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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: HB 1647 (PCB HCS 99-03)

RELATING TO: Child Deaths

SPONSOR(S): Committee on Health Care Services and Rep. Peaden

COMPANION BILL(S): HB 1645

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES YEAS 16 NAYS 0
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I. SUMMARY:

HB 1647 creates the State Child Death Review Act. A State Child Death Review Team is to be established within the Department of Health. The members of the State Child Death Review Team will be composed of representatives from state agencies and appointees of the Secretary of the Department of Health. Duties of the state review team include:

- developing a child death data collection system;
- preparing annual reports;
- providing training to cooperating agencies, individuals and local child death review teams 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; and
- recommending review of death certificates of deceased children, when appropriate.

HB 1647 also provides for the creation of local child death review teams at the county level in accordance with protocols established by the State Child Death Review Team. Duties of the local review teams include:
- reviewing all child deaths received by the Office of Vital Statistics;
- assisting the state team in collection of data;
- submitting records and written reports to the state team, as requested;
- abiding by the protocol developed by the state team; and
- requesting the state team review particular cases.

Finally, the bill gives members of the state and local review teams access to certain confidential information, authority to issue subpoenas, and protection from liability.

According to the Department of Health, costs for the first year of State Child Death Review would be $2,678,762**.** After the first year, the program would require $2,703,307 each year.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Comprehensive Mortality Review Program

Each year in Florida approximately twenty-eight hundred children die after the neonatal period. On average seven children from birth through nineteen years old die each day in Florida. According to the 1997 Kids Count Data Book, Florida ranked among the top ten states with the highest child death rate of children ages one through 14.

In 1997, a total of 2,740 children between the ages of birth and 19 years old died in Florida. Of these children, 1,358 were less than one year old and the leading cause of death 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 in 1997, 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 unitentional 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 vehichles (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).

Currently, 48 states and the District of Columbia have established either state or local child fatality review teams to review child deaths. Florida has local child fatality review teams 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.

Certain programs and task forces currently exist in Florida whose review process may deal with the issue of child death. These programs include Emergency Medical Services, the Domestic Violence Task Force, Fetal and Infant Mortality Review, Pregnancy Associated Mortality Review, and the Child Abuse and Neglect Mortality Review. Each of these reviews targets specific areas and is limited in scope. There is, however, no statewide review process that solely reviews child deaths. The Pregnancy Associated Mortality Review (PAMR) and a Fetal and Infant Mortality Review (FIMR) are established within the Department of Health. There is no statutory authority providing for these two reviews. The reviews were created by the Department of Health under its general public health authority. Both PAMR and FIMR are currently experiencing funding difficulties.

The purpose of PAMR is to identify gaps in care, systemic service delivery problems, and areas in which linkages between community resources can be improved to facilitate improvements in the systems of care. The review process focuses on the systems of perinatal care and examines pregnancy-associated deaths, including those related to physical, psychosocial, and environmental factors.

Florida's FIMR project was initiated in 1993 and has been implemented by the Healthy Start Coalitions since its inception. Currently, there are 13 FIMR projects in operation throughout the state with participation of 13 healthy start coalitions in 31 of the state's 67 counties. The FIMR process was implemented in order to establish a needs assessment and continuous quality improvement mechanism for communities, which complements the community-based nature of the Healthy Start coalitions. The Healthy Start Program assists pregnant women and infants to

obtain health care and social support needed to reduce the risks for maternal and infant heath and to promote good health and developmental outcomes. Healthy Start coalitions are responsible for developing comprehensive plans for maternal and child health care, monitoring the performance of health care delivery systems for pregnant women and children up to age three, and allocating resources in order to improve pregnancy outcomes and the health status of children.

Recently, Florida received federal grants through the Children's Justice Act that required the state to develop a process for the examinations of child deaths in the state. As a result of these grants, a multidisciplinary working group was established to design a system for universal child death review in Florida. The working group included representatives from the health professions, medical examiners, law enforcement, child welfare, child advocacy, and interested citizens. From these meetings, a plan was developed for the creation of local multidisciplinary and multiagency review groups to analyze all child deaths and create a uniform database for use by a statewide team. The plan includes the child death review project as part of a Comprehensive Mortality Review Program for Florida's Maternal and Child Health Population. Such a program would be established through the Department of Health and would require funding from General Revenue.

The department's plan for the Comprehensive Mortality Review Program is that it would include the Pregnancy Associated Mortality Review and the Fetal and Infant Mortality Review Project (both of which already exist), as well as a new Child Fatality Review Team created by statute.

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.) .

