SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 1406

SPONSOR: Health, Aging, and Long-term Care Committee and Senator Cowin

SUBJECT: Child Death Reviews

DATE: March 23, 1999 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Liem	Wilson	HC	Favorable/CS
2.			FP	
3.				
4.				
5.				

I. Summary:

Committee Substitute for Senate Bill 1406 creates a statewide multi-disciplinary, multi-agency child death assessment and prevention system. The bill establishes the State Child Death Review Committee within the Department of Health, and fosters the creation of local child death review committees. The membership of the state committee is specified.

The specified duties of the statewide committee are: developing a child death data collection system; preparing annual reports; providing training to cooperating agencies, individuals and local child death review committees on the uses of the data system; developing guidelines for child death reviews; studying the adequacy of laws to determine what changes are needed to prevent child deaths; educating the public and promoting continuing education; recommending review of death certificates of deceased children, when appropriate; and assisting in the development of, and providing consultation to, local committees.

County health departments are authorized to convene and support local child death review committees. Duties of local child death review committees include: reviewing all child deaths reported to the Office of Vital Statistics, assisting the state committee in collection of data, submitting records and written reports to the state committee (as requested), abiding by the standards and protocols developed by the state committee, and requesting the state committee to review particular cases.

The bill gives members of the state and local child death review committees access to certain confidential information, authority to request that the Department of Legal Affairs issue subpoenas, and protection from criminal and civil liability.

The bill creates eight undesignated sections of law.

II. Present Situation:

In 1997, a total of 2,740 children between the ages of birth and 19 years died in Florida. Of these children, 1,358 were less than one year old and the leading cause of death for them was related to perinatal conditions and congenital anomalies. Of the 516 children who were between 1 and 9 years old and the 866 who were 10 through 19 years old, the majority of deaths was due to injuries.

Studies done by the Florida Department of Health show that in Florida the leading causes of death for infants under one year old were perinatal conditions (653), congenital anomalies (268), and Sudden Infant Death Syndrome (139). For children ages 1 to 4, the leading causes of death were unintentional injury (127), congenital anomalies (39), and malignant neoplasm (29). The leading causes of injury-related death in children 1 to 4 were attributed to drowning (70), motor vehicles (25), and residential fires (11). The leading causes of death for children ages 5-9 were unintentional injuries, cancer, and congenital anomalies. The leading causes of death due to unintentional injuries for this age group were attributed to motor vehicles (26), drowning (21), and fires (10). For children ages 10-14, the leading causes of death were unintentional injuries (102), cancer (27), and suicide (16). The injuries which caused the most deaths for ages 10-14 were injuries relating to motor vehicles (70), drowning (13), and firearms (5). For teens ages 15-19, the leading causes of death were unintentional injury (317), homicide and legal intervention (105), and suicide (69). The leading causes of death due to unintentional injuries for ages 15-19 were attributed to motor vehicles (267), drowning (8), and firearms (5).

According to the Department of Health, 48 states and the District of Columbia have established either state or local child fatality review committees to review child deaths. Florida has local child fatality review committees in Hillsborough, Polk, and Palm Beach Counties, but does not have a database relating only to child deaths in the state or an established mechanism for reviewing diagnoses or conclusions reached by medical examiners in cases of child deaths. Little in-depth causal information relating to the number of child deaths in Florida is available.

According to the Department of Health, child death review activities would be one of three programs in a Comprehensive Mortality Review Program. The department's plan for the Comprehensive Mortality Review Program is that it would include the Pregnancy Associated Mortality Review Project and the Fetal and Infant Mortality Review Project (both of which already exist). The department's goal for such a comprehensive program is to provide a separate review process for three unique segments of the maternal and child health populations: pregnant women, infants, and children.

Subpoena Power

According to the Florida Rules of Civil Procedure, "subpoenas for testimony before the court, subpoenas for production of tangible evidence, and subpoenas for taking depositions may be issued by the clerk of court or by any attorney of record in an action." When a subpoena requires a person to produce documentary evidence, "the court, upon motion made promptly and in any event at or before the time specified in the subpoena for compliance therewith, may (1) quash or modify the subpoena if it is unreasonable and oppressive or (2) condition denial of the motion upon the advancement by the person in whose behalf the subpoena is issued of the reasonable cost

of producing the books, papers, documents, or tangible things." (Rule 1.410 of the Florida Rules of Civil Procedure) As a result, the mere issuance of a subpoena means nothing if the courts do not give the subpoena judicial effect through enforcement.

Through statute, the Legislature often gives administrative agencies investigative powers and devices which may include the authority to issue investigatory subpoenas. The United States Supreme Court has ruled that administrative agencies vested with investigatory power have broad discretion to require the disclosure of information concerning matters that are within their jurisdiction and reasonably relevant. (See *United States v. Morton Salt Co*., 338 U.S. 632, 642-43, 70 S.Ct. 357, 363-64, 94 L.Ed. 401, 1950). Whether an investigation is within the scope of a department's authority is central to whether or not an investigatory subpoena should be given judicial effect. (See *Florida Dept. of Ins. and Treasurer v. Bankers Ins. Co*., 694 So.2d 70 (Fla. 1st DCA, 1997).

