, as well as any sudden and unexpected deaths. This death review process provides a detailed understanding of how and why child deaths occur in Utah.

Committee Membership

Utah's Child Fatality Review Committee includes representatives from the following agencies:

- Utah Department of Health, Violence and Injury Prevention Program
- Office of the Medical Examiner
- Bureau of Vital Records
- Emergency Medical Services
- Reproductive Health
- Department of Human Services (DHS)
- Division of Mental Health
- Division of Child and Family Services
- Office of Service Review (DHS Fatality Review)
- Valley Mental Health

National Center for Prosecution of Child Abuse
National District Attorney Association

Utah State Office of Education
Salt Lake County District Attorney's Office
Primary Children's Medical Center
Utah Attorney General's Office, Children's Justice Division
Utah Attorney General's Office, Child Protection Division
Administrative Office of the Courts
Juvenile Justice Services
Utah law enforcement agencies

Periodically, other members are invited to attend reviews if they are involved in a case. These include representatives from support services, day care centers, and child advocacy centers.

Detailed information about the review process can be found in the Child Injury Deaths in Utah, 2005-2007 report.

VERMONT

VT. STAT. ANN. tit. 33, § 4917 (2011). Multidisciplinary teams; empaneling

(a) The commissioner or his or her designee may empanel a multidisciplinary team or a special investigative multitask force team or both wherever in the state there may be a probable case of child abuse or neglect which warrants the coordinated use of several professional services. These teams shall participate and cooperate with the local special investigation unit in compliance with 13 V.S.A. § 5415.

(b) The commissioner or his or her designee, in conjunction with professionals and community agencies, shall appoint members to the multidisciplinary teams which may include persons who are trained and engaged in work relating to child abuse or neglect such as medicine, mental health, social work, nursing, child care, education, law, or law enforcement. The teams shall include a representative of the department of corrections. Additional persons may be appointed when the services of those persons are appropriate to any particular case.

(c) The empaneling of a multidisciplinary or special investigative multi-task force team shall be authorized in writing and shall specifically list the members of the team. This list may be amended from time to time as needed as determined by the commissioner or his or her designee.

VT. STAT. ANN. tit. 33, § 4918 (2011). Multidisciplinary teams; functions; guidelines

(a) Multidisciplinary teams shall assist local district offices of the department in identifying and treating child abuse or neglect cases. With respect to any case referred to it, the team may assist the district office by providing:

- (1) case diagnosis or identification;
- (2) a comprehensive treatment plan; and
- (3) coordination of services pursuant to the treatment plan.

(b) Multidisciplinary teams may also provide public informational and educational services to the community about identification, treatment, and prevention of child abuse and neglect. It shall also foster communication and cooperation among professionals and organizations in its community, and provide such recommendations or changes in service delivery as it deems necessary.

VT. STAT. ANN. tit. 33, § 4919 (2011). Disclosure of registry records

(a) The commissioner may disclose a registry record only as follows:

- (1) To the state's attorney or the attorney general.
- (2) To the owner or operator of a facility regulated by the department for the purpose of informing the owner or operator that employment of a specific individual may result in loss of license, registration, certification, or authorization as set forth in section 309 of this title.
- (3) To an employer if such information is used to determine whether to hire or retain a specific individual providing care, custody, treatment, transportation, or supervision of children or vulnerable adults. The employer may submit a request concerning a current employee, volunteer, grantee, or contractor or an individual to whom the employer has given a conditional offer of a contract, volunteer position, or employment. The request shall be accompanied by a release signed by the current or prospective employee, volunteer, grantee, or contractor. If that individual has a record of a substantiated report, the commissioner shall provide the registry record to the employer. The employer shall not disclose the information contained in the registry report.
- (4) To the commissioners of disabilities, aging, and independent living, and of mental health, or their designees, for purposes related to the licensing or registration of facilities regulated by those departments.

(5) To the commissioners of health, of disabilities, aging, and independent living, and of mental health, or their designees, for purposes related to oversight and monitoring of persons who are served by or compensated with funds provided by those departments, including persons to whom a conditional offer of employment has been made.

(6) Upon request or when relevant to other states' adult protective services offices.

(7) Upon request or when relevant to other states' child protection agencies.

(8) To the person substantiated for child abuse and neglect who is the subject of the record.

(9) To the commissioner of the department of corrections in accordance with the provisions of 28 V.S.A. § 204a(b)(3).

(10) To the board of medical practice for the purpose of evaluating an applicant, licensee, or holder of certification pursuant to 26 V.S.A. § 1353.

(b) An employer providing transportation services to children or vulnerable adults may disclose registry records obtained pursuant to subdivision (a)(3) of this section to the agency of human services or its designee for the sole purpose of auditing the records to ensure compliance with this subchapter. An employer shall provide such records at the request of the agency or its designee. Only registry records regarding individuals who provide direct transportation services or otherwise have direct contact with children or vulnerable adults may be disclosed.

(c) Volunteers shall be considered employees for purposes of this section.

(d) Disclosure of registry records or information or other records used or obtained in the course of providing services to prevent child abuse or neglect or to treat abused or neglected children and their families by one member of a multidisciplinary team to another member of that team shall not subject either member of the multidisciplinary team, individually, or the team as a whole, to any civil or criminal liability notwithstanding any other provision of law.

(e) "Employer," as used in this section, means a person or organization who employs or contracts with one or more individuals to care for or provide transportation services to children or vulnerable adults, on either a paid or volunteer basis.

(f) In no event shall registry records be made available for employment purposes other than as set forth in this subsection, or for credit purposes. Any person who violates this subsection shall be fined not more than \$500.00.

(g) Nothing in this subsection shall limit the department's right to use and disclose information from its records as provided in section 4921 of this chapter.

VIRGINIA

VA. CODE ANN. § 2.1-283.2 (2011). Local and regional child fatality review teams established; membership; authority; confidentiality; immunity

A. Upon the initiative of any local or regional law-enforcement agency, fire department, department of social services, emergency medical services agency, Commonwealth's attorney's office, or community services board, local or regional child fatality teams may be established for the purpose of conducting contemporaneous reviews of local child deaths in order to develop interventions and strategies for prevention specific to the locality or region. Each team shall establish rules and procedures to govern the review process. Agencies may share information but shall be bound by confidentiality and execute a sworn statement to honor the confidentiality of the information they share. Violations shall be punishable as a Class 3 misdemeanor. The State Child Fatality Review Team shall provide technical assistance and direction as provided for in subsection A of § 32.1-283.1.

B. Local and regional teams may be composed of the following persons from the localities represented on a particular board or their designees: a local or regional medical examiner, a local social services official in charge of child protective services, a director of the relevant local or district health department, a chief law-enforcement officer, a local fire marshal, the attorney for the Commonwealth, an executive director of the local community services board or other local mental health agency, and such additional persons, not to exceed five, as may be appointed to serve by the chairperson of the local or regional team. The chairperson shall be elected from among the designated membership. The additional members appointed by the chairperson may include, but are not restricted to, representatives of local human services agencies; local public education agencies; local pediatricians, psychiatrists and psychologists; and local child advocacy organizations.

C. Each team shall establish local rules and procedures to govern the review process prior to conducting the first child fatality review. The review of a death shall be delayed until any criminal investigations connected with the death are completed or the Commonwealth consents to the commencement of such review prior to the completion of the criminal investigation.

