WEST VIRGINIA
SECRETARY OF STATE
NATALIE E. TENNANT
ADMINISTRATIVE LAW DIVISION

Form #2

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2014 JUN 27 P 3:54

OFFICE OF SECRETARY OF STATE

NOTICE OF A COMMENT PERIOD ON A PROPOSED RULE

AGENCY: DHHR - BUREAU FOR PUBLIC HEALTH TITLE NUMBER: 64

RULE TYPE: LEGISLATIVE CITE AUTHORITY: §§16-1-4 and 61-12a-2(c)

AMENDMENT TO AN EXISTING RULE: YES ____ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: ____

TITLE OF RULE BEING AMENDED: ____

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: 29

TITLE OF RULE BEING PROPOSED: FATALTY AND MORTALITY REVIEW TEAM

IN LIEU OF A PUBLIC HEARING, A COMMENT PERIOD HAS BEEN ESTABLISHED DURING WHICH ANY INTERESTED PERSON MAY SEND COMMENTS CONCERNING THESE PROPOSED RULES. THIS COMMENT PERIOD WILL END ON July 28, 2014 AT 12:00 noon ONLY WRITTEN COMMENTS WILL BE ACCEPTED AND ARE TO BE MAILED TO THE FOLLOWING ADDRESS:

Ann Goldberg, Director
Public Health Regulations
Bureau for Public Health, DHHR
350 Capitol Street, Room 702
Charleston, WV 25301
fax (304) 558-1035
ph. (304) 558-2971
ann.a.goldberg@wv.gov

THE ISSUES TO BE HEARD SHALL BE LIMITED TO THIS PROPOSED RULE.

Karen L Bowling
Authorized Signature

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

FISCAL NOTE FOR PROPOSED RULES

Rule Title:

FATALITY AND MORTALITY REVIEW 64CSR20

Type of Rule: **X** Legislative _____ Interpretive _____ Procedural

Agency: **Health and Human Resources**

Address: **One Davis Square**

Suite 100, East

Charleston, WV 25301

Phone Number: **304 558-2971** Email: ann.a.goldberg@wv.gov

Fiscal Note Summary

Summarize in a clear and concise manner what effect this measure will have on costs and revenues of state government.

This fiscal note provides cost estimates for inclusion of the Unintentional Pharmaceutical Drug Overdose Fatality Review Panel as part of the Fatality and Mortality Review Team. The Department of Health and Human Resources (DHHR), Bureau for Public Health is required to promulgate this rule to establish standard procedures for the conduct of the advisory panels and to establish the protocols for review and analysis of fatalities. The Fatality and Mortality Review team is required to establish four advisory panels, to wit: Unintentional Pharmaceutical Drug Overdose Fatality Review Panel (UPDOFRP); Child Fatality Review Panel (CFRP); Domestic Violence Fatality Review Panel (DVFRP) and Infant and Maternal Mortality Review Panel (IMMRP).

The Fatality and Mortality Review Team is a four person multidisciplinary team created to oversee and coordinate the examination, review and assessment of deaths of all persons in West Virginia who die as a result of unintentional prescription or pharmaceutical drug overdoses, all children who die under the age of 18, all deaths resulting from suspected domestic violence and all deaths of infants who die in the first year of life and women who die during pregnancy or at the time of birth or within one year of the birth of a child. The Fatality and Mortality Review team is made up of the Chief Medical Examiner from the Bureau for Public Health, who serves as the chairperson and is responsible for calling meetings, the Commissioner of the Bureau for Public Health, the Superintendent of the West Virginia State Police and a prosecuting attorney appointed by the Governor.

The DHHR estimates the work load of the UPDOFRP will be dramatically larger than any of the above listed panels, so it is expected that staffing and other support needs will also be greater. The anticipated caseload for review by the UPDOFRP would require 2.5 new FTE's, which are a full time program manager, programmer analyst (.5 FTE) and office assistant. In addition, the panel would be supported by existing staff from the Office of the Chief Medical Examiner. The DHHR estimates the total cost for this fiscal note to be $169,237 the first year and $163,237 thereafter.

Fiscal Note Detail

Show over-all effect in Item 1 and 2 and, in Item 3, give an explanation of Breakdown by fiscal year, including long-range effect.

