

**HB**

**395**

# Alaska State Legislature

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& SOCIAL SERVICES COMMITTEE

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## REPRESENTATIVE CON BUNDE

District 18

DURING SESSION  
STATE CAPITOL, ROOM 104  
JUNEAU, AK 99801-1182  
(907) 465-4843 (800) 892-4843

DURING INTERIM  
716 W. FOURTH AVE.  
ANCHORAGE, AK 99501-2133  
(907) 258-8168

E-MAIL  
Representative\_Con\_Bunde@legis.state.ak.us

## Sponsor Statement

### HB 395

#### **“ An Act relating to civil liability resulting from the use of a defibrillator in providing emergency aid”**

Every day nearly 1,000 people in the united states die unnecessarily due to sudden cardiac arrest. Most people die before they reach the hospital, usually within two hours. Research shows that early defibrillation, delivering an electrical current to the heart within minutes after sudden cardiac arrest, can raise survival rates to 30% or higher. That is 25% more lives (250 per day) than the current national survival rate of 5%.

The American Heart Association estimates that 20,000 or more unnecessary deaths could be prevented each year if automatic external defibrillators (AEDs) were more widely available. Implementation of a plan that allows both traditional and non-traditional targeted first responders to have access to and use of an AED in medical emergencies is needed.

HB 395 expands our state's Good Samaritan statute to provide protection from liability for people who are properly trained in the use of an AED. As a general rule, the American legal system does not require someone to rescue a victim. However, all states currently have Good Samaritan statutes that protect a volunteer who is aiding another in good faith. These statutes mainly apply to physicians and other health care providers who assist somebody voluntarily and do not expect any reimbursement for their services, but passersby who happen upon an accident and provide emergency assistance are also protected from liability. HB 395 clearly sets the standard for training and proper use of an automatic external defibrillator. Increased availability of automatic external defibrillators along with proper training will save lives. HB 395 will help make Alaska a safer place.

STATE OF ALASKA  
1998 LEGISLATIVE SESSION

Bill Version: CS# 395 (JUD)  
(H) Publish Date: 3/13/98

Revision Date: \_\_\_\_\_  
Title: An Act relating to civil liability resulting from the use of a defibrillator ...  
Sponsor: Representative Bunde  
Requestor: House (JUD)

Dept. Affected: Health and Social Services  
BRU: State Health Services  
Component: Community Health/EMS Services  
COMPONENT SERIAL NO. 2078  
See also (SN#): \_\_\_\_\_

**Expenditures/Revenues:**

(Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
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CHANGES IN REVENUES	0.0	0.0	0.0	0.0	0.0	0.0
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**FUND SOURCE**

(Thousands of Dollars)

1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	0.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health	0.0	0.0	0.0	0.0	0.0	0.0
Other (please specify)	0.0	0.0	0.0	0.0	0.0	0.0
<b>TOTAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

**POSITIONS:**

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of any current year (FY98) cost: \$0.0

**ANALYSIS:** (Attach a separate page if necessary)

2/20/98  
Prepared by: Peter M. Nakamura, MD, MPH  
Division: Public Health  
Approved by Commissioner: Gren Pardue, Commissioner  
Agency: Department of Health & Social Services

Phone: 465-3538  
Date: 2/25/98  
Date: 2/2/98

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Representative Porter moved and asked unanimous consent that the following committee substitute be adopted in lieu of the original bill:

CS FOR HOUSE BILL NO. 395(JUD)

"An Act relating to civil liability resulting from the use of a defibrillator in providing emergency aid or emergency training."

There being no objection, it was so ordered.

Representative Porter moved and asked unanimous consent that CSHB 395(JUD) be considered engrossed, advanced to third reading and placed on final passage. There being no objection, it was so ordered.

CSHB 395(JUD) was read the third time.

The question being: "Shall CSHB 395(JUD) pass the House?" The roll was taken with the following result:

CSHB 395(JUD)  
Third Reading  
Final Passage

YEAS: 38    NAYS: 0    EXCUSED: 0    ABSENT: 2

04/01/98

House Journal

Page 2834

HB 395

Yeas: Austerma, Berkowitz, Brice, Bunde, Cowdery, Croft, Davies, Davis, Dyson, Elton, Foster, Green, Grussendorf, Hanley, Hudson, Ivan, James, Joule, Kelly, Kemplen, Kohring, Kookesh, Kott, Kubina, Martin, Masek, Moses, Mulder, Nicholia, Ogan, Phillips, Porter, Rokeberg, Ryan, Sanders, Therriault, Vezey, Williams

Absent: Barnes, Hodgins

And so, CSHB 395(JUD) passed the House and was referred to the Chief Clerk for engrossment.

04/01/98

House Journal

Page 2842

HB 395

Representative Croft added his name as cosponsor to:

CS FOR HOUSE BILL NO. 395(JUD)

"An Act relating to civil liability resulting from the use of a defibrillator in providing emergency aid or emergency training."

04/01/98

House Journal

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HB 395

CSHB 395(JUD) was engrossed, signed by the Speaker and Chief Clerk and transmitted to the Senate for consideration.

Bill Root:

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BASIS Last Updated 4/16/98 8:43 AM

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DATE: Feb. 19, 1998

ATTN: Senator

ATTN: Representative

Good Morning:

I recently completed a CPR/First Aid class for my job where I was introduced to the AED (Automatic External Defibrillator) technology.

A heart attack doesn't play politics and could happen to anyone at anytime. Please spearhead the necessary changes that would legally allow the first trained person on the scene to have access to this amazing machine. As I understand it, the change should redefine AED as a basic life support skill and provide coverage under the state's Good Samaritan law for the trained person who would assist.

Please make this a top priority of this session. This is a win/win for all Alaskans.