D. All information and records obtained or created regarding the review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 9 of § 2.2-3705.5. All such information and

records shall be used by the team only in the exercise of its proper purpose and function and shall not be disclosed. Such information or records shall not be subject to subpoena, subpoena duces tecum, or discovery or be admissible in any criminal or civil proceeding. If available from other sources, however, such information and records shall not be immune from subpoena, subpoena duces tecum, discovery or introduction into evidence when obtained through such other sources solely because the information and records were presented to the team during a fatality review. No person who participated in the reviews nor any member of the team shall be required to make any statement as to what transpired during the review or what information was collected during the review. Upon the conclusion of the fatality review, all information and records concerning the victim and the family shall be returned to the originating agency or destroyed. However, the findings of the team may be disclosed or published in statistical or other form which shall not identify individuals. The portions of meetings in which individual cases are discussed by the team shall be closed pursuant to subdivision A 21 of § 2.2-3711. All team members, persons attending closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. Violations of this subsection shall be punishable as a Class 3 misdemeanor.

E. Members of teams, as well as their agents and employees, shall be immune from civil liability for any act or omission made in connection with participation in a child fatality review team review, unless such act or omission was the result of gross negligence or willful misconduct. Any organization, institution, or person furnishing information, data, testimony, reports or records to review teams as part of such review, shall be immune from civil liability for any act or omission in furnishing such information, unless such act or omission was the result of gross negligence or willful misconduct.

WASHINGTON

WASH. REV. CODE ANN. § 0.05.170 (2012). CHILD MORTALITY REVIEW

(1)(a) The legislature finds that the mortality rate in Washington state among infants and children less than eighteen years of age is unacceptably high, and that such mortality may be preventable. The legislature further finds that, through the performance of child mortality reviews, preventable causes of child mortality can be identified and addressed, thereby reducing the infant and child mortality in Washington state.

(b) It is the intent of the legislature to encourage the performance of child death reviews by local health departments by providing necessary legal protections to the families of children whose deaths are studied, local health department officials and employees, and health care professionals participating in child mortality review committee activities.

(2) As used in this section, “child mortality review” means a process authorized by a local health department as such department is defined in RCW 70.05.010 for examining factors that contribute to deaths of children less than eighteen years of age. The process may include a systematic review of medical, clinical, and hospital records; home interviews of parents and caretakers of children who have died; analysis of individual case information; and review of this information by a team of professionals in order to identify modifiable medical, socioeconomic, public health, behavioral, administrative, educational, and environmental factors associated with each death.

(3) Local health departments are authorized to conduct child mortality reviews. In conducting such reviews, the following provisions shall apply:

(a) All health care information collected as part of a child mortality review is confidential, subject to the restrictions on disclosure provided for in chapter 70.02 RCW. When documents are collected as part of a child mortality review, the records may be used solely by local health departments for the purposes of the review.

(b) No identifying information related to the deceased child, the child's guardians, or anyone interviewed as part of the child mortality review may be disclosed. Any such information shall be redacted from any records produced as part of the review.

(c) Any witness statements or documents collected from witnesses, or summaries or analyses of those statements or records prepared exclusively for purposes of a child mortality review, are not subject to public disclosure, discovery, subpoena, or introduction into evidence in any administrative, civil, or criminal proceeding related to the death of a child reviewed. This provision does not restrict or limit the discovery or subpoena from a health care provider of records or documents maintained by such health care provider in the ordinary course of business, whether or not such records or documents may have been supplied to a local health department pursuant to this section. This provision shall not restrict or limit the discovery or subpoena of documents from such witnesses simply because a copy of a document was collected as part of a child mortality review.

(d) No local health department official or employee, and no members of technical committees established to perform case reviews of selected child deaths may be examined in any administrative, civil, or criminal proceeding as to the existence or contents of documents assembled, prepared, or maintained for purposes of a child mortality review.

(e) This section shall not be construed to prohibit or restrict any person from reporting suspected child abuse or neglect under chapter 26.44 RCW nor to limit access to or use of any records, documents, information, or testimony in any civil or criminal action arising out of any report made pursuant to chapter 26.44 RCW.

(4) The department shall assist local health departments to collect the reports of any child mortality reviews conducted by local health departments and assist with entering the reports into a database to the extent that the data is not protected under subsection (3) of this section. Notwithstanding subsection (3) of this section, the department shall respond to any requests for data from the database to the extent permitted for health care information under chapter 70.02 RCW. In addition, the department shall provide technical assistance to local health departments and child death review coordinators conducting child mortality reviews and encourage communication among child death review teams. The department shall conduct these activities using only federal and private funding.

(5) This section does not prevent a local health department from publishing statistical compilations and reports related to the child mortality review. Any portions of such compilations and reports that identify individual cases and sources of information must be redacted.

WEST VIRGINIA

W. VA. CODE ANN. § 48-25A-1 (2011). LEGISLATIVE FINDINGS

The Legislature finds that there is a need for a process to study the causes of infant and maternal deaths. It has been found that comprehensive studies indicate that maternal mortalities are more extensive than first appear on death certificates.

The Legislature finds that more extensive studies of infant mortalities and maternal mortalities would enable a more developed plan to avoid these deaths in the future.

W. VA. CODE ANN. § 48-25A-2 (2011). Infant and Maternal Mortality Review Team

(a) The Maternal Mortality Review Team established under the Office of Maternal Child and Family Health is continued and renamed the Infant and Maternal Mortality Review Team. The Infant and Maternal Mortality Review Team is a multidisciplinary team created to review the deaths of all infants and women who die during pregnancy, at the time of birth or within one year of the birth of a child.

(b) The Infant and Maternal Mortality Review Team is to consist of the following members, appointed by the Governor:

(1) The Director of the Office of Maternal Child and Family Health, who is to serve as the chairperson of the Infant and Maternal Mortality Review Team and is responsible for calling and coordinating all meetings;

- (2) The Commissioner of the Bureau for Public Health or a designee;
 - (3) The Chief Medical Examiner in the Bureau for Public Health or a designee;
 - (4) The Director of the Division of Vital Statistics or a designee;
 - (5) Representation from each of the three medical schools in the state;
 - (6) The Director of Obstetrics, the Director of the Neonatal Intensive Care Unit and the Director of Pediatrics at each of the tertiary care hospitals in the state;
 - (7) One representative of the West Virginia State Medical Association;
 - (8) One representative of the West Virginia Nurses Association;
 - (9) One representative of the West Virginia Society of Osteopathic Medicine;
 - (10) One representative of West Virginia Academy of Family Physicians;
 - (11) One representative of the West Virginia Chapter of the American College of Nurse Midwives;
 - (12) One representative of the West Virginia Chapter of the American College of Obstetrics and Gynecology;
 - (13) One representative of the West Virginia Chapter of the American Academy of Pediatrics;
 - (14) The Director of the Child Fatality Review Team; and
 - (15) Any additional person that the chair of the team determines is needed on a particular case being considered.
- (c) Each member serves for a term of five years. Of the members of the commission first appointed, one shall be appointed for a term ending June 30, 2009, and one each for terms ending one, two, three and four years thereafter.
- (d) Members of the Infant and Maternal Mortality Review Team shall, unless sooner removed, continue to serve until their respective terms expire and until their successors have been appointed and have qualified.
- (e) An appointment of a physician, whether for a full term or to fill a vacancy, is to be made by the Governor from among three nominees selected by the West Virginia State Medical Association or the organization to be represented on the team. When an

appointment is for a full term, the nomination is to be submitted to the Governor not later than eight months prior to the date on which the appointment is to become effective. In the case of an appointment to fill a vacancy, the nominations are to be submitted to the Governor within thirty days after the request for the nomination has been made by the Governor to the chairperson or president of the organization. When an association fails to submit to the Governor nominations for the appointment in accordance with the requirements of this section, the Governor may make the appointment without nominations.