Effect of Proposal	Fiscal Year		
	2014 Increase/Decrease (use"-")	2015 Increase/Decrease (use"-")	Fiscal Year (Upon Full Implementation)
1. Estimated Total Cost	0	169,237	163,237
Personal Services	0	145,537	145,537
Current Expenses	0	17,700	17,700
Repairs and Alterations	0	0	0
Buildings	0	0	0
Equipment	0	6,000	0
Land	0	0	0
Other Assets	0	0	0
2. Estimated Total Revenues	0	0	0

3. Explanation of above estimates (including long-range effect):

Please include any increase or decrease in fees in your estimated total revenues.

DHHR estimates costs associated with the UPDOFRP to be $169,237 in the first year. The estimates are based on financial comparisons with the existing CFPR, DVFRP and IMMRP .

Personal Services costs are estimated to be $145,537. This amount consists of salaries, totaling $97,985, are calculated as follows: Program Manager, (HHR Specialist Sr., $44,412), Programmer Analyst (.5 FTE @ $28,053), and an Office Assistant III ($25,520). The estimated salaries were based upon the mid-range of the pay grade for each classification. Employee Benefits for Administrative Fees, FICA, PERS, Workers Compensation and OPEB are estimated to be $47,552. This estimate is based on administrative fees and health insurance at $7,858 per FTE X 2.5 = $19,645, FICA, retirement and workers' compensation at 23.46% of personal services is $22,987 WV OPEB contribution is $164 per month X 12 = $1,968 per year for each insurance policy holder. It is anticipated that each employee will have insurance; total WV OPEB cost for 2.5 employees is $4,920.

Current expense, totaling $17,700, is calculated as follows: rent/utilities/phone $7,200; office supplies and materials $2,500; travel $1,500; printing of annual report $3,000; and miscellaneous for program support $3,500.

A onetime purchase for computer equipment of $6,000 is estimated for the 2.5 FTE's listed above.

Memorandum

Please identify any areas of vagueness, technical defects, reasons the proposed rule **would not** have a fiscal impact, and/or any special issues not captured elsewhere on this form.

Date

6/27/14

Agency

Department of Health and Human Resources

Authorized Representative

Karen L. Bowling

Cabinet Secretary

Legislative Rule, 64CSR29
Department of Health and Human Resources
Bureau for Public Health
Fatality and Mortality Review Team

BRIEF SUMMARY

The Fatality and Mortality Review Team is a four person multidisciplinary team created to oversee and coordinate the examination, review and assessment of deaths of all persons in West Virginia who die as a result of unintentional prescription or pharmaceutical drug overdoses, all children who die under the age of 18, all deaths resulting from suspected domestic violence and all deaths of infants who die in the first year of life and women who die during pregnancy or at the time of birth or within one year of the birth of a child. The Fatality and Mortality Review team is made up of the Chief Medical Examiner from the Bureau for Public Health, who serves as the chairperson and is responsible for calling meetings, the Commissioner of the Bureau for Public Health, the Superintendent of the West Virginia State Police and a prosecuting attorney appointed by the Governor.

The Fatality and Mortality Review team is required to establish four advisory panels on the topics listed above, to wit: Unintentional Pharmaceutical Drug Overdose Review Panel (UPDORP); Child Fatality Review Panel (CFRP); Domestic Violence Fatality Review Panel (DVFRP) and Infant and Maternal Mortality Review Panel (IMMRP). The Bureau for Public Health is required to promulgate this rule to establish standard procedures for the conduct of the advisory panels and to establish the protocols for review and analysis of fatalities.

STATEMENT OF CIRCUMSTANCES

This rule is promulgated in compliance with the statutory mandate in SB 108 passed April 13, 2013.

QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period; Proposed Rule, and if needed, Emergency and Modified Rule.)