"Criminal intelligence information" and "criminal investigative information" are defined in s. 119.011(3)(a-c), F.S., as:

(3)(a) "Criminal intelligence information" means information with respect to an identifiable person or group of persons collected by a criminal justice agency in an effort to anticipate, prevent, or monitor possible criminal activity.

(b) "Criminal investigative information" means information with respect to an identifiable person or group of persons compiled by a criminal justice agency in the course of conducting a criminal investigation of a specific act or omission, including, but not limited to, information derived from laboratory tests, reports of investigators or informants, or any type of surveillance.

(c) "Criminal intelligence information" and "criminal investigative information" shall not include:
1. The time, date, location, and nature of a reported crime.
2. The name, sex, age, and address of a person arrested or of the victim of a crime except as provided in s. 119.07(3)(f).
3. The time, date, and location of the incident and of the arrest.
4. The crime charged.
5. Documents given or required by law or agency rule to be given to the person arrested, except as provided in s. 119.07(3)(f), and, except that the court in a criminal case may order that certain information required by law or agency rule to be given to the person arrested be maintained in a confidential manner and exempt from the provisions of s. 119.07(1) until released at trial if it is found that the release of such information would:

a. Be defamatory to the good name of a victim or witness or would jeopardize the safety of such victim or witness; and
b. Impair the ability of a state attorney to locate or prosecute a codefendant.

6. Informations and indictments except as provided in s. 905.26.

(d) The word "active" shall have the following meaning:

1. Criminal intelligence information shall be considered "active" as long as it is related to intelligence gathering conducted with a reasonable, good faith belief that it will lead to detection of ongoing or reasonably anticipated criminal activities.
2. Criminal investigative information shall be considered"active" as long as it is related to an ongoing investigation which is continuing with a reasonable, good faith anticipation of securing an arrest or prosecution in the foreseeable future.

In addition, criminal intelligence and criminal investigative information shall be considered "active" while such information is directly related to pending prosecutions or appeals. The word "active" shall not apply to information in cases which are barred from prosecution under the provisions of s. 775.15 or other statute of limitation.

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 states 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 cirumstance; 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, section 415.504(3), F.S., 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, F.S.)

Sharing of Information

Section 163.62, F.S., provides for the sharing of confidential client information within collaborative client information systems. These collaborative client information systems are made up of state and private agencies and may share client information "as long as the restrictions governing the confidential information are observed" (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.

B. EFFECT OF PROPOSED CHANGES:

A State Child Death Review Team will be created within the Department of Health. The state team will be composed of members appointed by the Secretary of the Department of Health and other heads of state agencies. The duties of the state team will be to: develop a child death data collection system; provide training to cooperating agencies, individuals and local child death review teams on the uses of the data system; prepare an annual statistical report; encourage and assist in the development of local child death review teams; develop guidelines, standards, and protocols for the teams; develop guidelines for child death reviews; study the adequacy of laws to determine what changes are needed to prevent child deaths; provide case consultation on individual cases to local teams; educate the public, promote continuing education; and recommend review of death certificates of deceased children when appropriate.

Local child death review teams at the county level will also be created in accordance with protocols established by the State Child Death Review Team. Duties of the local review teams will be to review all child deaths received by the Office of Vital Statistics; assist the state team in collection of data; submit records and written reports to the state team, as requested; abide by the protocol developed by the state team; and request that the state team review particular cases.

Members of the state and local review teams will also be given access to certain confidential information and protection from liability.

C. APPLICATION OF PRINCIPLES:

1. <u>Less Government:</u>

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

No.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

Yes, the bill creates within the Department of Health the State Child Death Review Team charged with developing a review system for child deaths with an emphasis on prevention.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

No.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

No.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

No.

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Sections 383.401, 383.402, 383.403, 383.404, 383.405, 383.406, 383.407, 383.408, and 383.409, F.S.

E. SECTION-BY-SECTION ANALYSIS:

Section 1. Creates s. 383.401, F.S., to provide that this act shall be known as the “Florida Child Death Review Act.”

Creates s. 383.402, F.S., relating to legislative policy and intent, to establish the policy of the state and intent of the Legislature in the assessment and prevention of child deaths.

Creates s. 383.403, F.S., relating to state team creation, to establish the State Child Death Review Team within the Department of Health composed of members appointed by the Secretary of the Department of Health and certain other state agency heads who shall serve for periods of up to two years without remuneration.