Sincerely,

Name Savanna C. Runnell <sup>Mailing</sup> Address P.O. Box 240467  
City/Zip Anchorage, AK 99524 Phone 907-344-3451  
Employed by Nordstrom

Residence 7312 Huntsman Cir Unit A Anch. AK 99501

# RESPOND SYSTEMS

Respond Systems  
First Aid and Safety Supplies  
9191 Old Seward Highway  
Anchorage, Alaska 99515

Post Office Box 220348  
Anchorage, Alaska 99522-0348  
(907) 344-0302  
Fax: (907) 522-2271

February 27, 1998

*3 Pages*

TO: Jack Evans-Public Relations  
ALASKA AIRLINES

FROM: Rose Marie Citti, Director of Training  
RESPOND SYSTEMS  
P.O. Box 220348  
Anchorage, AK 99522-0348

Phone: (907) 344-0302  
FAX: (907) 522-2271

Subject: Press release 2/27/98, Anchorage Daily News regarding AED's on aircraft.

I am delighted to see Alaska Airlines has taken a position on this important public issue. However, under current Alaska regulations, the use of an AED by anyone other than someone ETT-D trained or higher would be an unlawful act. We have made AED's a hot topic with the Legislature. Our position is the same as that stated in your press release. Due to the efforts of many, we are hopeful that this matter is resolved this session but time is running out. HB: 395 is in committee and proposed regulation changes are going through the public review process. When passed flight attendants, as well as any trained person with an *expectation, designation, or duty to respond to a medical emergency* would be covered.

Please go beyond your press release.

If Alaska Airlines would draft a letter of support I will make certain it gets into the hands of the appropriate persons.

I look forward to your support.

Sincerely,

*Rose Marie*

*Attachments: HB 395  
Proposed Legislation Change notice  
copy of letter sent to legislature*

## **Airline beefs up safety**

Over the next year, Alaska Airlines plans to equip its entire fleet of aircraft with defibrillators and enhanced emergency medical kits containing supplies beyond those required by the Federal Aviation Administration. The equipment will allow flight attendants or medical professionals traveling on Alaska airplanes to provide potentially life-saving care for passengers who might suffer a heart attack while in flight, said Jack Evans, airline spokesman. A defibrillator helps restore a regular heartbeat and can greatly improve the chances of survival for some individuals who suffer sudden cardiac arrest. An in-flight medical study released last month by the Air Transport Association, the trade group representing most U.S. commercial airlines, revealed that such incidents are rare. Data from 1996 when U.S. airlines carried 580 million passengers found just 141 in-flight heart attacks. Despite that finding, the industry trend is to boost on-board emergency supplies, Evans said. Major carriers including American Airlines, Delta Air Lines and United Airlines have recently announced plans to add such equipment to their fleets, Evans said.

2/27/98 - checked July

## READER'S DIGEST

emergency vehicle in America.

Last winter police in Cincinnati started testing AEDs in patrol cars. Similar programs have begun in Camden County, Georgia, and Greenwich, Conn. Within two weeks of training, Greenwich police saved two lives with the defibrillators.

Last July 2 fire-brigade members at New York City's Grand Central Terminal were trained to operate a newly purchased AED. The next day they used it to save the life of 42-year-old attorney Bob Adams, who went into cardiac arrest while trying to catch a train.

There are still legal and bureaucratic hurdles to wider AED access. In many states defibrillation is considered a medical procedure limited to doctors and EMTs. Chafing against such hidebound regulations, Dr. Weisfeldt stresses that the new AEDs are fail safe in the hands of trained adults. He predicts that 100,000 people could be saved each year if AED use were expanded to include firefighters, police officers, security guards and family members of heart-disease patients. "We should press ahead to provide defibrillators and training to thousands of people, such as apartment-house custodians, bus drivers and train conductors," Weisfeldt urges.

But the strongest advocates for this innovative technology are those whose lives it has saved.

On the afternoon of Monday, December 30, 1996, Steve Parinisi, 30, and his wife Karen, 31, sat in Boston's Logan Airport. The newlyweds were returning to their Pennsylvania home after a weekend trip. Suddenly Karen saw Steve go pale and his lips turn blue. *Oh, no*, she thought. On their honeymoon in Italy two months earlier, Steve had suffered symptoms of heart trouble, but had seemed in good health since.

But now a massive coronary-artery blockage had triggered ventricular fibrillation. Bystanders administered CPR until medics arrived. They had to shock Steve twice with an AED before his heart resumed spontaneous contractions.

"I was within minutes of death," Parinisi says. "But that defibrillator gave me back my life."

Reflecting on such rescues, David Dutton's widow, Sandra, notes sadly that her husband could also be alive today if AEDs had been available that March night on the commuter train. "David's needless death should be a lesson to all of us," she says. "The equipment to save thousands of lives exists. Now we must demand that it be made available everywhere.

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# This Machine Could Save Your Life

So why isn't it widely available?

BY MALCOLM MCCONNELL

COMMERCIAL ARTIST David Dutton, 56, sat on a commuter train, returning from New York City to his Long Island home on the evening of March 20, 1997. Dutton had no known health problems, but as the train clattered through Queens, he suddenly gasped, his face turned a mottled red, and he slumped unconscious in his seat. It was 7:30 p.m. He had gone into cardiac arrest.

While the train crew called ahead

for medical aid, a passenger performed CPR, alternately doing chest compressions and mouth-to-mouth breathing. But Dutton's heart was seized by the chaotic rhythm called ventricular fibrillation (VF), and CPR alone could not jump-start it.

Dutton's only hope was the process called defibrillation: a brief electrical shock that overpowers the irregular VF rhythm so the heart can resume its natural contractions.

But by the time a rescue team

## READER'S DIGEST

carrying a defibrillator reached the train, it had been more than six minutes since Dutton's collapse, and his heart did not respond to attempts to restart it.

The great majority of cardiac-arrest victims die before help can reach them. But these deaths are not inevitable. "Many of the thousand cardiac-arrest incidents each day are clearly survivable," says Dr. Myron Weisfeldt, chairman of the American Heart Association's (AHA) task force on automatic external defibrillation. Time is critical: many cardiac arrests become fatal four to seven minutes after VF begins, so early defibrillation is the single most crucial factor. Every minute that passes before returning the heart to its normal rhythm decreases the chance of survival by ten percent; after just four minutes without defibrillation, only about 60 percent of victims survive. After ten minutes, few survive.

But in congested cities, emergency medical technicians (EMTs) equipped with defibrillators usually arrive too late. For years the cardiac-arrest survival rate in New York City, for example, was just over one percent. Nationwide it averages less than ten percent.