DATE: _____

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM:(*Agency Name, Address & Phone No.*) DHHR Bureau for Public Health
350 Capitol Street, Room 702
Charleston, WV 25301
(304) 558-2971

LEGISLATIVE RULE TITLE: Fatality and Mortality Review Team, 64 CSR29

1. Authorizing statute(s) citation WV Code §§ 16-1-4, and 61-12A-2(c)

2. a. Date filed in State Register with Notice of Hearing or Public Comment Period:

   b. What other notice, including advertising, did you give of the hearing?
   N/A

   c. Date of Public Hearing(s) ***or*** Public Comment Period ended:
   N/A

   d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

   Attached N/A No comments received N/A

e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)

N/A

f. **Name, title, address and <u>phone/fax/e-mail numbers</u>** of agency person(s) to receive all *written correspondence* regarding this rule: (Please type)

Ann Goldberg, Director
Public Health Regulations
350 Capitol Street Room 702
Charleston, WV 25301
Phone (304) 558-2971
Fax (304) 558-1035
ann.a.goldberg@wv.gov

g. **<u>IF DIFFERENT</u> FROM ITEM 'f'**, please give **Name, title, address and phone number(s)** of agency person(s) who wrote and/or has responsibility for the contents of this rule: (Please type)

Patricia McCay, Coordinator	Kathy Cummons, Director
OCME, Fatality Review Panels	OMCFH, Research, Evaluations
619 Virginia Street West	and Planning
Charleston, WV 25302	350 Capitol Street Room 427
Phone (304)558-6920 ext. 4010	Charleston, WV 25301
Fax (304)558-9038	Phone (304) 558-5388
patricia.a.mccay@wv.gov	Fax (304) 558-3510
	kathy.g.cummons@wv.gov

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

N/A

b. Date of hearing or comment period:

N/A

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

N/A

d. Attach findings and determinations and reasons:

Attached N/A

TITLE 64
LEGISLATIVE RULE
BUREAU FOR PUBLIC HEALTH

SERIES 29
FATALITY AND MORTALITY REVIEW TEAM

§64-29-1. General.

1.1. Scope - This rule establishes standard procedures for the formation and conduct of the Fatality and Mortality Review Team. The Fatality and Mortality Review Team (FMRT) is a multidisciplinary team created to oversee and coordinate the examination, review and assessment of special cases of death where other than natural causes are suspected. This rule should be read in conjunction with W. Va. Code §61-12A-1, et seq. The W. Va. Code is available in public libraries and on the Legislature's web page, http://www.legis.state.wv.us/ .

1.2. Authority - W. Va. Code §§16-1-4 and 61-12A-2(c).

1.3. Filing Date - June 27, 2014

1.4. Effective Date -

§64-29-2. Application and Enforcement.

2.1. Application - This rule applies to the Fatality and Mortality Review Team and also to four fatality and mortality advisory panels described in this rule.

2.2. Enforcement - This rule is enforced by the commissioner and by the chief medical examiner in the bureau for public health.

§64-29-3. Definitions.

3.1. Bureau – The Bureau for Public Health in the Department of Health and Human Resources.

3.2. Child - A person less than eighteen (18) years of age.

3.3. Child Fatality Review Panel (CFRP) - A multidisciplinary group of professionals including representatives from public health, medicine, law and law enforcement, and child welfare that reviews the circumstances surrounding the deaths of children.

3.4. Commissioner – The Commissioner of the Bureau for Public Health or his or her designee.

3.5. Department - The West Virginia Department of Health and Human Resources.

3.6. Domestic violence fatality - An unnatural death precipitated by events surrounding a relationship among individuals who are family or household members as defined in W. Va. Code §48-27-204.

3.7. Domestic Violence Fatality Review Panel (DVFRP) - A multidisciplinary and multi-agency group of professionals including but not limited to representatives from public health, mental health,

medicine, law and law enforcement and adult welfare that reviews the circumstances surrounding the deaths of children or adults which may be related to incidents of domestic violence.

3.8. Domestic violence incident - An unnatural death reviewed by the panel. The final determination as to whether an incident is a domestic violence fatality will be made at the time of the team review.

3.9. Immediate review - A review of the circumstances surrounding the death of a child that occurs between twenty-four (24) and forty-eight (48) hours after the death of a child.

3.10. Infant and Maternal Mortality Review Panel (IMMRP) - A multi-disciplinary group of professionals including representatives from public health and the medical community that reviews the circumstances surrounding the deaths of infants who die in the first year of life and women who die during pregnancy, at the time of birth or within one year of the birth of a child.