(f) Each member of the Infant and Maternal Mortality Review Team shall serve without additional compensation and may not be reimbursed for any expenses incurred in the discharge of his or her duties under the provisions of this article.

W. VA. CODE ANN. § 48-25A-3 (2011). Responsibilities of the Infant and Maternal Mortality Review Team

(a) The Bureau for Public Health in consultation with the Infant and Maternal Mortality Review Team shall, pursuant to the provisions of article three, chapter twenty-nine-a, promulgate rules applicable to the following:

(1) The standard procedures for the establishment, formation and conduct of the Infant and Maternal Mortality Review Team; and

(2) The protocols for the review of infant and maternal mortalities.

(b) The Infant and Maternal Mortality Review Team shall:

(1) Review deaths of all infants and of all women who die during pregnancy, at the time of birth or within one year of the birth of a child;

(2) Establish the trends, patterns and risk factors;

(3) Provide statistical analysis regarding the causes of infant and maternal fatalities in West Virginia; and

(4) Promote public awareness of the incidence and causes of infant and maternal fatalities, including recommendations for their reduction.

(c) The Infant and Maternal Mortality Review Team shall submit an annual report to the Governor and to the Legislature concerning its activities and the incidents of infant and maternal fatalities within the state. The report is due annually on December 1. The report is to include statistics setting forth the number of infant and maternal fatalities,

identifiable trends in infant and maternal fatalities in the state, including possible causes, if any, and recommendations to reduce the number of preventable infant and maternal fatalities in the state. The report is to also include the number of infant and mothers whose deaths have been determined to have been unexpected or unexplained.

(d) The Infant and Maternal Mortality Review Team, in the exercise of its duties as defined in this section, may not:

- (1) Call witnesses or take testimony from individuals involved in the investigation of an infant or maternal fatality;
- (2) Contact a family member of the deceased infant or mother, except if a member of the team is involved in the investigation of the death and must contact a family member in the course of performing his or her duties outside of the team; or
- (3) Enforce any public health standard or criminal law or otherwise participate in any legal proceeding, except if a member of the team is involved in the investigation of the death or resulting prosecution and must participate in a legal proceeding in the course of performing in his or her duties outside of the team.

(e) Proceedings, records and opinions of the Infant and Maternal Mortality Review Team are confidential, in accordance with section one, article seven, chapter forty-nine of this code, and are not subject to discovery, subpoena or introduction into evidence in any civil or criminal proceeding. Nothing in this subsection is to be construed to limit or restrict the right to discover or use in any civil or criminal proceeding anything that is available from another source and entirely independent of the proceedings of the Infant and Maternal Mortality Review Team.

(f) Members of the Infant and Maternal Mortality Review Team may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a meeting of the team. Nothing in this subsection prevents a member of the Infant and Maternal Mortality Review Team from testifying to information obtained independently of the team or which is public information.

WISCONSIN

Wisconsin does not have legislation enabling or mandating the creation of local Child Death Review Teams, nor does it provides direct financial resources.⁴ However, Wisconsin Department of Health Services (DHS), the Department of Children and

⁴ Wisconsin State Child Death Review Team, *Keeping Kids Alive in Wisconsin: Child Death Review Guidelines*; available at www.chawisconsin.org/documents/CDRFinal10.13.08.pdf (accessed Feb. 21 2012).

Families (DCF) and the State Department of Justice (DOJ) are collaborating to implement CDR teams in Wisconsin.⁵ Approximately 13 of the 72 counties have some form of CDR team.⁶

WYOMING

WYO. STAT. ANN. § 14-3-201 (2011). Purpose

The purpose of W.S. 14-3-201 through 14-3-216 is to delineate the responsibilities of the state agency, other governmental agencies or officials, professionals and citizens to intervene on behalf of a child suspected of being abused or neglected, to protect the best interest of the child, to further offer protective services when necessary in order to prevent any harm to the child or any other children living in the home, to protect children from abuse or neglect which jeopardize their health or welfare, to stabilize the home environment, to preserve family life whenever possible and to provide permanency for the child in appropriate circumstances. The child's health, safety and welfare shall be of paramount concern in implementing and enforcing this article.

WYO. STAT. ANN. § 14-3-202 (2011). Definitions

(a) As used in W.S. 14-3-201 through 14-3-216:

(i) “A person responsible for a child's welfare” includes the child's parent, noncustodial parent, guardian, custodian, stepparent, foster parent or other person, institution or agency having the physical custody or control of the child;

(ii) “Abuse” means inflicting or causing physical or mental injury, harm or imminent danger to the physical or mental health or welfare of a child other than by accidental means, including abandonment, unless the abandonment is a relinquishment substantially in accordance with W.S. 14-11-101 through 14-11-109, excessive or unreasonable corporal punishment, malnutrition or substantial risk thereof by reason of intentional or unintentional neglect, and the commission or allowing the commission of a sexual offense against a child as defined by law:

(A) “Mental injury” means an injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in his ability to function within a normal range of performance and behavior with due regard to his culture;

⁵ *Id.*

⁶ *Id.*

(B) “Physical injury” means any harm to a child including but not limited to disfigurement, impairment of any bodily organ, skin bruising if greater in magnitude than minor bruising associated with reasonable corporal punishment, bleeding, burns, fracture of any bone, subdural hematoma or substantial malnutrition;

(C) “Substantial risk” means a strong possibility as contrasted with a remote or insignificant possibility;

(D) “Imminent danger” includes threatened harm and means a statement, overt act, condition or status which represents an immediate and substantial risk of sexual abuse or physical or mental injury. “Imminent danger” includes violation of W.S. 31-5-233(m).

(iii) “Child” means any person under the age of eighteen (18);

(iv) “Child protective agency” means the field or regional offices of the department of family services;

(v) “Court proceedings” means child protective proceedings which have as their purpose the protection of a child through an adjudication of whether the child is abused or neglected, and the making of an appropriate order of disposition;

(vi) “Institutional child abuse and neglect” means situations of child abuse or neglect where a foster home or other public or private residential home, institution or agency is responsible for the child's welfare;

(vii) “Neglect” means a failure or refusal by those responsible for the child's welfare to provide adequate care, maintenance, supervision, education or medical, surgical or any other care necessary for the child's well being. Treatment given in good faith by spiritual means alone, through prayer, by a duly accredited practitioner in accordance with the tenets and practices of a recognized church or religious denomination is not child neglect for that reason alone;

(viii) “State agency” means the state department of family services;

(ix) “Subject of the report” means any child reported under W.S. 14-3-201 through 14-3-216 or the child's parent, guardian or other person responsible for the child's welfare;

(x) “Unsubstantiated report” means any report made pursuant to W.S. 14-3-201 through 14-3-216 that, upon investigation, is not supported by a preponderance of the evidence;

(xi) “Substantiated report” means any report of child abuse or neglect made pursuant to W.S. 14-3-201 through 14-3-216 that, upon investigation, is supported by a preponderance of the evidence;

(xii) to (xiv) Repealed by Laws 2002, Sp. & Bud. Sess., Ch. 86, § 3.

(xv) “Collaborative” means the interagency children's collaborative created by W.S. 14-3-215;

(xvi) “Department” means the state department of family services and its local offices;

(xvii) “Transportation” means the provision of a means to convey the child from one place to another by the custodian or someone acting on his behalf in the performance of required duties, but does not require the state to provide incidental travel or to purchase a motor vehicle for the child's own use to travel.