But a safe and effective technology exists that could improve these odds dramatically. It is the automatic external defibrillator (AED), a small computerized, battery-operated device, which can be as small as a book and weigh as little as four pounds. AEDs are nearly foolproof to operate. And

their cost keeps going down: some devices now sell for around \$3000.

In Rochester, Minn., automatic defibrillators have transformed emergency care of cardiac-arrest patients. In 1990 the Mayo Clinic's Dr. Roger D. White, medical director of the city's ambulance service, noted that police cars often reached cardiac-arrest victims two to three minutes before EMTs did. As trained "first responders," police officers gave CPR, but had no way of defibrillating victims, who often died. "What if we equip cars with defibrillators and train patrol officers to use them?" White suggested to the police.

Seven years later Rochester boasts what may be the highest cardiac-arrest survival rate in the world—45 percent. In the program's first five years, police defibrillated 31 cardiac-arrest patients, 18 of whom survived. Their lifesaving efficiency was tested last January 3.

Software designer Peter Czok, 50, had complained to co-worker Doreen Marks that his chest felt congested. "Maybe I'm catching pneumonia," he said. Then after lunch his head dropped, and Marks heard a weird gurgling from his throat. "Peter, don't fool around," she chided.

Czok toppled limply from his swivel chair. His face was a muddy red, his mouth agape, his sightless eyes open and blank. Terrified, Marks called 911 at 2:27 p.m.

Officer Eileen Morrison and his partner, rookie Steve Thompson, arrived at 2:30 p.m. By then Czok's

## THIS MACHINE COULD SAVE YOUR LIFE

### To Make Sure This Device Is in Your Life:

1. Ask your community police and fire departments if their "first response" vehicles contain AEDs. If not, send a letter or fax requesting them, and suggest they call Leonard Matarese, who heads the International Association of Chiefs of Police defibrillation effort, at 305-865-7586 for more information.
2. Call the nurse or medical department at your workplace to find out if your employer provides AEDs and has trained operators. If not, send a copy of this article. As Dr. Weisfeldt notes, "Thousands of people needlessly die of cardiac arrest each year in our offices and factories."
3. If your state limits access to AEDs (to find out, call the AHA at the number below), write your state senator or legislator, telling them you support changes in the law permitting trained responders to use AEDs, and that sample legislation is available from the AHA.

To learn more about sudden cardiac arrest and what you can do to bring early defibrillation to your community, contact the American Heart Association at 1-800-AHA-USA-1 or on-line at <http://www.arnhrt.org>.

face was a ghastly purple. Probing for a pulse, Thompson announced, "He's in cardiac arrest!"

As Morrison cut open Czok's shirt, Thompson pressed defibrillation pads firmly onto his chest. The computer's voice announced, "Analyzing heart rhythm. Do not touch the patient."

Within seconds the recorded voice intoned, "Shock advised. Stay clear of patient." The orange shock button flashed. "Deliver shock now." Thompson stabbed the button. "Shock delivered," the computer announced. It was 2:31 p.m. Less than five minutes had elapsed since the 911 call.

Peter Czok was released from the hospital a week later. "I was dying when the officers arrived," he says.

"If they hadn't used a defibrillator, I never would have survived."

Rochester's experience has demonstrated that nonmedical professionals equipped with AEDs and proper training can save many cardiac arrest victims. Following this city's lead, other police agencies nationwide have embraced the use of AEDs.

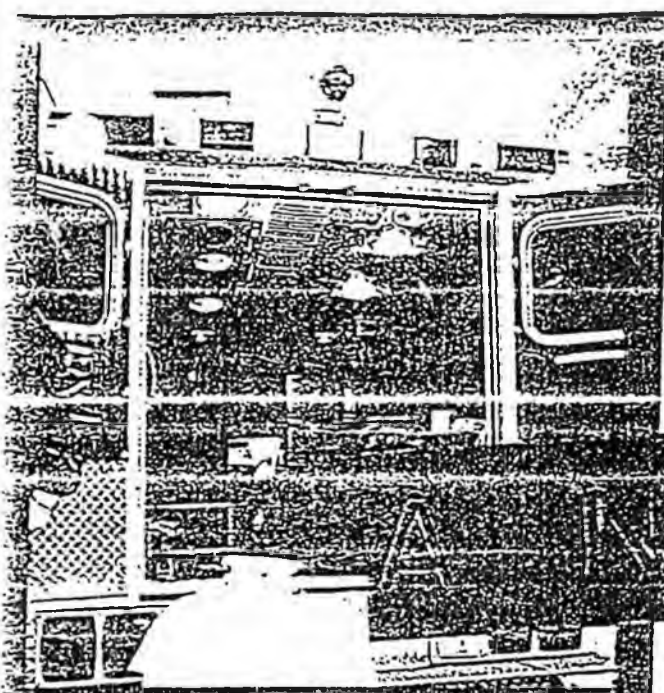
"The Rochester experience has shown that the police can consistently reach cardiac-arrested patients before EMTs do," stresses Leonard Matarese, chief of public safety in Florida's Indian Creek Village. Last year he equipped all of his squad cars and patrol boats with AEDs. And Matarese is helping forge an alliance between the nation's fire and police chiefs that he hopes will soon put an AED in every

RECEIVED

MAY 8 1988

Community Liaison and  
Employee Resources

# Suicide



Somewhere over the Pacific, aboard Qantas Flight 12 from Los Angeles to Sydney, Australia, Roland Koenig suddenly felt his head "spinning off." He knew something was terribly wrong but blacked out before he could react. Chief purser David Furey hurriedly pulled the stricken passenger to one of the exits for an examination. No pulse, no breathing—cardiac arrest.

Koenig's prognosis could not have been worse: minutes from death and hours from the nearest hospital. Luckily Furey had a secret weapon. He calmly called for the plane's onboard defibrillator, placed its two paddles on Koenig's chest and zapped his heart back to life with a series of electric shocks.

If the American Heart Association (AHA) has its way, such revivals will be repeated tens of thousands of times a year throughout the U.S.—in shopping malls, office buildings and homes too—as defibrillators become as commonplace and easy to use as fire extinguishers.