3.11. Infant mortality - Death of a live born infant in the first year of life.

3.12. Incident – An unnatural death reviewed by a panel. The final determination as to whether an incident is a child fatality, domestic violence fatality, infant or maternal fatality or an unintentional pharmaceutical drug overdose fatality will be made at the time of the panel's review.

3.13. Maternal mortality - Death of a woman during pregnancy, at the time of birth or within one year of the birth of a child from any cause related to or aggravated by pregnancy or its management but not from accidental or incidental causes.

3.14. Review - The process by which all of the facts and circumstances about a deceased child or person suspected to have died due to domestic violence, unintentional pharmaceutical drug overdose or an infant or maternal death are known to members of a panel and are shared and discussed among the members of that panel.

3.15. Unexpected death - The death of a healthy child whose immediate death is not anticipated.

3.16. Unexplained death - The cause and manner of death that cannot be determined after an autopsy and thorough investigation of the circumstances surrounding the death.

3.17. Unintentional pharmaceutical drug overdose – The death of a person from an apparent unintentional drug overdose of either a prescription drug or other pharmaceutical drugs.

3.18. Unintentional Pharmaceutical Drug Overdose Review Panel (UPDORP) – A multi-disciplinary panel created to examine, review and analyze the deaths of all persons in the state of West Virginia who die as a result of unintentional prescription or pharmaceutical drug overdoses.

§64-29-4. Conduct and Membership of the Fatality and Mortality Review Team.

4.1. The Fatality and Mortality Review Team (FMRT) is a multidisciplinary team created to oversee and coordinate the examination, review and assessment of the unexplained, unexpected or unintentional deaths of children, infants, mothers during pregnancy or within one year of giving birth, persons suspected to have died from domestic violence and those who die from an unintentional prescription or pharmaceutical drug overdose.

4.2. The Chief Medical Examiner (CME) in the Bureau for Public Health, or his or her designee, shall serve as the chairperson and is responsible for calling and coordinating meetings of the FMRT as well as the meetings of the four (4) advisory panels described in this rule.

4.3. In addition to the Chief Medical Examiner there shall be three other members of the FMRT, as follows:

4.3.a. The Commissioner of the Bureau for Public Health or his or her designee;

4.3.b. The Superintendent of the West Virginia State Police or his or her designee; and

4.3.c. A Prosecuting Attorney, who shall be appointed by the Governor and who shall serve for a term or three years and may be reappointed for a second or subsequent term. The prosecuting attorney appointed to the FMRT shall continue to serve until his or her term expires or until his or her successor has been appointed.

4.4. Each member of the FMRT shall serve without additional compensation and may not be reimbursed for any expenses incurred in the discharge of his or her duties under this rule.

§64-29-5. Responsibilities of the Fatality and Mortality Review Team.

5.1. The Fatality and Mortality Review Team shall establish four advisory panels to carry out the purposes of the WV Code §61-12A-1, et seq. The members of the FMRT shall serve on each of the advisory panels described in this rule.

5.2. The four advisory panels and their duties shall be described in detail in this rule and are to be named as follows:

5.2.a. An unintentional pharmaceutical drug overdose review panel (UPDORP) created to examine, analyze and review deaths from unintentional prescription or pharmaceutical drug overdoses;

5.2.b. A child fatality review panel (CFRP) to examine, analyze and review deaths of children under the age of eighteen years;

5.2.c. A domestic violence fatality review panel (DVFRP) to examine, analyze and review deaths resulting from suspected domestic violence; and

5.2.d. An infant and maternal mortality review panel (IMMRP) to examine, analyze and review the deaths of infants and women who die during pregnancy, at the time of birth or within one year of the birth of a child.

5.3. The Fatality and Mortality Review Team shall submit an annual report to the Governor and to the Legislative Oversight Committee on Health and Human Resourced Accountability concerning its activities and the activities of the advisory panels. The report is due annually on December 1 and it shall include statistical information concerning cases reviewed during the year, trends and patterns concerning these cases and the team's recommendations to reduce the number of fatalities and mortalities that occur in the state.

§64-29-6. Membership and Responsibilities of the Unintentional Pharmaceutical Drug Overdose Review Panel.