WYO. STAT. ANN. § 14-3-203 (2011). Duties of state agency; on-call services

(a) The state agency shall:

(i) Administer W.S. 14-3-201 through 14-3-215;

(ii) Be responsible for strengthening and improving state and community efforts toward the prevention, identification and treatment of child abuse and neglect in the state; and

(iii) Refer any person or family seeking assistance in meeting child care responsibilities, whether or not the problem presented by the person or family is child abuse or neglect, to appropriate community resources, agencies, services or facilities.

(iv) Repealed by Laws 2005, ch. 236, § 4.

(b) The state agency may contract for assistance in providing on-call services. The assistance may include screening protection calls, making appropriate referrals to law enforcement and the agency, and maintaining a record of calls and referrals. Contractors shall have training in child protection services.

(c) The state agency shall ensure that all child protective service workers are trained:

(i) In the principles of family centered practice that focus on providing services to the entire family to achieve the goals of safety and permanency for children, including balancing the best interests of children with the rights of parents;

(ii) In the duty of the workers to inform the individual subject to a child abuse or neglect allegation, at the earliest opportunity during the initial contact, of the specific complaints or allegations made against the individual;

(iii) Concerning constitutional and statutory rights of children and families from and after the initial time of contact and the worker's legal duty not to violate the constitutional and statutory rights of children and families from and after the initial time of contact;

(iv) To know the state's legal definitions of physical abuse, sexual abuse, neglect, dependency and endangerment;

(v) To know the provisions of federal and state laws governing child welfare practice, including but not limited to the Adoption and Safe Families Act, Indian Child Welfare Act, Multi-Ethnic Placement Act and the Child Abuse Prevention and Treatment Act, as amended.

WYO. STAT. ANN. § 14-3-204 (2011). Duties of local child protective agency

(a) The local child protective agency shall:

(i) Prepare a plan for child protective services under guidelines prepared by the state agency, and provide services under the plan to prevent further child abuse or neglect. The plan shall be reviewed annually by both agencies;

(ii) Receive, assess, investigate or arrange for investigation and coordinate investigation or assessment of all reports of known or suspected child abuse or neglect;

(iii) Within twenty-four (24) hours after notification of a suspected case of child abuse or neglect, initiate an investigation or assessment and verification of every report. The representative of the child protective agency shall, at the initial time of contact with the individual subject to a child abuse and neglect investigation or assessment, advise the individual of the specific complaints or allegations made against the individual. A thorough investigation or assessment and report of child abuse or neglect shall be made in the manner and time prescribed by the state agency pursuant to rules and regulations adopted in accordance with the Wyoming Administrative Procedure Act. If the child protective agency is denied reasonable access to a child by a parent or other persons and the agency deems that the best interest of the child so requires, it shall seek an appropriate court order by ex parte proceedings or other appropriate proceedings to see the child. The child protective agency shall assign a report:

(A) For investigation when allegations contained in the report indicate:

(I) That criminal charges could be filed, the child appears to be in imminent danger and it is likely the child will need to be removed from the home; or

(II) A child fatality, major injury or sexual abuse has occurred.

(B) For assessment when the report does not meet the criteria of subparagraph (A) of this paragraph.

(iv) If the investigation or assessment discloses that abuse or neglect is present, initiate services with the family of the abused or neglected child to assist in resolving problems that lead to or caused the child abuse or neglect;

(v) If the child protective agency is able through investigation to substantiate a case of abuse or neglect, it shall notify the person suspected of causing the abuse or neglect by first class mail to his last known address of his right to request a hearing on the agency's determination for a final determination before the office of administrative hearings pursuant to the Wyoming Administrative Procedure Act;

(vi) Make reasonable efforts to contact the noncustodial parent of the child and inform the parent of substantiated abuse or neglect in high risk or moderate risk cases as determined pursuant to rules and regulations of the state agency and inform the parent of any proposed action to be taken;

(vii) Cooperate, coordinate and assist with the prosecution and law enforcement agencies;

(viii) When the best interest of the child requires court action, contact the county and prosecuting attorney to initiate legal proceedings and assist the county and prosecuting attorney during the proceedings. If the county attorney elects not to bring court action the local child protective agency may petition the court for appointment of a guardian ad litem who shall act in the best interest of the child and who may petition the court to direct the county attorney to show cause why an action should not be commenced under W.S. 14-3-401 through 14-3-439; and

(ix) Refer a child receiving department services who is under the age of six (6) years to the department of health, division of developmental disabilities preschool program for educational and developmental screening and assessment.

(b) The local child protective agency may appeal an adverse determination of the office of administrative hearings.

WYO. STAT. ANN. § 14-3-205 (2011). Child abuse or neglect; persons required to report

(a) Any person who knows or has reasonable cause to believe or suspect that a child has been abused or neglected or who observes any child being subjected to conditions or circumstances that would reasonably result in abuse or neglect, shall immediately report it to the child protective agency or local law enforcement agency or cause a report to be made.

(b) If a person reporting child abuse or neglect is a member of the staff of a medical or other public or private institution, school, facility or agency, he shall notify the person in charge or his designated agent as soon as possible, who is thereupon also responsible to make the report or cause the report to be made. Nothing in this subsection is intended to relieve individuals of their obligation to report on their own behalf unless a report has already been made or will be made.

(c) Any employer, public or private, who discharges, suspends, disciplines or penalizes an employee solely for making a report of neglect or abuse under W.S. 14-3-201 through 14-3-215 is guilty of a misdemeanor punishable by imprisonment for not more than six (6) months, a fine of not more than seven hundred fifty dollars (\$750.00), or both.

(d) Any person who knowingly and intentionally makes a false report of child abuse or neglect, or who encourages or coerces another person to make a false report of child abuse or neglect, is guilty of a misdemeanor punishable by imprisonment for not more than six (6) months, a fine of not more than seven hundred fifty dollars (\$750.00), or both.

WYO. STAT. ANN. § 14-3-206 (2011). Child abuse or neglect; written report; statewide reporting center; documentation; costs and admissibility thereof

(a) Reports of child abuse or neglect or of suspected child abuse or neglect made to the local child protective agency or local law enforcement agency shall be:

(i) Conveyed immediately by the agency receiving the report to the appropriate local child protective agency or local law enforcement agency. The agencies shall continue cooperating and coordinating with each other during the investigation; and

(ii) Followed by a written report by the receiving agency confirming or not confirming the facts reported. The report shall provide to law enforcement or the local child protective agency the following, to the extent available:

- (A) The name, age and address of the child;
 - (B) The name and address of any person responsible for the child's care;
 - (C) The nature and extent of the child's condition;
 - (D) The basis of the reporter's knowledge;
 - (E) The names and conditions of any other children relevant to the report;
 - (F) Any evidence of previous injuries to the child;
 - (G) Photographs, videos and x-rays with the identification of the person who created the evidence and the date the evidence was created; and
 - (H) Any other relevant information.
- (b) The state agency may establish and maintain a statewide reporting center to receive reports of child abuse or neglect on a twenty-four (24) hour, seven (7) day week, toll free telephone number. Upon establishment of the service, all reports of child abuse or neglect may be made to the center which shall transfer the reports to the appropriate local child protective agency.
- (c) Any person investigating, examining or treating suspected child abuse or neglect may document evidence of child abuse or neglect to the extent allowed by law by having photographs taken or causing x-rays to be made of the areas of trauma visible on a child who is the subject of the report or who is subject to a report. The reasonable cost of the photographs or x-rays shall be reimbursed by the appropriate local child protective agency. All photographs, x-rays or copies thereof shall be sent to the local child protective agency, admissible as evidence in any civil proceeding relating to child abuse or neglect, and shall state:
- (i) The name of the subject;
 - (ii) The name, address and telephone number of the person taking the photographs or x-rays; and
 - (iii) The date and place they were taken.