Koenig, a 73-year-old retiree from South Colleyville, Tex., was in many respects a typical victim of cardiac arrest—an older man with no obvious signs of heart disease. In the most crucial respect, however, Koenig was quite unusual: He survived. Most of the time, emergency medical personnel don't arrive fast enough and lack the portable defibrillators that could save lives. Only 5% of Americans who go into cardiac arrest come out of it alive. The prognosis is even worse in gridlocked urban areas such as New York City, where a scant 1% to 2% of the stricken are revived.

Those who don't survive are said to have suffered sudden

DAVID SELTZER

# an Death

## Public-access defibrillation could prevent 100,000 deaths a year

By Gary Goldenberg

cardiac death, which accounts for about 350,000 fatalities each year in the U.S. and is the

country's leading medical emergency. In almost all cases, the deceased had some type of underlying heart disease. But it's not correct, as often happens, to label every sudden cardiac death a "massive heart attack," since the two are actually different (see "Heart Attack or Sudden Death?" p. 66).

Typically, cardiac arrest strikes without warning. The heart's built-in electrical system—nerves embedded in the heart muscle that trigger each heartbeat—suddenly goes haywire. The main pumping chamber (the left ventricle) is swiftly reduced to a quivering blob that can no longer propel oxygen-laden blood throughout the body and, most importantly, to the brain. Death within minutes is inevitable, unless the spastic action, known as ventricular fibrillation, is corrected. And that demands a defibrillator.

As you may have seen on TV's *ER* or *Rescue 911*, these devices can shock erratically beating hearts back to a normal rhythm. "The beauty of defibrillation is that almost nothing else needs to be done for the patient if it's done fast enough," says Dr. Myron Weisfeldt, chairman of medicine at Columbia-Presbyterian Medical Center in New York City.

When it comes to saving these victims of cardiac arrest, defibrillation is actually much more helpful than cardiopulmonary resuscitation, in which rescuers alternate between breathing into the mouth and pushing on the chest. CPR oxygenates the blood and keeps it flowing to the brain, buying precious minutes until help arrives. But for the heart to restart, CPR must be followed immediately by defibrillation. In fact, when hospitalized patients go into cardiac arrest,

"the prevailing wisdom is to forget CPR and go ahead with defibrillation," says Dr. William Kava, a critical-care physician at Brown University and an expert in resuscitation training.

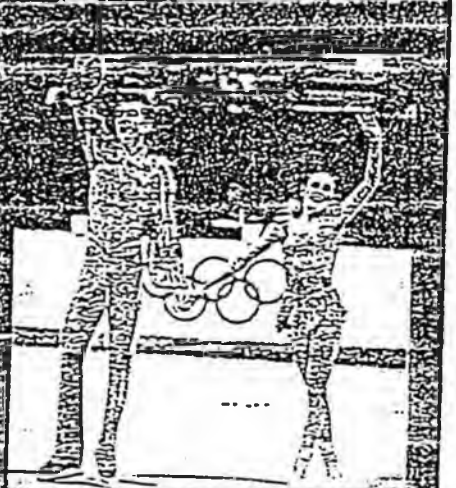
Defibrillation is a proven lifesaver, but it must be performed within 10 minutes of cardiac arrest. "Every minute the heart stays in fibrillation, we lose about 10% of the likelihood that we'll get it restarted," says Dr. Joseph Ornato, a cardiologist at the Medical College of Virginia in Richmond and chairman of the AHA National Emergency Cardiac Care Committee. Unfortunately, poor 911 systems, traffic snarls and slow elevators generally keep emergency personnel from arriving within the magic 10-minute window. Moreover, Ornato says, fewer than one in three U.S. ambulances carries a defibrillator.

Seattle and other cities have poured enormous resources into streamlining their emergency response systems, equipping all rescue personnel with defibrillators and training vast numbers of citizens in CPR. But even in Seattle, arguably the best large city in the country in which to collapse on a street corner, fewer than three in 10 cardiac arrest victims survive.

The AHA has concluded that a radically different strategy is needed to save more people from sudden cardiac death. In a statement issued last November, the organization endorsed what it calls "public-access defibrillation." The initial goal is to put defibrillators in the hands of the people most likely to arrive first at the scene of an emergency and to teach those



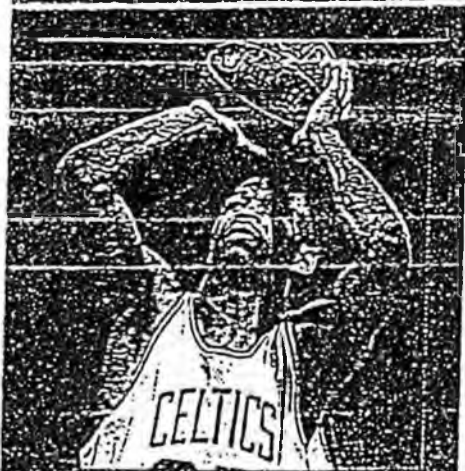
**Hank Gathers: cardiomyopathy**



**Serge Courty—Alton Forrest**



**Jim Fox: heart attack?**



**Reggie Lewis: cardiomyopathy**

people how to use them.

"We want to equip police cars and rescue units with these devices and then provide them to every company that has a nurse's station or employee health service," says Weisfeldt, who is leading the AHA's defibrillator campaign. "Next we would probably target security guards in office buildings and other heavily trafficked areas."

The ultimate goal is to put defibrillators wherever people congregate—retirement communities, apartment buildings, sporting arenas and schools—and to make them so easy to use that even untrained bystanders can operate them. But first some product improvements are needed.

Today's portable defibrillators—the ones aboard Qantas planes as well as fire engines and ambulances—have built-in computers that guide users through the procedure, voicing instructions and also displaying them on a screen. In addition, the devices automatically assess the patient's heart rhythm, judge whether defibrillation is required and then signal the operator to give the shock. But using them still requires some training, they're heavy (up to 25 pounds) and expensive (\$2,500 to \$8,000), and the devices need frequent maintenance.

"What we're looking for is a 'brilliant' defibrillator," says Weisfeldt. This Phi Beta Kappa of resuscitation instruments would weigh a mere five to 10 pounds, cost \$1,500 to \$2,000, fit inside a briefcase, guide the user with multilingual voice prompts and be durable, maintenance free and tamper resistant. Several companies are working intensively to develop such a device, and Weisfeldt predicts it will be available in a few years.