6.1. The Unintentional Pharmaceutical Drug Overdose Fatality Review Panel (UPDORP) shall consist of the following members appointed by the Fatality and Mortality Review Team:

6.1.a. The Chief Medical Examiner in the Bureau for Public Health or his or her designee, who is to serve as the chairperson and who is responsible for calling and coordinating all meetings;

6.1.b. The Director of the West Virginia State Board of Pharmacy or his or her designee;

6.1.c. The Commissioner of the Bureau for Public Health or his or her designee;

6.1.d. The Director of the Division of Vital Statistics or his or her designee;

6.1.e. The Superintendent of the West Virginia State Police or his or her designee;

6.1.f. One representative who is a physician nominated by the West Virginia State Medical Association. Each appointment of a physician, whether for a full term or to fill a vacancy, is to be made by the FMRT from among three nominees selected by the West Virginia State Medical Association;

6.1.g. One representative who is a registered nurse nominated by the West Virginia Nurses Association. Each appointment of a registered nurse, whether for a full term or to fill a vacancy, is to be made by the FMRT from among three nominees selected by the West Virginia Nurses Association;

6.1.h. One representative who is a doctor of osteopathy nominated by the West Virginia Society of Osteopathic Medicine. Each appointment of a doctor of osteopathy, whether for a full term or to fill a vacancy, is to be made by the FMRT from among three nominees selected by the West Virginia Society of Osteopathic Medicine;

6.1.i. One licensed physician or doctor of osteopathy who practices pain management as a principal part of his or her practice;

6.1.j. One representative who is a doctor of pharmacy, with a background in prescription drug abuse and diversion, nominated by the West Virginia Pharmacists Association;

6.1.k. One representative who is a licensed counselor nominated by the West Virginia Association of Alcoholism and Drug Abuse Counselors;

6.1.l. One representative of the United States Drug Enforcement Administration;

6.1.m. One representative who is a prosecuting attorney nominated by the West Virginia Prosecuting Attorneys Institute;

6.1.n. A person who is considered an expert in bio-ethics training;

6.1.o. One representative who is a licensed dentist nominated by the Board of Dental Examiners. Each appointment of a dentist, whether for a full term or to fill a vacancy, is to be made by the FMRT from among three nominees selected by the West Virginia Dental Association; and

6.1.p. Any additional persons that the chairperson of the panel determines is needed in the review and consideration of a particular case.

6.2. The FMRT may make appointments without nomination for all representatives identified in subsection 6.1. of this rule where a list of nominees is not required.

6.3. Each member of the Unintentional Pharmaceutical Drug Overdose Fatality Review Panel shall serve for a term of three years, unless otherwise reappointed to a second or subsequent term. Members shall continue to serve until their respective terms expire or until their successors have been appointed.

6.4. Each member of the Unintentional Pharmaceutical Drug Overdose Fatality Review Panel 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.

6.5. The Unintentional Pharmaceutical Drug Overdose Review Panel shall:

6.5.a. Review and analyze all deaths occurring within the State of West Virginia where the cause of death was determined to be due to unintentional pharmaceutical drug overdose, specifically excluding the death of persons suffering from a mortal disease or instances where the manner of the overdose death was suicide;

6.5.b. Ascertain and document the trends, patterns and risk factors related to unintentional pharmaceutical drug overdose fatalities occurring within the State of West Virginia;

6.5.c Ascertain and document patterns related to the sale and distribution of pharmaceutical prescriptions by those otherwise licensed to provide said prescriptions, including the application of information included within the Controlled Substances Monitoring Program database kept and maintained by the West Virginia Board of Pharmacy;

6.5.d. Develop and implement standards for the uniform and consistent reporting of unintentional pharmaceutical drug overdose deaths by law-enforcement or other emergency-service responders; and

6.5.e. Provide statistical information and analysis regarding the causes of unintentional pharmaceutical drug overdose fatalities.

6.6. The Unintentional Pharmaceutical Drug Overdose Review Panel, in the exercise of its duties as defined in this section, may not:

6.6.a. Call witnesses or take testimony from individuals involved in the investigation of a pharmaceutical drug overdose fatality;

6.6.b. Contact a family member of the deceased;

6.6.c. Enforce any public health standard or criminal law or otherwise participate in any legal proceeding; or

6.6.d. Otherwise take any action which, in the determination of a prosecuting attorney or his or her assistants, impairs the ability of the prosecuting attorney, his or her assistants or any law-enforcement officer to perform his or her statutory duties.

