

Senate Engrossed

child fatality; maternal mortality

State of Arizona
Senate
Fifty-seventh Legislature
First Regular Session
2025

SENATE BILL 1316

AN ACT

AMENDING SECTION 36-3501, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 35, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-3501.01; AMENDING SECTIONS 36-3502 AND 36-3503, ARIZONA REVISED STATUTES; RELATING TO CHILD FATALITIES.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Heading change

3 A. The chapter heading of title 36, chapter 35, Arizona Revised
4 Statutes, is changed from "CHILD FATALITIES" to "CHILD AND MATERNAL
5 DEATHS".

6 B. The article heading of title 36, chapter 35, article 1, Arizona
7 Revised Statutes, is changed from "GENERAL PROVISIONS" to "CHILD
8 FATALITIES AND MATERNAL MORTALITY".

9 Sec. 2. Section 36-3501, Arizona Revised Statutes, is amended to
10 read:

11 36-3501. State child fatality review team; membership;
12 duties; reporting requirements

13 A. The state child fatality review team is established in the
14 department of health services. The state team is composed of the head of
15 the following entities or that person's designee:

- 16 1. Attorney general.
- 17 2. Office of women's and children's health in the department of
18 health services.
- 19 3. Arizona health care cost containment system.
- 20 4. Division of developmental disabilities in the department of
21 economic security.
- 22 5. Department of child safety.
- 23 6. Governor's office ~~for~~ OF youth, faith and family.
- 24 7. Administrative office of the courts' parent assistance program.
- 25 8. Department of juvenile corrections.
- 26 9. Arizona chapter of a national pediatric society.

27 B. The director of the department of health services shall appoint
28 the following members to serve on the state team:

- 29 1. A medical examiner who is a forensic pathologist.
- 30 2. A maternal and child health specialist who is involved with the
31 treatment of Native Americans.
- 32 3. A representative of a private nonprofit organization of tribal
33 governments in this state.
- 34 4. A representative of the Navajo tribe.
- 35 5. A representative of the United States military family advocacy
36 program.
- 37 6. A representative of a statewide prosecuting attorneys advisory
38 council.
- 39 7. A representative of a statewide law enforcement officers
40 advisory council who is experienced in child homicide investigations.
- 41 8. A representative of an association of county health officers.
- 42 9. A child advocate who is not employed by or an officer of this
43 state or a political subdivision of this state.
- 44 10. A local child fatality review team member.

1 C. The state team shall:

2 1. Develop a child fatalities data collection system.

3 2. Provide training to cooperating agencies, individuals and local
4 child fatality review teams on the use of the child fatalities data
5 system.

6 3. Conduct an annual statistical report on the incidence and causes
7 of child fatalities in this state during the past year and submit a copy
8 of this report, including its recommendations for action, to the governor,
9 the president of the senate and the speaker of the house of
10 representatives on or before November 15 of each year. The report shall
11 include available information regarding plans for or progress toward
12 implementation of recommendations. Recommendations made to a state
13 agency, board or commission shall require a written response indicating
14 whether the agency is capable of implementing the recommendations within
15 its existing authority and resources, including any applicable
16 implementation plan, to the governor, the president of the senate, the
17 speaker of the house of representatives and the state child fatality
18 review team within sixty days after the report is submitted.

19 4. Encourage and assist in the development of local child fatality
20 review teams.

21 5. Develop standards and protocols for local child fatality review
22 teams and provide training and technical assistance to these teams.

23 6. Develop protocols for child fatality investigations, including
24 protocols for law enforcement agencies, prosecutors, medical examiners,
25 health care facilities and social service agencies.

26 7. Study the adequacy of statutes, ordinances, rules, training and
27 services to determine what changes are needed to decrease the incidence of
28 preventable child fatalities and, as appropriate, take steps to implement
29 these changes.

30 8. Provide case consultation on individual cases to local teams if
31 requested.

32 9. Educate the public regarding the incidence and causes of child
33 fatalities as well as the public's role in preventing these deaths.

34 10. Designate a state team chairperson.

35 11. Develop and distribute an informational brochure that describes
36 the purpose, function and authority of the state team. The brochure shall
37 be available at the offices of the department of health services.