The AHA estimates that public-access defibrillation could save as many as 100,000 lives a year, a number matched by few other public health measures. "The science is fairly straightforward, so it's difficult to argue with the idea that this can help save lives," says S. Elizabeth White, senior associate for health and safety services at the American Red Cross, which, along with many other health and medical organizations, strongly endorses the AHA campaign.

Actually, those at highest risk of cardiac arrest—people who've survived one in the past—are not a target of the

# CARDIOVASCULAR

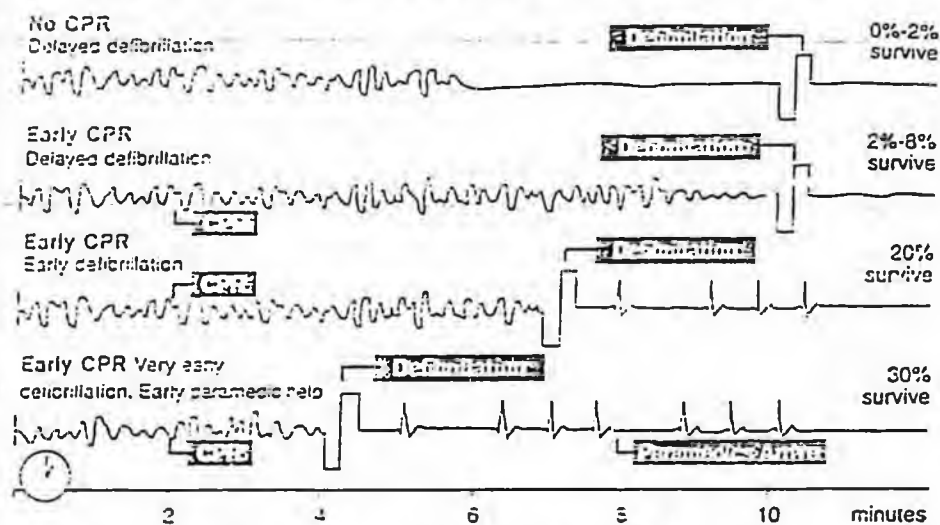
AHA's campaign. Instead they're usually walking around with their own defibrillators: wallet-sized, battery-powered units surgically implanted in the chest or upper abdomen and attached to the heart by electrodes. Like their external cousins, internal defibrillators sense abnormal heart rhythms and, within seconds of detecting a fibrillation, deliver an electrical jolt that feels like a sharp punch to the chest. Developed in the early 1980s, internal defibrillators enable thousands of Americans who are at risk of erratic heartbeats to lead relatively normal lives. (Internal defibrillators are different from those other implanted devices, pacemakers, which regulate and adjust the heartbeat continuously.)

Weisfeldt's ultimate goal is to link portable defibrillators to emergency services through telephones. "The minute the defibrillator is removed from the phone, 911 would automatically be dialed," he explains. "The 911 system would know exactly which phone and which building was using the defibrillator, and within seconds an ambulance would be on its way to the scene."

Anyone who questions defibrillation's value should look to Rochester, Minn. (population: 110,000), home of the Mayo Clinic, which has equipped all its police cars and fire rescue units with the devices. Over a recent two-year period, the two departments encountered 44 people in cardiac arrest and successfully defibrillated 21 of them—only five fewer cardiac arrest victims than were saved in all of New York City in 1991.

Some hurdles must first be overcome if public-access defibrillation is to become reality. New laws will be needed so that Good Samaritans who use defibrillators on their fellow citizens are protected from liability. And even if mass production slashes the price of defibrillators, distributing thousands of them across the country will still cost millions of dollars. Congress and the states will have to provide some of that money. And businesses will have to show more interest in having defibrillators on hand.

Each year, for example, 200 to 300 people die on planes due to cardiac arrest—more than die in most years from commercial air crashes. Yet Qantas remains one of the only airlines to carry defibrillators.



Cardiac arrest means certain death when neither cardiopulmonary resuscitation nor defibrillation is used. If a bystander begins CPR within two minutes, survival chances rise to between 2% and 8%. When both CPR and defibrillation occur within eight minutes, the likelihood of survival goes up to 20%. The figure rises to 30% when the victim receives a combination of CPR and defibrillation within four minutes and paramedic help within eight minutes.

Source: American Heart Association

Of course, making something available won't help unless people are willing to use it. In 1990 basketball star Hank Gathers of Loyola Marymount University in Los Angeles collapsed in cardiac arrest in the middle of a game. Emergency medical personnel worked feverishly, pumping his chest and inflating his lungs in the prescribed CPR manner, all to no avail. Gathers was carried off the court in front of a shocked and silent crowd. Equally shocking was a *Sports Illustrated* photo showing one of the stretcher bearers, a team physician, carrying a defibrillator. It was never used.

Roland Koenig, on the other hand, has recovered well and resumed his daily 1½-mile runs and extensive travel. Since his episode on November 5th, 1994, another Qantas passenger was also saved with a defibrillator, giving the AHA another convert to its cause. Chief purser David Furey, who saved Koenig, is another supporter.

"I can't tune my videocassette recorder at home, but I can use the Heartstart machine," he says, referring to the brand of defibrillator Qantas uses. "I think that says it all." ●

Gary Goldenberg is a freelance writer in Port Chester, N.Y.

# Heart Attack or Sudden Death?

When two-time Olympic gold medalist figure skater Sergei Grinkov collapsed and died during practice at a Lake Placid, N.Y., rink in November, 1995, the prevailing reaction was shock: How could that happen to a world-class athlete only 28 years old? But as it turned out, Grinkov had something in common with the great majority of sudden cardiac death victims: underlying heart disease.

Grinkov's heart was enlarged, reportedly due to severe hypertension, which can also damage the coronary arteries. An autopsy revealed that two coronary arteries were almost completely blocked and that the skater had suffered a heart attack less than 4 hours before his collapse.

Sudden cardiac death can result from many heart problems, but heart attack is the most common trigger. Indeed, sudden cardiac death is often labeled "massive heart attack." Despite their frequent interconnection, however, heart attack and sudden cardiac death are distinct events.