WYO. STAT. ANN. § 14-3-207 (2011). Abuse or neglect as suspected cause of death; coroner's investigation

Any person who knows or has reasonable cause to suspect that a child has died as a result of child abuse or neglect shall report to the appropriate coroner. The coroner shall investigate the report and submit his findings in writing to the law enforcement agency, the appropriate district attorney and the local child protective agency.

WYO. STAT. ANN. § 14-3-208 (2011). Temporary protective custody; order; time limitation; remedial health care

(a) When a child is taken into temporary protective custody pursuant to W.S. 14-3-405(a) and (b), the person taking custody shall immediately notify the local department of family services office and place or transfer temporary protective custody to the local department of family services office as soon as practicable. The local department of family services office shall:

(i) Accept physical custody of the child;

(ii) Make reasonable efforts to inform the parent, noncustodial parent or other person responsible for the child's welfare that the child has been taken into temporary protective custody, unless otherwise ordered by a court of competent jurisdiction;

(iii) Arrange for care and supervision of the child in the most appropriate and least restrictive setting necessary to meet the child's needs, including foster homes or other child care facilities certified by the department or approved by the court. When it is in the best interest of the child, the department shall place the child with the child's noncustodial birth parent or with the child's extended family, including adult siblings, grandparents, great-grandparents, aunts or uncles. Prior to approving placement with the child's noncustodial birth parent or extended family, the department shall determine whether anyone living in the home has been convicted of a crime involving serious harm to children or has a substantiated case listed on the central registry established pursuant to W.S. 14-3-213. The department may leave the child in the care of a physician or hospital when necessary to ensure the child receives proper care. A neglected child shall not be placed in a jail or detention facility other than for a delinquent act;

(iv) Initiate an investigation of the allegations; and

(v) Assess the child's mental and physical needs, provide for the child's ordinary and emergency medical care and seek emergency court authorization for any extraordinary medical care that is needed prior to the shelter care hearing.

(b) The law enforcement or medical provider shall promptly notify the court and the district attorney of any child taken into temporary protective custody and placed in its care pursuant to W.S. 14-3-405 without a court order.

(c) Temporary protective custody shall not exceed forty-eight (48) hours, excluding weekends and legal holidays.

(d) When the court orders the child into the legal custody of the department pursuant to W.S. 14-3-409(d) or 14-3-429, the department shall:

(i) Accept legal custody of the child;

(ii) Continue or arrange for, care, transportation and supervision of the child as provided in paragraph (a)(iii) of this section;

(iii) Assess the child's mental and physical health needs and provide for the child's ordinary and emergency medical care;

(iv) Arrange for the provision of the education of the child, including participation in individualized education or developmental services;

(v) Participate in multidisciplinary team meetings to develop treatment recommendations for the child;

(vi) Perform any other duties ordered by the court relating to the care or custody of the child.

WYO. STAT. ANN. § 14-3-209 (2011). Immunity from liability

Any person, official, institution or agency participating in good faith in any act required or permitted by W.S. 14-3-201 through 14-3-215 is immune from any civil or criminal liability that might otherwise result by reason of the action. For the purpose of any civil or criminal proceeding, the good faith of any person, official or institution participating in any act permitted or required by W.S. 14-3-201 through 14-3-215 shall be presumed.

WYO. STAT. ANN. § 14-3-2010 (2011). Admissibility of evidence constituting privileged communications

(a) Evidence regarding a child in any judicial proceeding resulting from a report made pursuant to W.S. 14-3-201 through 14-3-215 shall not be excluded on the ground it constitutes a privileged communication:

(i) Between husband and wife;

(ii) Claimed under any provision of law other than W.S. 1-12-101(a)(i) and (ii); or

(iii) Claimed pursuant to W.S. 1-12-116.

WYO. STAT. ANN. § 14-3-2011 (2011). Appointment of counsel for child and other parties

(a) The court shall appoint counsel to represent any child in a court proceeding in which the child is alleged to be abused or neglected. Any attorney representing a child under this section shall also serve as the child's guardian ad litem unless a guardian ad litem has been appointed by the court. The attorney or guardian ad litem shall be charged with representation of the child's best interest.

(b) The court may appoint counsel for any party when necessary in the interest of justice.

WYO. STAT. ANN. § 14-3-2012 (2011). Child protection teams; creation; composition; duties; records confidential

(a) The state agency and the local child protective agency shall encourage and assist in the creation of child protection teams within the communities in the state. The purposes of the child protection teams shall be to identify or develop community resources to serve abused and neglected children within the community, to advocate for improved services or procedures for such children and to provide information and assistance to the state agency, local child protection agency and multidisciplinary teams, if a multidisciplinary team has been appointed. The department may promulgate reasonable rules and regulations in accordance with the Wyoming Administrative Procedure Act to define the roles and procedures of child protection teams.

(b) The local child protection team shall be composed of:

(i) A member of the district attorney's office;

(ii) A designated representative from the school district or districts within the area served by the team;

(iii) A representative from the local field office of the department of family services;

(iv) A representative from the county government;

(v) A representative from each city and town in the county;

(vi) Representatives from other relevant professions; and

(vii) Temporary members selected for the needs of a particular case as determined by the team.

(c) The local child protection team may:

(i) Assist and coordinate with the state agency, the local child protective agency and all available agencies and organizations dealing with children;

(ii) Repealed by Laws 2005, ch. 236, § 4.

(iii) Coordinate the provision of appropriate services for abused and neglected children and their families;

(iv) Identify or develop community resources to serve abused and neglected children and advocate for improved services and procedures for such children;

(v) Identify training needs, sponsor training and raise community awareness of child protection issues; and

(vi) Assist and make recommendations of appropriate services in individual cases brought to it by the state agency or the local child protection agency.

(d) The local child protection team shall not act as a multidisciplinary team, but members of the child protection team may serve on a multidisciplinary team if appointed pursuant to W.S. 14-3-427.

(e) All records and proceedings of the child protection teams are subject to W.S. 14-3-214.

WYO. STAT. ANN. § 14-3-2013 (2011). Central registry of child protection cases; establishment; operation; amendment, expungement or removal of records; classification and expungement of reports; statement of person accused

(a) The state agency shall establish and maintain a record of all child protection reports and a central registry of “under investigation” or “substantiated” child protection reports in accordance with W.S. 42-2-111.

(b) Through the recording of reports, the state agency's recordkeeping system shall be operated to enable the state agency to:

(i) Immediately identify and locate prior reports of cases of child abuse or neglect to assist in the diagnosis of suspicious circumstances and the assessment of the needs of the child and his family;

(ii) Continuously monitor the current status of all pending child protection cases;

(iii) Regularly evaluate the effectiveness of existing laws and programs through the development and analysis of statistical and other information; and

(iv) Maintain a central registry of “under investigation” reports and “substantiated” reports of child abuse or neglect for provision of information to qualifying applicants pursuant to W.S. 14-3-214(f).

(c) Upon good cause shown and upon notice to the subject of an “under investigation” or “substantiated” report, the state agency may list, amend, expunge or remove any record from the central registry in accordance with rules and regulations adopted by the state agency.

(d) All reports of child abuse or neglect contained within the central registry shall be classified in one (1) of the following categories:

(i) “Under investigation”; or

(ii) “Substantiated”.

(iii) Repealed by Laws 2005, ch. 23, § 2.

(e) Within six (6) months all reports classified as “under investigation” shall be reclassified as “substantiated” or expunged from the central registry, unless the state agency is notified of an open criminal investigation or criminal prosecution. Unsubstantiated reports shall not be contained within the central registry.