In determining whether an agency's investigatory subpoena should be enforced, courts also look to whether an agency's investigatory subpoena "is overly broad or otherwise unduly burdensome, and whether enforcement would violate some privilege or constitutional right." *Id. at 73.*

Criminal Information

Section 119.07(3)(b), F.S., states that active criminal intelligence information and active criminal investigative information are exempt from the provisions of subsection (1) and s. 24(a) Art. 1 of the State Constitution. Other exemptions for criminal intelligence information or criminal investigative information include personal information of a victim of sexual battery and information revealing the personal assets of the victim of a crime, other than property stolen or destroyed during the commission of the crime, s. 119. 07(3)(f) and (g), F.S.

Autopsy Requirements

Section 406.11, F.S., requires a medical examiner to determine the cause of death of a human being when any person in the state dies: of criminal violence; by accident; by suicide; suddenly, when in apparent good health; unattended by a practicing physician or other recognized practitioner; in any prison or penal institution; in police custody; in any suspicious or unusual circumstance; by criminal abortion; by poison; by disease constituting a threat to public health; and by disease, injury, or toxic agent resulting from employment. Autopsies are also required when a dead body is brought into the state without proper medical certification and when a body is to be cremated, dissected, or buried at sea.

Additionally, s. 39.201(3), F.S., 1998 Supplement, specifies that a medical examiner shall perform an autopsy on a child when there is a suspicion that the child's death was a result of abuse or neglect. Medical examiners are also required to perform an autopsy upon any infant under the age of one year old when it is suspected that the infant died of Sudden Infant Death Syndrome. (s. 383.3362(4), F.S.)

Sharing of Information

Section 163.62, F.S., provides for the sharing of confidential client information among agencies within collaborative client information systems. These collaborative client information systems can include state, local and private agencies. Client information, including confidential information, may be shared as long as the restrictions governing the confidential information are observed, in accordance with s. 163.64, F.S. Furthermore, s. 163.65, F.S., encourages agencies that receive moneys from a federal, state, or local agency to participate in a collaborative client information system that is within the service area of the agencies.

III. Effect of Proposed Changes:

The bill creates the State Child Death Review Committee within the Department of Health. The committee will be composed of members appointed by the Secretary of the Department of Health and other heads of state agencies. The duties of the committee will be to develop a child death data collection system and statewide data collection protocols; provide training to cooperating agencies, individuals and local child death review committees on the uses of the data system; prepare an annual statistical report on the incidence and causes of child death; encourage and assist in the development of local child death review committees; develop guidelines, standards, and protocols and provide technical assistance and training for the local committees; develop guidelines for child death reviews including guidelines to be used by law enforcement, prosecutors, medical examiners, health care facilities and social service agencies; study the adequacy of laws to determine what changes are needed to prevent child deaths; provide case consultation on individual cases to local committees; educate the public; promote continuing education; and recommend review of death certificates of deceased children, when appropriate.

At the direction of the Secretary of the Department of Health, local child death review committees may be convened, at the county level, by the director of the county health department. These committees may be multi-county by agreement of two or more county health department directors. The local committees must operate in accordance with protocols established by the State Child Death Review Committee. Duties of the local review committees will be to review all child deaths reported to the Office of Vital Statistics; assist the state committee in collection of data; submit records and written reports to the state committee, as requested; abide by the standards and protocols developed by the state committee; and request that the state committee review particular cases.

Both the statewide committee and local committees are given access to a wide variety of information pertaining to a child whose death is being reviewed, including otherwise confidential information. Such information includes medical, dental, and mental health information held by public or private providers; information held by any state agency or political subdivision; and information held by law enforcement agencies which is not the subject of an investigation or is not active criminal intelligence and which pertains to the review of the death of a child. The bill allows health care providers to charge a maximum fee of 50 cents per page for printed records and $1 per fiche for microfiche records. The chairperson of the State Child Death Review Committee may require the production of records by requesting a subpoena through the Department of Legal Affairs. The bill does not authorize the members of the committee to have access to any grand jury proceedings. The bill prohibits committee members who are not state employees or public

officers from contacting, interviewing or obtaining information by request or subpoena from a member of a deceased child's family.

The bill provides civil and criminal immunity for committee members, agents or employees if the person acted in good faith and without malice in carrying out responsibilities conferred by law or rule. A person who has attended or otherwise participated in committee activities may not be permitted or required to testify in civil, criminal, or administrative proceedings. A person, organization, institution or committee member who furnishes information, data, reports or records to a child death review committee is not liable for damages and is not subject to any other civil or criminal recourse as a result of furnishing the information. This subsection does not apply to a person who admits committing a crime.

The bill authorizes the Department of Health to administer funds appropriated to operate the review committees, hire staff or consultants, apply for grants and accept donations. Members of the state and local review committees serve without compensation, but are entitled to reimbursement for travel expenses, to the extent funds are available.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The bill allows local health departments and the Florida Department of Health to gain custody of information of a sensitive, personal nature in the form of medical, dental, and mental health records. Senate Bill 1408, providing an exemption from the Public Records Law, complements this bill with the appropriate and necessary language for making confidential and exempt from the requirements of the Public Records Law those records held by the state and local child death review committees which are otherwise confidential or exempt. Additionally, Senate Bill 1408 contains the appropriate and necessary language to exempt from the Public Records Law records pertaining to criminal investigations.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None

B. Private Sector Impact:

None.

C. Government Sector Impact:

According to the Department of Health, costs for the first year of the Child Death Review Program would be $2,664,698. After the first year, the program would require $2,703,607 each year.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.