Heart attacks generally occur when a clot in a coronary artery shuts off the blood supply to part of the heart muscle. Death can usually be avoided if the clot is cleared (typically with a clot-buster drug or balloon angioplasty) within six hours of the attack. But about one of every six heart attacks results directly in sudden cardiac death by immediately causing the heart to go into ventricular fibrillation, the ineffectual fluttering of its main chamber. To save someone from sudden cardiac death, lifesaving measures must occur within about 10 minutes.

Here's the link between heart attacks and sudden cardiac death: By cutting off blood flow to

the heart and damaging its tissue, the heart attack can interfere with the nerves responsible for the heart's orderly beating. That alone can be enough to trigger cardiac arrest. But even among heart attack survivors, that shutdown of blood may cause a portion of the heart muscle to die. Days or even years later, that scar tissue may disrupt nerve impulses and cause a fatal arrhythmia and sudden death. One reason prompt treatment for heart attack is so crucial is to minimize heart muscle damage and its potential to disrupt the normal heartbeat.

Exertion can play a major role in sudden death. When a middle-aged man dies from shoveling snow or running (as in the case of jogger-catcher Jim Fixx), his rapid heart rate may have dislodged a fatty deposit that clogged a coronary artery, causing a heart attack that in turn triggered immediate fibrillation. Alternately, when someone with underlying heart disease exerts himself, his rapid heartbeat itself can evolve into a fatal arrhythmia.

Other factors besides exertion can disrupt the heartbeat and cause sudden cardiac death. They include:

- **Fear.** Like exertion, fear also causes the heart to race, which can cause arrhythmic and cardiac death in someone with heart disease. It now appears that some people are especially vulnerable to being literally scared to death—and that a simple test can predict which ones.

Harvard University researchers asked 40,000 male health professionals to take an eight-question test that assessed their "phobic anxiety" level. The researchers focused on the 34,000 men in the group who had not been diagnosed with heart disease (although undiagnosed heart disease could not be ruled out).

When the men without heart disease were evaluated two years later, those with the highest anxiety levels were more than six times as likely to have suffered sudden cardiac death as the least anxious

men. The researchers concluded that high anxiety is a potent risk factor for sudden cardiac death. One possible explanation: Hyperventilation induced by anxiety may cause coronary artery spasms.

- **Alcohol.** Heavy drinking can disrupt the heartbeat, a phenomenon known as "holiday heart syndrome." Even healthy people can experience such arrhythmias, but those most likely to suffer sudden cardiac death from binge drinking are chronic alcoholics with liver disease.

- **Congestive heart failure.** In CHF, the heart has been damaged by heart attack, hypertension or some other condition, and it no longer pumps efficiently. Although people with this usually treatable problem can live with it for many years, they're six to nine times likelier to suffer sudden cardiac death than those without CHF.

- **Cardiomyopathy.** When sudden death strikes a middle-aged athlete, a heart attack or underlying coronary artery disease is almost always responsible. But in young athletes, sudden death is often due to an underlying heart muscle abnormality, also known as cardiomyopathy. Two basketball stars, Hank Gathers of Loyola Marymount University in Los Angeles and Boston Celtic great Reggie Lewis, died from this condition.

Lewis's death was attributed to a virus that inflamed his heart muscle and caused scarring, which ultimately disturbed his heart rhythm.

But often such deaths are due to a genetic disorder known as familial hypertrophic cardiomyopathy, the most common cause of sudden cardiac death in the young, especially athletes. (Hypertrophic means that a chamber of the heart becomes abnormally enlarged and loses its flexibility.) A genetic test carried out on blood cells can now determine whether relatives of a person with the disorder are also at risk of developing it. Those with the trait should be warned against participating in strenuous sports that might trigger sudden cardiac death.

—DCUG BRADLEY



**Citizen CPR  
Foundation, Inc.**

Member of the  
Chain of Survival

**American Heart  
Association**  
Fighting Heart Disease  
and Stroke



# Currents in Emergency Cardiac Care

**Public access defibrillation comes of age**  
*PAD conference April 17-19 in DC; American Airlines adds AEDs*

**P**ublic Access Defibrillation—the AHA initiative begun in October 1993 to enable the use of AEDs by the general public—reaches maturity this spring in Washington, DC. On April 17-19 the AHA will sponsor *Public Access Defibrillation II: Strengthening the Chain of Survival*. This conference will focus on research in public access defibrillation (PAD), results of the PAD initiative to date, and the AHA's plans to continue the initiative.

The conference will be held at the Hyatt Regency Crystal City in Washington, DC. The planning committee for the conference is the AHA's Automatic External Defibrillation Task Force, chaired by Myron L. Weisfeldt, MD.

The conference comprises five state-of-the-art sessions, seven concurrent workshops, and a poster session. (See page 7 for details.)

Since the first PAD conference, in December 1994, the concept of public access defibrillation has gained increasing acceptance nationwide. A milestone for the PAD initiative is the decision by American Airlines to place AEDs on board its international flights and some domestic over-water flights.

### First US airline to add AEDs

On November 19, 1996, Robert L. Crandall, chairman and CEO, and David McKenas, MD, American's corporate medical director, announced plans to buy 300 AEDs for its long-haul flights, the first to be delivered in January and the rest in time for the airline's busy summer tourist season. American thus becomes the first US airline to equip its planes with AEDs.



Clay Newlin, emergency procedures instructor, and Linda Camocell, aeromedical lead nurse, helped American Airlines test off CPR-D in the air with a training program Jan 29 in Fort Worth, Tex. AHA volunteers Ricardo Cummins, MD, Mary Fran Rozinski, RN, and Ed Stibston, EMCP, provided state-of-the-art presentations and educational materials.

"This is a potential major advance in saving lives," said Weisfeldt.

American has also announced plans to work with the AHA in training its personnel in use of the AED and in evaluation of the airline's AED program. Beginning in February, 2300 flight attendants will be trained in the use of the AED. By the end of 1998 all 20,000 of American's flight attendants will have been trained to use the device.

"Other carriers are now talking with the manufacturers," said David Fuscus, spokesman for the Air Transport Association, which represents major airlines. Northwest Airlines, United, and Delta are studying the need for defibrillators. A spokesman for the Federal Aviation Administration also said in November that the agency will study whether AEDs should be mandatory on airplanes.