38 ~~12. Evaluate the incidence and causes of maternal fatalities~~
39 ~~associated with pregnancy in this state. For the purposes of this~~
40 ~~paragraph, "maternal fatalities associated with pregnancy" means the death~~
41 ~~of a woman while she is pregnant or within one year after the end of her~~
42 ~~pregnancy.~~

43 ~~13.~~ 12. Beginning January 1, 2025, conduct an annual statistical
44 report on the incidence and causes of child fatalities and near fatalities
45 identified by the department of child safety pursuant to section 8-807.01

1 for the past year and submit a copy of this report, including its
2 recommendations for action, to the governor, the president of the senate
3 and the speaker of the house of representatives on or before November 15
4 of each year. The report shall include available information regarding
5 plans for or progress toward implementation of recommendations.
6 Recommendations made to a state agency, board or commission shall require
7 a written response indicating whether the agency is capable of
8 implementing the recommendations within its existing authority and
9 resources, including any applicable implementation plan, to the governor,
10 the president of the senate, the speaker of the house of representatives
11 and the state child fatality review team within sixty days after the
12 report is submitted.

13 ~~14.~~ 13. Inform the governor and the legislature of the need for
14 specific recommendations regarding sudden unexpected infant death.

15 ~~15.~~ 14. Periodically review the infant death investigation
16 checklist developed by the department of health services pursuant to
17 section 36-3506. In reviewing the checklist, the state team shall
18 consider guidelines endorsed by national infant death organizations.

19 D. State team members are not eligible to receive compensation, but
20 members appointed pursuant to subsection B of this section are eligible
21 for reimbursement of expenses pursuant to title 38, chapter 4, article 2.

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

24 F. Notwithstanding subsections C and D of this section, this
25 section does not require expenditures above the revenue available from the
26 child fatality review fund.

27 Sec. 3. Title 36, chapter 35, article 1, Arizona Revised Statutes,
28 is amended by adding section 36-3501.01, to read:

29 36-3501.01. Maternal mortality review program; committee;
30 members; reports; compensation; definition

31 A. THE MATERNAL MORTALITY REVIEW PROGRAM IS ESTABLISHED TO EVALUATE
32 THE INCIDENCE, CAUSES AND PREVENTABILITY OF PREGNANCY-ASSOCIATED DEATHS.
33 THE PROGRAM SHALL COORDINATE AND FACILITATE CASE REVIEWS BY THE MATERNAL
34 MORTALITY REVIEW COMMITTEE. IN COLLABORATION WITH THE MATERNAL MORTALITY
35 REVIEW PROGRAM, THE MATERNAL MORTALITY REVIEW COMMITTEE SHALL PRODUCE
36 PREVENTION RECOMMENDATIONS THAT AIM TO ADDRESS THE CONTRIBUTING FACTORS
37 THAT LEAD TO PREVENTABLE PREGNANCY-ASSOCIATED DEATHS.

38 B. THE MATERNAL MORTALITY REVIEW PROGRAM IS COMPOSED OF THE
39 MATERNAL MORTALITY REVIEW COMMITTEE AND THE COMMITTEE'S STAFF. THE
40 DIRECTOR OF THE DEPARTMENT OF HEALTH SERVICES SHALL APPOINT THE MEMBERS OF
41 THE COMMITTEE. THE DIRECTOR OR THE DIRECTOR'S DESIGNEE SHALL SERVE AS
42 COCHAIRPERSON OF THE COMMITTEE. THE COMMITTEE SHALL ELECT A SECOND
43 COCHAIRPERSON FROM THE COMMITTEE'S MEMBERSHIP.