(f) Any person named as a perpetrator of child abuse or neglect in any report maintained in the central registry which is classified as a substantiated report as defined in W.S. 14-3-202(a)(xi) shall have the right to have included in the report his statement concerning the incident giving rise to the report. Any person seeking to include a statement pursuant to this subsection shall provide the state agency with the statement. The state agency shall provide notice to any person identified as a perpetrator of his right to submit his statement in any report maintained in the central registry.

WYO. STAT. ANN. § 14-3-2014 (2011). Confidentiality of records; penalties; access to information; attendance of school officials at interviews; access to central registry records pertaining to child protection cases

(a) All records concerning reports and investigations of child abuse or neglect are confidential except as provided by W.S. 14-3-201 through 14-3-215. Any person who willfully violates this subsection is guilty of a misdemeanor and upon conviction shall be

fined not more than five hundred dollars (\$500.00) or imprisoned in the county jail not more than six (6) months, or both.

(b) Applications for access to records concerning child abuse or neglect contained in the state agency or local child protective agency shall be made in the manner and form prescribed by the state agency. Upon appropriate application, the state agency shall give access to any of the following persons or agencies for purposes directly related with the administration of W.S. 14-3-201 through 14-3-216:

(i) A local child protective agency;

(ii) A law enforcement agency, guardian ad litem, child protection team or the attorney representing the subject of the report;

(iii) A physician or surgeon who is treating an abused or neglected child, the child's family or a child he reasonably suspects may have been abused or neglected;

(iv) A person legally authorized to place a child in protective temporary custody when information in the report or record is required to determine whether to place the child in temporary protective custody;

(v) A person responsible for the welfare of the child;

(vi) A court or grand jury upon a showing that access to the records is necessary for the determination of an issue, in which case access shall be limited to in camera inspection unless the court finds public disclosure is necessary;

(vii) Court personnel who are investigating reported incidents of child abuse or neglect;

(viii) An education or mental health professional serving the child, if the state agency determines the information is necessary to provide appropriate educational or therapeutic interventions.

(c) A physician or person in charge of an institution, school, facility or agency making the report shall receive, upon written application to the state agency, a summary of the records concerning the subject of the report.

(d) Any person, agency or institution given access to information concerning the subject of the report shall not divulge or make public any information except as required for court proceedings.

(e) Nothing in W.S. 14-3-201 through 14-3-215 prohibits the attendance of any one (1) of the following at an interview conducted on school property by law enforcement or child

protective agency personnel of a child suspected to be abused or neglected provided the person is not a subject of the allegation:

(i) The principal of the child's school or his designee; or

(ii) A child's teacher or, counselor, or specialist employed by the school or school district and assigned the duties of monitoring, reviewing or assisting in the child's welfare in cases of suspected child abuse or neglect.

(f) Upon appropriate application, the state agency shall provide to any chapter of a nationally recognized youth organization, child caring facility certified under W.S. 14-4-101 et seq., public or private school or state institution for employee or volunteer screening purposes a summary of central registry records maintained under state agency rules since December 31, 1986, for purposes of screening employees or volunteers. The state agency shall provide the results of the records check to the applicant by certified mail if the records check confirms the existence of a report "under investigation" or a "substantiated" finding of abuse or neglect. Otherwise, the state agency shall provide the results of the records check to the applicant by United States mail. The written results shall confirm that there is a report "under investigation", a "substantiated" finding of abuse or neglect on the central registry naming the individual or confirm that no record exists. When the individual is identified on the registry as a "substantiated" perpetrator of abuse or neglect, the report to the applicant shall contain information with respect to the date of the finding, specific type of abuse or neglect, a copy of the perpetrator's voluntary statement and whether an appeal is pending. The applicant shall submit a fee of ten dollars (\$10.00) and proof satisfactory to the state agency that the prospective or current employee or volunteer whose records are being checked consents to the release of the information to the applicant. The applicant shall use the information received only for purposes of screening prospective employees and volunteers who may, through their employment or volunteer services, have unsupervised access to minors. Applicants, their employees or other agents shall not otherwise divulge or make public any information received under this section. The state agency shall notify any applicant receiving information under this subsection of any subsequent reclassification of the information pursuant to W.S. 14-3-213(e). The state agency shall screen all prospective agency employees in conformity with the procedure provided under this subsection.

(g) There is created a program administration account to be known as the "child and vulnerable adult abuse registry account". All fees collected under subsection (f) of this section shall be credited to this account.

WYO. STAT. ANN. § 14-3-2015 (2011). Interagency children's collaborative

(a) There is created an interagency children's collaborative. The collaborative shall be composed of:

(i) The director of the department of family services, or his designee;

(ii) The director of the department of health, or his designee;

(iii) The superintendent of public instruction, or his designee;

(iv) The director of the department of workforce services, or his designee; and

(v) The governor's appointee who shall represent families receiving services from the state agencies represented in paragraphs (i) through (iv) of this subsection.

(b) The department of family services shall adopt rules by July 1, 2005, to establish guidelines for review of case files of children in state custody as a result of any action commenced under this title. The rules shall be adopted by the department of family services with the advice of the departments of education, health and workforce services. In addition to providing for the review of cases and the progress made towards returning children in state custody to their homes, communities or other permanent placements, the guidelines shall provide specific processes for:

(i) Local multidisciplinary teams to voluntarily present case files to the collaborative for review;

(ii) The review of cases in which more than one (1) state agency provides services to the child and his family; and

(iii) The review of statewide availability and utilization of resources for children in state custody.

WYO. STAT. ANN. § 14-3-2016 (2011). Other laws not superseded

No laws of this state are superseded by the provisions of W.S. 14-3-201 through 14-3-216.

FEDERAL LEGISLATION/ U.S. TERRITORIES

FEDERAL LEGISLATION

42 U.S.C.S. § 622 (2011). State plans for child welfare services

(a) Joint development

In order to be eligible for payment under this subpart, a State must have a plan for child welfare services which has been developed jointly by the Secretary and the State agency designated pursuant to subsection (b)(1) of this section, and which meets the requirements of subsection (b) of this section.

(b) Requisite features of State plans

Each plan for child welfare services under this subpart shall--

(1) provide that (A) the individual or agency that administers or supervises the administration of the State's services program under division A [FN1] of subchapter XX of this chapter will administer or supervise the administration of the plan (except as otherwise provided in section 103(d) of the Adoption Assistance and Child Welfare Act of 1980), and (B) to the extent that child welfare services are furnished by the staff of the State agency or local agency administering the plan, a single organizational unit in such State or local agency, as the case may be, will be responsible for furnishing such child welfare services;

(2) provide for coordination between the services provided for children under the plan and the services and assistance provided under division A [FN1] of subchapter XX of this chapter, under the State program funded under part A of this subchapter, under the State plan approved under subpart 2 of this part, under the State plan approved under the State plan approved [FN2] under part E of this subchapter, and under other State programs having a relationship to the program under this subpart, with a view to provision of welfare and related services which will best promote the welfare of such children and their families;

(3) include a description of the services and activities which the State will fund under the State program carried out pursuant to this subpart, and how the services and activities will achieve the purpose of this subpart;

(4) contain a description of--

(A) the steps the State will take to provide child welfare services statewide and to expand and strengthen the range of existing services and develop and implement services to improve child outcomes; and

(B) the child welfare services staff development and training plans of the State;

(5) provide, in the development of services for children, for utilization of the facilities and experience of voluntary agencies in accordance with State and local programs and arrangements, as authorized by the State;