6.7. The Unintentional Pharmaceutical Drug Overdose Review Panel may request information and records as necessary to carry out its responsibilities. Records and information that may be requested under this section include:

6.7.a. Medical, dental and mental health records;

6.7.b. Substance abuse records to the extent allowed by federal law; and

6.7.c. Information and records maintained by any state, county and local government agency, except as provided in subdivision 6.6.d. of this rule.

6.8. State, county and local government agencies shall provide the Unintentional Pharmaceutical Drug Overdose Fatality Review Panel with any information requested in writing by the panel.

§64-29-7. Responsibilities of Child Fatality Review Panel.

The CFRP shall perform reviews of deaths of all children who were residents of the State of West Virginia at the time of death, regardless of the place of death, with the objective of identifying causal patterns in child fatalities.

§64-29-8. Conduct and Membership of the Child Fatality Review Panel.

8.1. The current membership of the CFRP shall remain effective and authorized to carry out the duties described in this rule and the authorizing statute. Any vacancies shall be filled by nomination from the Fatality and Mortality Review Team. The CFRP shall meet monthly.

8.2. The chairperson of the panel shall appoint persons to vacancies on the CFRP on an interim basis, while awaiting completion of the nomination and appointment process by the FMRT.

8.3. The chairperson of the CFRP, or his or her designee, and the panel members shall review death certificates of children sent monthly by the office of vital statistics and shall determine which deaths are unexpected or unexplained.

8.4. Each member of the CFRP shall examine the records of his or her agency to determine if the child, or the child's parents or guardians, have received services at his or her agency, and if necessary, may contact other agencies to complete the review.

8.5. Panel members shall present to the rest of the CFRP the information obtained from the record reviews, but shall retain the documents in each's agency's files.

8.6. All documents regarding a particular case that are reviewed by the CFRP shall be destroyed by the CFRT after the publication of the FMRT annual report in which that case data is included.

§64-29-9. Responsibilities of Domestic Violence Fatality Review Panel.

The DVFRP shall perform reviews of all suspected domestic violence deaths occurring in the State of West Virginia.

§64-29-10. Conduct and Membership of Domestic Violence Fatality Review Panel.

10.1. The DVFRP shall meet as needed to fulfill its mission, but no less frequently than quarterly.

10.2. The current membership of the DVFRP shall remain effective and authorized to carry out the duties described in this rule and the authorizing statute. In the future, the membership of the DVFRP shall be appointed by the FMRT to give broad representation to those individuals, agencies, organizations and groups who have particular interest and expertise to contribute to the review of deaths from domestic violence.

10.3. The chairperson of the DVFRP, or his or her designee, will screen adult deaths that are reported to the chief medical examiner, under W. Va. Code §61-12-8(a), in an attempt to identify those incidents that might be domestic violence related. DVFRP members may also submit incidents for review by the

panel to determine whether it is a domestic violence incident.

10.4. Each member of the DVFRP shall examine the records of his or her agency to determine if they have information relating to the incident under review. Members may contact other agencies to collect pertinent records and information if necessary.

10.5. Panel members shall present to the rest of the DVFRP the information obtained from the record reviews and information collection.

§64-29-11. Responsibilities of Infant and Maternal Mortality Review Panel.

The Infant and Maternal Mortality Review Panel shall perform the duties including review of all deaths of infants who die in the first year of life and women who die during pregnancy, at the time of birth or within one year of the birth of a child from any cause related to or aggravated by pregnancy or its management but not from accidental or incidental causes; establish the trends, patterns and risk factors; provide statistical analysis regarding the causes of infant and maternal deaths in West Virginia; and promote public awareness of the incidence and causes of infant and maternal deaths.

§64-29-12. Conduct and Membership of Infant and Maternal Mortality Review Panel.

12.1. The Infant and Maternal Mortality Review Panel shall meet two to four times per year, based upon the number of deaths.

12.2. The current membership of the IMMAP shall remain effective and authorized to carry out the duties described in this rule and the authorizing statute. In the future the FMRT shall appoint members to serve on the IMMAP and shall also appoint persons to fill vacancies on the Infant and Maternal Mortality Review Panel.

