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**WEST VIRGINIA CODE CHAPTER 61**  
**ARTICLE 12A**

WV Legislature

**§61-12A-1. Fatality and Mortality Review Team.**

(a) The Fatality and Mortality Review Team is continued under the Department of Health. The Fatality and Mortality Review Team is a multidisciplinary team created to oversee and coordinate the examination, review, and assessment of

The deaths resulting from suspected domestic violence; and

The deaths of all infants and all women who die during pregnancy, at the time of birth, or within one year of the birth of a child, and the deaths of children under 18 years of age;

(b) The Fatality and Mortality Review Team shall consist of the following members:

(1) The state health officer, who is to serve as the chairperson and who is responsible for calling and coordinating at least quarterly, or more often, if needed, meetings of the Fatality and Mortality Review Team;

(2) The Commissioner of the Bureau for Public Health or his or her designee;

(3) The Superintendent of the West Virginia State Police or his or her designee;

(4) A prosecuting attorney, as appointed by the Prosecuting Attorneys Institute, who shall serve for a term of three years unless otherwise reappointed. A prosecuting attorney appointed to the team shall continue to serve until his or her term expires or until his or her successor has been appointed;

(5) A designee of the Chief Medical Examiner;

(6) A designee selected by the Chair of the Minority Health Institute at Marshall University that has an expertise in the causes of the disproportionate high mortality rates of minority births in West Virginia;

(7) A designee of the Perinatal Partnership;

(8) A licensed physician with training in obstetrics, appointed by the state health officer;

(9) A licensed physician with training in neonatology, appointed by the state health officer;

(10) A hospital-based nurse with experience in obstetrics, labor and delivery, post-partum, or maternity care, appointed by the state health officer;

(11) A licensed nurse or physician with training in domestic violence, appointed by the state health officer; and

(12) Any additional persons may be added on a case-by-case basis when expertise is needed, as determined by the chair. The designee may change based upon the circumstances of each particular case.

(c) Each member 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.

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**§61-12A-2. Responsibilities of the Fatality and Mortality Review Team.**

(a) The Fatality and Mortality Review Team shall:

(A) Review and analyze the deaths resulting from suspected domestic violence, the deaths of all infants and all women who die during pregnancy, at the time of birth or within one year of the birth of a child, and the deaths of children under 18 years of age;

(B) Ascertain and document the trends, patterns, and risk factors; and

(C) Provide statistical information and analysis regarding the causes of certain fatalities; and

(D) Establish processes and protocols for the review and analysis of fatalities and mortalities of those who were not suffering from mortal diseases shortly before death;

(b) Actions the team may not take or engage in, including:

(A) Call witnesses or take testimony from individuals involved in the investigation of a fatality;

(B) Contact a family member of the deceased, unless there is a clear public health interest which is approved by a majority vote of the team;

(C) Enforce any public health standard or criminal law or otherwise participate in any legal proceeding; or

(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.

(c) The Fatality and Mortality Review Team shall submit an annual report to the Governor, the Office of the Inspector General, and to the Legislative Oversight Commission on Health and Human Resources Accountability concerning its activities. The report is due annually starting on December 1, 2024, and shall reflect the previous year's data. The report is to include statistical information and an epidemiological analysis 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.

(d) The Fatality and Mortality Review Team may provide reporting to birth facilities, practitioners, and government entities to inform internal peer review activities of recommend changes to practices or policies. The information is confidential and shall be used only for peer review purposes.

**§61-12A-3. Access to information; other agencies of government required to cooperate.**

(a) Notwithstanding any other provision of this code to the contrary, the Fatality and Mortality Review Team may request information and records as necessary to carry out its responsibilities. Records and information that may be requested under this section include:

- (1) Medical, dental, and mental health records;
- (2) Substance abuse records to the extent allowed by federal law; and
- (3) Information and records maintained by any state, county, and local government agency, except as provided in §61-12A-2(b) of this code.

(b) State, county, and local government agencies shall provide the Fatality and Mortality Review Team with any information requested in writing.

**§61-12A-4. Confidentiality.**

(a) Proceedings, records, and opinions of the Fatality and Mortality Review Team are confidential and are not subject to discovery, subpoena, or introduction into evidence in any civil or criminal proceeding. This section does not limit or restrict the right to discover or use in any civil or criminal proceeding anything that is available from another credible source and entirely independent of the proceedings of the team.

(b) Members of the Fatality and Mortality Review Team 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 team. This subsection does not prevent a member of the team from testifying to information obtained independently of the team which is public information.

(c) Proceedings, records, and opinions of the Fatality and Mortality Review Team are exempt from disclosure under the Freedom of Information Act as provided in §29B-1-1 *et seq.* of this code.

(d) Notwithstanding any other provisions to the contrary, the Fatality and Mortality Review Team may prepare a data compilation to be shared, on an annual basis or more often as needed, with the Centers for Disease Control and Prevention to study maternal mortality in an effort to reduce mortality rates. No individually identifiable records may be produced.

**§61-12A-5. Required reporting and analysis.**

[Repealed]

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