(6) provide that the agency administering or supervising the administration of the plan will furnish such reports, containing such information, and participate in such evaluations, as the Secretary may require;

(7) provide for the diligent recruitment of potential foster and adoptive families that reflect the ethnic and racial diversity of children in the State for whom foster and adoptive homes are needed;

(8) provide assurances that the State--

(A) is operating, to the satisfaction of the Secretary--

(i) a statewide information system from which can be readily determined the status, demographic characteristics, location, and goals for the placement of every child who is (or, within the immediately preceding 12 months, has been) in foster care;

(ii) a case review system (as defined in section 675(5) of this title) for each child receiving foster care under the supervision of the State;

(iii) a service program designed to help children--

(I) where safe and appropriate, return to families from which they have been removed; or

(II) be placed for adoption, with a legal guardian, or, if adoption or legal guardianship is determined not to be appropriate for a child, in some other planned, permanent living arrangement, which may include a residential educational program; and

(iv) a preplacement preventive services program designed to help children at risk of foster care placement remain safely with their families; and

(B) has in effect policies and administrative and judicial procedures for children abandoned at or shortly after birth (including policies and procedures providing for legal

representation of the children) which enable permanent decisions to be made expeditiously with respect to the placement of the children;

(9) contain a description, developed after consultation with tribal organizations (as defined in section 450b of Title 25) in the State, of the specific measures taken by the State to comply with the Indian Child Welfare Act [25 U.S.C.A. § 1901 et seq.];

(10) contain assurances that the State shall make effective use of cross-jurisdictional resources (including through contracts for the purchase of services), and shall eliminate legal barriers, to facilitate timely adoptive or permanent placements for waiting children;

(11) contain a description of the activities that the State has undertaken for children adopted from other countries, including the provision of adoption and post-adoption services;

(12) provide that the State shall collect and report information on children who are adopted from other countries and who enter into State custody as a result of the disruption of a placement for adoption or the dissolution of an adoption, including the number of children, the agencies who handled the placement or adoption, the plans for the child, and the reasons for the disruption or dissolution;

(13) demonstrate substantial, ongoing, and meaningful collaboration with State courts in the development and implementation of the State plan under this subpart, the State plan approved under subpart 2 of this part, and the State plan approved under part E of this subchapter, and in the development and implementation of any program improvement plan required under section 1320a-2a of this title;

(14) not later than October 1, 2007, include assurances that not more than 10 percent of the expenditures of the State with respect to activities funded from amounts provided under this subpart will be for administrative costs;

(15)(A) provides [FN3] that the State will develop, in coordination and collaboration with the State agency referred to in paragraph (1) and the State agency responsible for administering the State plan approved under subchapter XIX of this chapter, and in consultation with pediatricians, other experts in health care, and experts in and recipients of child welfare services, a plan for the ongoing oversight and coordination of health care services for any child in a foster care placement, which shall ensure a coordinated strategy to identify and respond to the health care needs of children in foster care placements, including mental health and dental health needs, and shall include an outline of--

(i) a schedule for initial and follow-up health screenings that meet reasonable standards of medical practice;

(ii) how health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from home;

(iii) how medical information for children in care will be updated and appropriately shared, which may include the development and implementation of an electronic health record;

(iv) steps to ensure continuity of health care services, which may include the establishment of a medical home for every child in care;

(v) the oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications;

(vi) how the State actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children; and

(vii) steps to ensure that the components of the transition plan development process required under section 675(5)(H) of this title that relate to the health care needs of children aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under State law, and to provide the child with the option to execute such a document, are met; and

(B) subparagraph (A) shall not be construed to reduce or limit the responsibility of the State agency responsible for administering the State plan approved under subchapter XIX of this chapter to administer and provide care and services for children with respect to whom services are provided under the State plan developed pursuant to this subpart;

(16) provide that, not later than 1 year after September 28, 2006, the State shall have in place procedures providing for how the State programs assisted under this subpart, subpart 2 of this part, or part E of this subchapter would respond to a disaster, in accordance with criteria established by the Secretary which should include how a State would--

(A) identify, locate, and continue availability of services for children under State care or supervision who are displaced or adversely affected by a disaster;

(B) respond, as appropriate, to new child welfare cases in areas adversely affected by a disaster, and provide services in those cases;

(C) remain in communication with caseworkers and other essential child welfare personnel who are displaced because of a disaster;

(D) preserve essential program records; and

(E) coordinate services and share information with other States;

(17) not later than October 1, 2007, describe the State standards for the content and frequency of caseworker visits for children who are in foster care under the responsibility of the State, which, at a minimum, ensure that the children are visited on a monthly basis and that the caseworker visits are well-planned and focused on issues pertinent to case planning and service delivery to ensure the safety, permanency, and well-being of the children;

(18) include a description of the activities that the State has undertaken to reduce the length of time children who have not attained 5 years of age are without a permanent family, and the activities the State undertakes to address the developmental needs of such children who receive benefits or services under this part or part E; and

(19) contain a description of the sources used to compile information on child maltreatment deaths required by Federal law to be reported by the State agency referred to in paragraph (1), and to the extent that the compilation does not include information on such deaths from the State vital statistics department, **child death review teams**, law enforcement agencies, or offices of medical examiners or coroners, the State shall describe why the information is not so included and how the State will include the information.

(c) Definitions

In this subpart:

(1) Administrative costs

The term “administrative costs” means costs for the following, but only to the extent incurred in administering the State plan developed pursuant to this subpart: procurement, payroll management, personnel functions (other than the portion of the salaries of supervisors attributable to time spent directly supervising the provision of services by caseworkers), management, maintenance and operation of space and property, data processing and computer services, accounting, budgeting, auditing, and travel expenses (except those related to the provision of services by caseworkers or the oversight of programs funded under this subpart).

(2) Other terms

For definitions of other terms used in this part, see section 675 of this title.

AMERICAN SAMOA

GUAM

GUAM CODE ANN. TIT. 9, § 13331 (2011). Multidisciplinary Teams.

Child protective agencies are authorized to establish multidisciplinary teams for the prevention, intervention, and treatment of child abuse and neglect.

PUERTO RICO

P.R. LAWS ANN. TIT. 8, § 444c (2009). Responsibilities and coordination with other agencies

To guarantee faithful compliance with the public policy set forth in this chapter, the agencies and municipalities of the Commonwealth of Puerto Rico shall give priority to any situations of abuse, institutional abuse, neglect, and/or institutional neglect of which they become aware. The Department of the Family, the Department of Education, the Department of Health, the Mental Health and Addiction Services Administration, the Department of Housing, the Department of Justice, the Puerto Rico Police, [the Puerto Rico Broadcasting Corporation], the Corrections Administration, and the Administration of Juvenile Institutions shall be under the obligation [with the urgency and sensitivity merited by each case] to give priority to attending to situations of abuse, institutional abuse, neglect, and/or institutional neglect. They shall coordinate their efforts when services are needed in connection with the identification, prevention, or treatment of minors who are victims of abuse, institutional abuse, neglect, and/or institutional neglect.

Agency coordination shall include joint planning, public education and information services, the use of each other's facilities, joint training and activities for personnel development, and evaluation and handling of cases. Agencies and municipalities shall ensure that the services that have been delegated for their rendering onto privatized entities or providers offer immediate attention to situation where there is abuse.

The agencies of the Commonwealth of Puerto Rico must:

- (1) Identify and report situations where abuse, institutional abuse, neglect, and/or

institutional neglect exists or is suspected to exist so that they may be investigated as provided for in this chapter.

