ONE HUNDRED THIRD LEGISLATURE - FIRST SESSION - 2013
COMMITTEE STATEMENT
LB361

Hearing Date: Friday March 01, 2013
Committee On: Health and Human Services
Introducer: Howard
One Liner: Name the Child and Maternal Death Review Act and change review procedures

Roll Call Vote - Final Committee Action:
Advanced to General File

Vote Results:

Aye:	7	Senators Campbell, Cook, Crawford, Gloor, Howard, Krist, Watermeier
Nay:		
Absent:		
Present Not Voting:		

Proponents:	**Representing:**
Senator Sara Howard	District #9
Ann Frohman	Nebraska Medical Association
Heather Swanson	Nebraska Affiliate of the American College of Nurse-Midwives
Opponents:	**Representing:**
Neutral:	**Representing:**
Jim Cunningham	Nebraska Catholic Conference

Summary of purpose and/or changes:
LB 361 shall be known and cited as the Child and Maternal Death Review Act. The bill provides that it is in the best interests of the state and its residents that the number and causes of maternal death in Nebraska be examined. There is a need for a comprehensive integrated review of all maternal deaths in Nebraska and a system for statewide retrospective review of existing records relating to each maternal death.

LB 361 amends the team created pursuant to the State Child Death Review Team to include up to fifteen members renamed the State Child and Maternal Death Review Team. The department shall be responsible for the general administration and shall employ or contract with a team coordinator to provide administrative support for the team.

Team responsibilities will now relate to child and maternal deaths. The team shall review all maternal deaths occurring on or after January 1, 2014. Investigation of maternal death means a review of existing records and other information regarding the woman from relevant agencies, professionals, and providers of medical, dental, prenatal and mental health care. The records to be reviewed may include, but not be limited to medical records, coroner's reports, autopsy reports, social services records, education records, emergency and paramedic records and law enforcement reports. The members must 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 members shall identify the prevent-ability of death, the possibility of domestic abuse, the medical care issues of access and adequacy, and the nature and extent of inter-agency communications. The team may enter into agreements with a local public health department to act as the agent of the team in conducting all information gathering and investigation necessary for the purposes of the Child and Maternal Death Review Act. Moreover, the team may enter into consultation agreements with relevant experts to evaluate the information and records collected by the team. All of the

confidentiality provisions shall apply to the activities of a consulting expert. Finally, the bill allows de-identified information and records obtained by the team may be released to a researcher under the terms specified in the Act.

Kathy Campbell, Chairperson