See PAD, page 3

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Number 4  
Winter 1996

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9 **New textbooks**

Mnemonic for stroke

NRP grant

9 **ECC advisory statement: Innovations in ECC**

32 **Mike Bell: New director of training**

February 28, 1998

Dear Representative Bunde:

The issue of *public access* Automated External Defibrillation (AED) has wide private sector support. I have collected over a 100 citizen endorsement letters signed by representatives of companies that had their staff CPR/First Aid trained in the past 3 weeks. (example attached)\*

Please publicly support this important issue.

Quick review of the companies mentioned above:

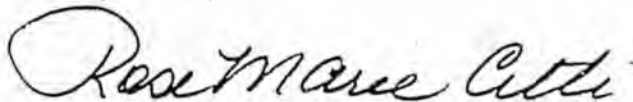
Veco	Alaska Airlines
Prudential Vista Real Estate	AVEC
RAM, Inc.	Laidlaw Environmental
Princess Tours	Alaska Village Electric
Howard Molanax	Doyon Drilling, Inc.
Van Waters & Rogers	Regal Alaskan Hotel
Tracy Vrem Guide Service	North West Handling Systems
Scoggin Excuvation Service	H & H Construction Co, Inc.
Herring Counseling Services, Inc.	Fred Meyer
AWAIC	Regina's Home Health Care
Alaska Mechanical	Nordstrom
Value Village	Chugach Electric Association (CEA)
Rasmussen Asphalt	Municipal Light & Power

\* Copies of all endorsement letters have been sent to the offices of Representative Bunde and Senator Taylor.

I can assure you as more companies & students become aware of this technology more letters will be forthcoming.

Please don't let us down.

Respectfully,



Rose Marie Citti  
P.O. Box 220348  
Anchorage, AK 99522-0348

Home: 243-2990  
Business: 344-0302  
FAX: 522-2271

Enclosures: Endorsement letter  
Alaska Airlines Press Release

March 2, 1998

Representative Alan Austerman  
State Capitol  
Juneau, AK 99801

Dear Alan:

Thank you for sending copies of house bills 335 and 307. I have read and strongly support passage of these bills. I ask you to support them.

I offer the following comments on each Bill:

House Bill No. 307 addresses a central issue of "being denied visitation", as I was for 15 months.

It is critical for children to have both parents in their lives, and preclude one parent from denying access by moving to another state. This is a frequent tactic, and often successful. I believe house bill 307 will begin to provide an adequate deterrent and reduce the damaging effects children sustain when one parent uses children to punish the other parent. The effects on children are lifelong.

I strongly support all sections and intent, and encourage passage of House Bill No. 307.

House Bill No. 335 amends current statute for compliance with Uniform Child Custody Act.

Its passage is much needed to provide clear defined process when disputing jurisdiction, home state, filing, and simultaneous proceedings. As was also addressed in my own case, the lack of clarity and jurisdiction became a central issue.

Any parent at this time can leave the state with children, claiming residency of another state, and effectively stall proceedings with jurisdictional issues while denying visitation and most likely end up with custody. The reluctance of judges to bring children back to the home state and the emotional violence perpetrated by an angry parent upon the child is devastating.

I believe House Bill 335 will address many of the existing loopholes, and reduce damage to children. I support all amendments, sections, and encourage passage of this bill.

As per our previous conversation, my children were removed from school in September of 1996, using a domestic violence order obtained in Washington State. The order was served on the court in Kodiak, Alaska, although Alaska was the home state and correct state of jurisdiction. The children were removed from school by police and returned to Washington within two hours. Washington was led to believe it was home state, by the defendant in this action, but three months later remanded jurisdiction back to Alaska. As courts are reluctant to return children or move them around, they stayed in Washington with defendant and could not return to Alaska. This began a long exhausting legal process and denial of visitation by the defendant that lasted sixteen months. Although hearings were held, and orders issued to the defendant, nothing can be done to bring a defendant in another state into compliance.

I seek to protect children from this kind of trauma and emotional violence, close loopholes that allow attorneys to advise clients to do this and minimize damage to children as innocent victims. I find House Bill No 307, an 335 to be a step in the right direction, but also legislation that protects children from being moved from any jurisdiction without a hearing first!

At this time, I am also asking for an investigation regarding application of domestic violence laws regarding my own case. Further I am asking for the Attorney General to review case 3KO 96 00236 CI. I believe you can make this request, and I thank you for your consideration.

Regards,

Jeffrey G. Knaut.

c.c. Senator Jerry Mackie  
Governor Tony Knowles

HB 395

## Defibrillators Enter the Business Marketplace

*An evolving legal trend may ultimately lead to higher risks for businesses that fail to purchase and use AEDs.*

**N**ow, a new wave of small, portable defibrillators is being developed...Manufacturers even envision a day when the devices, technically known as automatic external defibrillators and costing \$2,500 to \$4,000 each, will be as common as fire extinguishers.

The Wall Street Journal  
Aug. 5, 1996

In 1990, the American Heart Association challenged the medical device industry to develop a state-of-the-art automated external defibrillator (AED) capable of being used by virtually anyone. As *The Wall Street Journal* noted, the industry responded in a manner leading to significant advances in AED technology. Smaller, lighter, cheaper, easier, sturdier and more effective AEDs are now available. As a result, many businesses are now considering the benefits associated with the purchase of AEDs for use by trained individuals on site.

Despite technological progress, tort liability fears create impediments to the widespread deployment and use of these life-saving machines within the commercial business environment. In other words, before AEDs can become "as common as fire extinguishers," legal concerns must be acknowledged, understood, and addressed.

### AEDs in the Land of Torts

One significant obstacle to large-scale AED distribution in the business world is fear of exposure to negligence liability lawsuits. Would-be AED purchasers appear to perceive heightened legal risk flowing from the acquisition, deployment, and use of the device.

Prudent businesses must certainly analyze relative risks and benefits when considering whether to adopt or not adopt

AED programs. In this context, two recent jury verdicts suggest an evolving legal trend that may ultimately lead to higher risks for businesses that fail to purchase and use AEDs. A basic negligence primer helps explain why.