12.3. Each member shall serve for a term of three years. Of the members of the panel first appointed, one shall be appointed for a term ending the thirtieth day of June, two thousand eleven, and one each for terms ending one, two and three years thereafter.

12.4. Members of the Infant and Maternal Mortality Review Panel shall, unless sooner removed, continue to serve until their respective terms expire and until their successors have been appointed and have qualified.

12.5. An appointment of a physician, whether for a full term or to fill a vacancy, is to be made by the FMRT from among three nominees selected by the West Virginia State Medical Association or the organization to be represented on the panel. When an appointment is for a full term, the nomination is to be submitted to the FMRT 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 FMRT within thirty days after the request for the nomination has been made by the FMRT to the chairperson or president of the organization. When an association fails to submit to the FMRT nominations for the appointment in accordance with the requirements of this section, the FMRT may make the appointment without nominations.

12.6. Each member of the Infant and Maternal Mortality Review Panel 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.

12.7. The Office Director of the Office of Maternal Child and Family Health in the Bureau shall serve as the chairperson of the Infant and Maternal Mortality Review Panel, or his or her designee. The IMMRP shall review death certificates of infants and women sent monthly by the office of vital statistics.

12.8. Each member of the Infant and Maternal Mortality Review Panel shall examine the records of his or her agency to determine if the infant or woman received services at his or her agency, and if necessary, may contact other agencies to complete the review.

12.9. Panel members shall present to the rest of the Infant and Maternal Mortality Review Panel the information obtained from the record reviews, but shall retain the documents in each agency's files.

12.10. All documents regarding a particular case that are reviewed by the Infant and Maternal Mortality Review Panel shall be destroyed by the Panel after the publication of the FMRT annual report in which that case data is included.

12.11. The Infant and Maternal Mortality Review Panel members, in the exercise of their duties as defined in this subsection, may not:

12.11.a. Call witnesses or take testimony from individuals involved in the investigation of an infant or maternal fatality;

12.11.b. Contact a family member of the deceased infant or mother, except if a member of the panel 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 panel; or

12.11.c. Enforce any public health standard or criminal law or otherwise participate in any legal proceeding, except if a member of the panel 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 his or her affiliation with the panel.

§64-29-13. Recommended Protocols for Review of Infant and Maternal Mortality.

13.1. The following are recommended protocols to aid in the review of infant and maternal deaths.

13.1.a. All Infant and Maternal Mortality Review Panel members shall sign a sworn statement promising to maintain the confidentiality of information, records, discussions and opinions disclosed during infant and maternal mortality reviews.

13.1.b. The Infant and Maternal Mortality Review Panel may call for an immediate review of medical records requested from physicians and hospitals treating the infant and the infant's mother before death or woman before, during and after her pregnancy to try and determine causes and possible preventative measures related to the death.

13.1.c. Review Panel members shall receive materials in advance of the meeting and review cases de-identified following nationally recommended guidelines and processes at meetings.

13.2. Physicians and health care providers asked to supply medical records shall do so for evaluation/review purposes only regarding the death of the infant in the first year of life or woman during her pregnancy, at the time of birth or within one year of the birth of a child. Patient, hospital, and medical

practitioner names are removed following nationally recommended guidelines and processes to ensure confidentiality.

13.3. Infant and maternal mortality data forms shall be completed using the provided information from medical records received from physicians and health care providers. Data will be compiled for the annual report to be submitted by the FMRT to the Governor and Legislature. No identifying information will be released in this report, only compiled data following nationally recommended guidelines and processes will be used.

13.4. Summaries and reports on Panel findings and recommendations that depict patterns and trends in infant and maternal deaths shall be presented in aggregate form.

13.5. All case review materials are collected at the conclusion of each meeting and properly destroyed.

§64-29-14. Confidentiality.

14.1. All information and records of the FMRT, and opinions expressed by members are confidential not to be released or disclosed except as aggregate data in the FMRT annual report required to be filed in accordance with subsection 5.3 of this rule.

14.2. Proceedings, records and opinions of the FMRT and each of the advisory panels is confidential, and is 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 FMRT or any of the advisory panels.

14.3. Members of the FMRT and each of the advisory panels 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 panel. Nothing in this subsection may be construed to prevent a member of the FMRT and each of the advisory panels from testifying to information obtained independently of the panel or which is public information.