1 C. THE DIRECTOR OF THE DEPARTMENT OF HEALTH SERVICES SHALL APPOINT
2 AT LEAST THE FOLLOWING MEMBERS OF THE MATERNAL MORTALITY REVIEW COMMITTEE,
3 ONE OF WHOM IS FROM A COUNTY WITH A POPULATION OF LESS THAN FIVE HUNDRED
4 THOUSAND PERSONS:
5 1. TWO OBSTETRICIANS WHO ARE LICENSED PURSUANT TO TITLE 32, CHAPTER
6 13 OR 17, AT LEAST ONE OF WHOM IS A MATERNAL FETAL MEDICINE SPECIALIST.
7 2. A CERTIFIED NURSE MIDWIFE WHO IS LICENSED PURSUANT TO TITLE 32,
8 CHAPTER 15.
9 3. A REPRESENTATIVE OF A NONPROFIT ORGANIZATION THAT PROVIDES
10 EDUCATION, SERVICES OR RESEARCH RELATED TO MATERNAL AND CHILD HEALTH.
11 4. A REPRESENTATIVE OF AN ORGANIZATION THAT REPRESENTS HOSPITALS IN
12 THIS STATE.
13 5. A BEHAVIORAL HEALTH PROFESSIONAL.
14 6. A DOMESTIC OR INTERPERSONAL VIOLENCE SPECIALIST.
15 7. A FORENSIC PATHOLOGIST OR TOXICOLOGIST.
16 8. AN INDIVIDUAL WITH PERSONAL OR COMMUNITY-LEVEL EXPERIENCE IN
17 MATERNAL HEALTH ISSUES.
18 9. A REPRESENTATIVE FROM THE ARIZONA HEALTH CARE COST CONTAINMENT
19 SYSTEM.
20 10. A REPRESENTATIVE FROM THE DEPARTMENT OF CHILD SAFETY.
21 11. A REPRESENTATIVE FROM THE ARIZONA PERINATAL TRUST.
22 12. A REPRESENTATIVE OF INDIAN HEALTH SERVICES.
23 D. THE MATERNAL MORALITY REVIEW PROGRAM SHALL:
24 1. DEVELOP A DATA COLLECTION SYSTEM FOR MATERNAL FATALITIES.
25 2. PROVIDE TRAINING TO COOPERATING AGENCIES AND INDIVIDUALS ON
26 IDENTIFICATION, REVIEW AND DISSEMINATION PROCESSES.
27 3. ON OR BEFORE MAY 15 OF EACH EVEN-NUMBERED YEAR, PRODUCE A
28 STATISTICAL REPORT ON THE INCIDENCE AND CAUSES OF PREGNANCY-RELATED DEATHS
29 IN THIS STATE AND SUBMIT A COPY OF THIS REPORT, INCLUDING THE COMMITTEE'S
30 RECOMMENDATIONS FOR PREVENTING MATERNAL FATALITIES, TO THE GOVERNOR, THE
31 PRESIDENT OF THE SENATE, THE SPEAKER OF THE HOUSE OF REPRESENTATIVES AND
32 THE CHAIRPERSONS OF THE HEALTH AND HUMAN SERVICES COMMITTEES OF THE HOUSE
33 OF REPRESENTATIVES AND THE SENATE, OR THEIR SUCCESSOR COMMITTEES.
34 4. STUDY THE ADEQUACY OF STATUTES, ORDINANCES, RULES, TRAINING AND
35 SERVICES TO DETERMINE THE CHANGES THAT ARE NEEDED TO DECREASE THE
36 INCIDENCE OF PREVENTABLE MATERNAL FATALITIES.
37 E. COMMITTEE MEMBERS ARE NOT ELIGIBLE TO RECEIVE COMPENSATION, BUT
38 MEMBERS APPOINTED PURSUANT TO SUBSECTION C OF THIS SECTION ARE ELIGIBLE
39 FOR REIMBURSEMENT OF EXPENSES PURSUANT TO TITLE 38, CHAPTER 4, ARTICLE 2.
40 F. FOR THE PURPOSES OF THIS SECTION, "PREGNANCY-ASSOCIATED DEATH"
41 MEANS A DEATH THAT OCCURRED DURING PREGNANCY OR WITHIN ONE YEAR AFTER THE
42 END OF PREGNANCY.

1 Sec. 4. Section 36-3502, Arizona Revised Statutes, is amended to
2 read:

3 36-3502. Local child fatality review teams; members; duties

4 A. Local child fatality review teams shall abide by the standards
5 and protocol for local child fatality review teams developed by the state
6 team and must have prior authorization from the state team to conduct
7 reviews. Local teams shall be composed of the head of the following
8 departments, agencies or associations, or that person's designee:

- 9 1. County medical examiner.
- 10 2. Department of child safety.
- 11 3. County health department.