Creates s. 383.404, F.S., relating to state team duties, to establish that the duties of the State Child Death Review Team shall be to: develop a child death data collection system; provide training to cooperating agencies, individuals and local child death review teams on the uses of the data system; prepare an annual statistical report; encourage and assist in the development of local child death review teams; develop guidelines, standards, and protocols for the teams; develop guidelines for child death reviews; study the adequacy of laws to determine what changes are needed to prevent child deaths; provide case consultation on individual cases to local teams; educate the public, promote continuing education; and recommend review of death certificates of deceased children when appropriate.

Creates s. 383.405, F.S., relating to local child death review teams, to establish county or multicounty child death review teams composed of members determined by guidelines developed by the state team. Duties of the local teams are to: review all child deaths that are received by the Office of Vital Statistics; assist the state team in collecting data on child deaths; submit written reports to the state team; submit all records requested by the state team; abide by the standards and protocols developed by the state team; and request that the state team review data of particular cases when appropriate.

Creates s. 383.406, F.S., relating to access to information, to provide that: the chairperson of the state team or the chairperson of a local team have access to certain information regarding the review of a child's death; that the state and local teams have access to all non-active law enforcement investigative information; teams may share information; public officers or employees may contact family members of a child whose death is being reviewed as part of their official duties; and the state team chairperson may require production of records through subpoena.

Creates s. 383.407, F.S., relating to protection from liability, to provide state and local team members and their authorized agents and employees who act in good faith and without malice with protection from liability. Individuals attending state and local team meetings will not be required to testify in criminal and civil proceedings as to what transpired at the meeting, and persons or entities supplying information to the teams shall not be liable. Admissions of any crime are an exception to this provision.

Creates s. 383.408, F.S., relating to funding, to provide that the Department of Health shall administer the funds and may apply for grants and accept donations to fund the act.

Section 2. Provides for an appropriation from the General Revenue fund and allows for other uses of funding.

Section 3. Provides an effective date of July 1, 1999, if the companion public records bill passes concurrently.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

Children's Medical Services Budget Entity (All General Revenue)

	Year 1	Year 2
First-Year Start-Up Effects:		
EXPENSE:	$5,710	
OCO:	$8,354	
Total	$14,064	
Health Services Budget Entity (Note: General Revenue except where indicated otherwise)		
First-Year Start-Up Effects:		
EXPENSE:	$8,865	
OCO:	$19,545	
Total	$28,410	
Total Non-Recurring	**$42,474**	

2. Recurring Effects:

Children's Medical Services Budget Entity (All General Revenue)	Year 1	Year 2
Recurring or Annualized Continuation Effects:		
SALARIES: (25% Lapse - 1st Yr.)	$81,381	$108,508
EXPENSE:	$36,746	$36,746
CONTRACTED SERVICES	$1,761,813	$1,761,813
Total	$1,879,940	$1,907,067

Health Services Budget Entity (Note: General Revenue except where indicated otherwise)		
Recurring or Annualized Continuation Effects:		
SALARIES: (25% Lapse-1st Yr.)	$119,675	$159,567
OPS:	$39,387	$39,387
EXPENSE:	$105,689	$105,689
COALTNS: General Revenue	$391,999	$291,999
Federal Grants Trust Fund	$99,598	$99,598
Total	$756,348	$796,240
Total Recurring	**$2,636,288**	**$2,703,307**

3. Long Run Effects Other Than Normal Growth:

None.

4. Total Revenues and Expenditures:

	Year 1	Year 2
	$2,678,762	**$2,703,307**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

   N/A

2. Recurring Effects:

   N/A

3. Long Run Effects Other Than Normal Growth:

   N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   None.

2. Direct Private Sector Benefits:

   The review teams will implement strategies to decrease the child fatality rate throughout the state.

3. Effects on Competition, Private Enterprise and Employment Markets:

   None.

D. FISCAL COMMENTS:

None.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

The Comprehensive Mortality Review Program

According to the Department of Health, State Child Death Review 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 and the Fetal and Infant Mortality Review Project (both of which already exist), as well as a new Child Fatality Review Team created by statute. 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.

Agency Jurisdiction

Administrative agencies are created by statute to fulfill a needed purpose in a particular area. In *Florida Dept. of Ins. and Treasurer v. Bankers Ins. Co*., 694 So. 2d 70 (Fla. 1st DCA 1997), the court stated that an agency's "legitimate regulatory realm is no more and no less than what the Legislature prescribes by law. Yet it is also true that an agency's own views on where its jurisdictional bournes lie reflect a putative expertise....Where a statute draws an uncertain boundary, judicial deference to an agency's jurisdictional determination is appropriate." There is some question as to whether a review team conducting research on child deaths remains solely within the "jurisdictional bournes" of public health. A possibility of tension may exist between child death teams and law enforcement agencies conducting criminal investigations.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

None.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

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