- (2) Provide protection to minors in emergency situations including transportation, coordination of medical services, emergency custody, and any other service needed until the Department of the Family intervenes.
- (3) Support the victims of abuse, institutional abuse, neglect, and/or institutional neglect.
- (4) Support minors in potentially traumatic situations.
- (5) Protect the civil rights, privacy, and integrity of minors.
- (6) Coordinate services for abused minors with government and nongovernmental agencies.
- (7) Develop and implement prevention programs for parents and children throughout Puerto Rico.
- (8) Collaborate with multidisciplinary teams dealing with cases of abuse.
- (9) Adopt orientation, training and prevention programs on abuse and/or institutional abuse for the personnel of their agencies or municipalities, in addition to the scopes and implementation of this chapter.
- (10) Design, develop, and implement an intervention protocol for situations of abuse, institutional abuse, neglect, and/or institutional neglect aimed at attending to abused children, abusers, and victims of domestic violence. Services offered to abused children, abusers, and victims of domestic violence shall be rendered in a manner so as to guarantee the safety of victims and of the assistance professionals handling these situations.

The Department and the agencies of the Commonwealth of Puerto Rico shall draft and adopt the regulations and collaborative agreements needed to implement this chapter, as provided below:

(a) Department of Education.--

- (1) Develop school policies and protocols to report situations of abuse, institutional abuse, neglect, and/or institutional neglect.
- (2) Participate in evaluations and provide support and follow-up services in situations of abuse, institutional abuse, neglect, and/or institutional neglect.

(3) Intervene and provide services related to situations of neglect of school children.

(4) Provide help to parents through school-sponsored programs, pursuant to the obligations and duties provided for in the Department of Education Organic Act, §§ 143a-146e of Title 3.

(5) Facilitate and guarantee school placement and transportation for minors under the custody of the Department, within a term not to exceed seventy-two (72) hours, so as not to interrupt the school services of the minors. In the case of children with disabilities, whose emergency placement in a school requires the continuation of a specially designed school program, the school director, the special education teacher who will provide the service, and the school social worker shall meet and coordinate the placement of the minor within the period stipulated in this section. To that end, all public or private schools shall maintain an updated directory or catalog of specialized resources and facilities to facilitate and expedite the placement of the minor with disabilities.

(6) Provide advice and expertise regarding situations of institutional abuse and/or institutional neglect in educational institutions.

(7) Facilitate the investigation of referrals of institutional abuse and institutional neglect. The school social worker who attends to abuse cases referred by teachers shall maintain periodic communication with the social workers of the Department of the Family in order to participate actively in the intervention protocol that has been designed for the referred minor, as well as for his or her family, including the abuser.

(8) Petition for protective orders on behalf of minors.

(b) Department of Health.--

(1) Provide diagnosis and medical treatment services to abused minors and their families.

(2) Provide advice and consulting services to the Department on medical aspects of the abuse, upon request.

(3) Provide expert testimony, certifications, or written reports in court actions, when required to do so.

(4) Identify and provide support to families at risk of suffering abuse.

(5) Provide training for medical and nonmedical professionals on medical aspects of child abuse.

(6) Provide evaluation and priority medical attention to minors in the custody of the Department, subject to the protocols established by the Department of Health.

(7) Guarantee health services to the minors under the protection of the Department, regardless of where they have been placed.

(8) Establish service programs for abused children with special health needs.

(9) Provide advice and expertise in situations of institutional abuse and/or institutional neglect in educational institutions.

(10) Facilitate the investigation of abuse, institutional abuse, and/or institutional neglect referrals.

(11) Ensure that the providers or privatizing entities of mental health services and facilities give immediate attention to situations involving abuse, as well as medications, and that they fulfill the obligations of the Department of Health imposed herein.

(c) Mental Health and Addiction Services Administration.--

(1) Provide care and integrated and effective residential or outpatient treatment to abused minors in matters related to mental health or addiction conditions. In the case of residential treatment, admission shall be subject to the determination of its clinical team after an evaluation process.

(2) Provide mental health and/or addiction services to parents or to the persons responsible for a minor who commit abuse, as part of the process of reeducation and other reasonable efforts.

(3) Coordinate the services provided for addiction and mental health with the Service Plan of the Department.

(4) Develop cooperation agreements with the government entities bound by this chapter to provide mental health and addiction services to the minors, parents or persons responsible for a minor who have incurred abusive behavior.

(5) Provide expert testimony, certifications, and written reports in court actions, when required to do so.

(6) Provide advice and expertise regarding situations of institutional abuse and/or institutional neglect in healthcare institutions.

(7) Facilitate the investigation of institutional abuse and institutional neglect referrals.

(8) Ensure that the providers or privatizing entities of mental health services and facilities give immediate attention to situations involving abuse, and that they fulfill the

obligations of the Mental Health and Addiction Services Administration imposed herein.

(d) Department of Housing.--

(1) Give priority attention, as a protective measure, to applications involving a situation of abuse when the minors are under the custody of the Department; and the father, mother, or other person in charge of the minor is able to furnish evidence of compliance with the Service Plan, subject to applicable federal regulations.

(2) Give priority attention, as a protective measure, to applications involving situations where both domestic violence and child abuse are present, subject to applicable federal regulations.

(3) Identify temporary homes for use in emergency situations in which placement is difficult, subject to applicable federal regulations.

(4) Amend the rental agreement when the same is in under the abuser's name to make it possible for the minor to continue to live at home, subject to applicable federal regulations.

(5) Ensure that the administrative personnel of housing facilities gives priority attention to situations involving abuse and fulfill the obligations of the Department of Housing imposed herein.

(e) Puerto Rico Police.--

(1) Receive and investigate complaints of abuse, institutional abuse, neglect, and/or institutional neglect.

(2) Assist and collaborate with the personnel of the Department when their safety is at risk, and they so request.

(3) Cooperate actively with the Department in any affirmative action aimed at assuming the custody of a minor and carrying out other services related to the protection of minors.

(4) Appear at judicial hearings to testify about investigation procedures in cases of abuse, neglect, and/or institutional neglect.

(5) Keep a record of the restraining orders issued under this chapter.

(f) Corrections Administration.--

(1) Keep a register of participants of the system accused of incidents of abuse.

(2) Inform the Department and the person in charge of a minor of the release, passes granted, probation, and parole of an abusing parent, as a protective measure for minors.

(3) Provide educational programs to abusing parents aimed at reeducating them.

(4) Establish, administer, and operate reeducation and retraining programs for persons convicted of abuse or offenders.

(g) Administration of Juvenile Institutions.--

(1) Identify and refer to the Department of the Family, the Department of Justice, and the Puerto Rico Police, cases of institutional abuse and institutional neglect by personnel of the Administration of Juvenile Institutions.

(2) When incidents involving minors occur that may constitute offenses, the investigations must include a presumption of institutional neglect.

(3) Ensure that the civil rights of minors are protected.

(4) Keep a register of cases of institutional abuse and/or institutional neglect.

(5) Facilitate the investigation of referrals of institutional abuse and institutional neglect.

(6) Keep a register of [abusive minor parents].

(7) Inform the Department of services provided and the progress observed in the minor.

(8) Inform the Department and the person in charge of a minor about the release or temporary or extended passes granted to an abusing parent, as a protective measure for the abused minor.

(9) Provide educational programs to abusive parents aimed at reeducating them.

(h) Puerto Rico Public Broadcasting Corporation.--

(1) Collaborate with the Department of the Family, subject to the provisions of §§ 501 - 513 of Title 27, in the development and broadcasting of the child abuse and neglect television program referred to in § 445 of this title.

VIRGIN ISLANDS