12 B. The chairperson of the state child fatality review team shall
13 appoint the following members of the local team:

- 14 1. A domestic violence specialist.
- 15 2. A mental health specialist.
- 16 3. A pediatrician who is certified by the American board of
17 pediatrics or a family physician who is certified by the American board of
18 family medicine. The pediatrician or family physician shall also be
19 licensed in this state.
- 20 4. A person from a local law enforcement agency.
- 21 5. A person from a local prosecutor's office.
- 22 6. A parent.

23 C. Local child fatality review teams shall:

- 24 1. Designate a team chairperson who shall review the death
25 certificates of all children ~~and women~~ who die within the team's
26 jurisdiction and call meetings of the local team when necessary.
- 27 2. Assist the state team in collecting relevant data.
- 28 3. Submit written reports to the state team as directed by that
29 team. These reports shall include nonidentifying information on
30 individual cases and steps taken by the local team to implement necessary
31 changes and improve the coordination of services and investigations.

32 Sec. 5. Section 36-3503, Arizona Revised Statutes, is amended to
33 read:

34 36-3503. Access to information; confidentiality; violation;
35 classification

36 A. On request of the chairperson of the state or a local child
37 fatality review team OR THE MATERNAL MORTALITY REVIEW PROGRAM and as
38 necessary to carry out the team's OR PROGRAM'S duties, the chairperson
39 shall be provided within five days excluding weekends and holidays with
40 access to all information and records regarding a child whose fatality or
41 near fatality is being reviewed by the team, ~~or~~ or information and records
42 regarding the child's family and records of a maternal fatality associated
43 with pregnancy pursuant to section ~~36-3501, subsection C~~ 36-3501.01:

- 44 1. From a person or institution providing medical, dental, nursing
45 or mental health care.

1 2. From this state or a political subdivision of this state that
2 might assist a team OR PROGRAM to review a child fatality or near fatality
3 OR A CASE OF MATERNAL MORTALITY.

4 B. A law enforcement agency with the approval of the prosecuting
5 attorney may withhold from release pursuant to subsection A of this
6 section any investigative records that might interfere with a pending
7 criminal investigation or prosecution.

8 C. The director of the department of health services or the
9 director's designee may apply to the superior court for a subpoena as
10 necessary to compel the production of books, records, documents and other
11 evidence related to a team investigation. Subpoenas issued shall be
12 served and, on application to the court by the director or the director's
13 designee, enforced in the manner provided by law for the service and
14 enforcement of subpoenas. A law enforcement agency is not required to
15 produce the information requested under the subpoena if the subpoenaed
16 evidence relates to a pending criminal investigation or prosecution. All
17 records shall be returned to the agency or organization on completion of
18 the review. Written reports or records containing identifying information
19 shall not be kept by the team.

20 D. All information and records acquired by the state team, any
21 local team or a program are confidential and are not subject to subpoena,
22 discovery or introduction into evidence in any civil or criminal
23 proceedings, except that information, documents and records otherwise
24 available from other sources are not immune from subpoena, discovery or
25 introduction into evidence through those sources solely because they were
26 presented to or reviewed by a team or program.

27 E. Members of a team OR PROGRAM, persons attending a team OR
28 PROGRAM meeting and persons who present information to a team OR PROGRAM
29 may not be questioned in any civil or criminal proceedings regarding
30 information presented in or opinions formed as a result of a meeting.
31 This subsection does not prevent a person from testifying to information
32 that is obtained independently of the team OR PROGRAM or that is public
33 information.

34 F. Pursuant to policies adopted by the state child fatality review
35 team or ~~a~~ THE maternal mortality review program, a member of the state or
36 a local child fatality review team or ~~a~~ THE maternal mortality review
37 program, or the member's designee, may contact, interview or obtain
38 information from a close contact or family member of a child or woman who
39 dies within the team's or program's jurisdiction. The state child
40 fatality review team and maternal mortality review program shall establish
41 a process for approving any contact, interview or request before any team
42 or program member or designee contacts, interviews or obtains information
43 from the close contact or family member of a child or woman who dies
44 within the team's or program's jurisdiction. Policies adopted pursuant to
45 this subsection must require that any individual who engages with a family

1 member be trained in trauma informed interview techniques and educated on
2 support services available to the close contact or family member.

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

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