In order for a plaintiff to successfully sue an AED purchaser or user, four essential elements must be proven. These include duty, breach of duty, causation of injury, and legally recognized damages. The failure to prove any one of these elements is fatal to a plaintiff's case. The element of greatest import in the AED context is that of duty.

Duty in negligence law is defined as "an obligation, to which the law will give recognition and effect, to conform to a particular standard of conduct toward another." In the absence of a legal duty, no liability can be imposed. In other words, one cannot be successfully sued for failing to perform an act in the absence of a legally mandated obligation to perform the act in the first place.

In the context of duty, businesses contemplating the purchase of AEDs must consider whether a legal obligation to render medical aid to patrons exists and, if so, the scope of the obligation. In effect, this constitutes an analysis of legal risk.

While bystanders generally have no legal obligation to provide affirmative medical aid to ill or injured persons, the existence of certain relationships between a victim and one in a position to render aid may create a duty to provide assistance. Business sectors including common carriers (airlines, passenger rail lines, cruise ship lines, etc.), innkeepers (hotels, motels, etc.), and commercial business establishments open to the public (most other businesses) may be compelled by law to render a minimum level of first aid

care and to timely summon outside emergency medical assistance. The scope of this duty is generally defined by appellate court case law, trial courts and juries.

Historically, appellate courts have been generally resistant to requiring common carriers, innkeepers, and commercial businesses faced with ill or injured patrons to do more than summon an ambulance. Two recent trial court verdicts, however, suggest an evolving trend toward higher standards requiring the protection of customer health and safety in the commercial business environment.

In June 1996, a Florida jury found Busch Gardens negligent for not properly training its employees to provide emergency care and for failing to have essential medical equipment, including a defibrillator, on the premises. The jury awarded the plaintiff \$500,000 in damages for the resulting death of her 13-year-old daughter.

In another recent case, a federal judge found Lufthansa Airlines negligent for failing to timely provide treatment for a passenger suffering a cardiac emergency and awarded \$2.7 million in damages. In light of this case and a variety of other factors, the Federal Aviation Administration is currently considering the mandatory deployment of AEDs on all commercial aircraft.

While it is unclear whether the Busch Gardens and Lufthansa verdicts will survive court appeals, modern advances in AED technology coupled with low cost and the proven ability of these devices to save lives may persuade more and more trial and appellate courts to sanction businesses that fail to adopt AED programs. Prudent businesses can avoid this legal risk by purchasing AEDs and training employees in their use.

### Balancing Risks and Benefits

Legal risks associated with adoption and implementation of business-based AED

By RICHARD A. LAZAR

# Occupational Health & Safety

AUGUST 1997

## DEFIBRILLATORS ENTER THE BUSINESS MARKETPLACE

programs, while not zero, appear quite negligible. At least one industry believes greater risks flow from the failure to adopt such programs.

Airline industry observers also say they expect other U.S. airlines to follow American Airlines' footsteps (American has announced a plan to equip all its foreign and domestic aircraft with portable defibrillators by the end of 1998) in hopes of avoiding potential lawsuits for negligence that might arise from a failure to provide appropriate medicines and equipment needed to treat a sick passenger in flight.

The following factors highlight why business-based AED programs generally constitute a low-risk endeavor:

- No lawsuits, verdicts, or appellate cases are identified involving the use of a defibrillator in the business environment to help a victim of sudden cardiac arrest (SCA).

- SCA victims are, in effect, already dead. Use of an AED can only help, it cannot hurt.

- Many if not most businesses carry liability insurance coverage protecting the busi-

ness in the event of an AED related lawsuit.

- Many states have laws limiting the types and scope of negligence lawsuits permissible against lay individuals rendering emergency medical care (tort limitation, Good Samaritan, and a variety of immunity laws).

In sum, increased liability risk, if any, associated with adoption of a business-based AED program is quite minimal. In contrast to limited risk, the benefits of AED program adoption are quite remarkable.

For example, published medical research suggests that persons suffering certain forms of SCA who are defibrillated in less than one minute have a 90 percent chance of surviving. For each minute of continued SCA, the likelihood of successful conversion decreases by approximately 10 percent. Thus, from a public health perspective, businesses adopting AED programs can actually increase the likelihood of saving lives.

From a public relations perspective, AED programs offer businesses the opportunity to distinguish themselves in

the marketplace. American Airlines, emphasizing passenger welfare benefits, received significant positive media attention following its AED announcement.

Overall, the benefits of AED program adoption in the commercial business arena far outweigh any risks. As these benefits become better understood and disseminated within the business community, it is highly likely AEDs will, indeed, become as common as fire extinguishers. **OHS**

*Richard A. Lazar, a lawyer, is a consultant to the emergency medical services and AED industries from his home base in Portland, Ore.*

### References

1. Cobb, LA, et al. Report of the American Heart Association Task Force on the Future of Cardiopulmonary Resuscitation. *Circulation*. 1992;85:2346-2355.

2. W. Page Keeton et al., Prosser and Keeton on the Law of Torts § 53, at 356 (5th ed. 1984).

3. Restatement (Second) of Torts § 314A.

4. "Finally, The Right Tools to Save Lives in the Air." *Chicago Tribune*, Dec. 22, 1996. Discussing American Airlines' plan to equip all its foreign and domestic aircraft with portable defibrillators by the end of 1998.

# SENATE COMMITTEE REPORT

DATE: 4/2/98

FURTHER:

DATE TURNED  
IN TO OFFICE: 4-21-98

Judiciary Committee considered CS FOR HOUSE BILL NO. 395(JUD)

"An Act relating to civil liability resulting from the use of a defibrillator in providing emergency aid or emergency training."

and recommends:

- be replaced with SENATE CS FOR CS FOR HB 395 ( JUD )
- adopt previous CS \_\_\_\_\_ ( \_\_\_\_\_ )
- attached amendment(s)
- adopt Letter of Intent by \_\_\_\_\_ Committee
- further referral to the \_\_\_\_\_ Committee

- Senate Bill:**
- same title
  - new title
- House Bill:**
- same title
  - technical title
  - new: SCR# \_\_\_\_\_

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	NR	DNP	AM
Mike Miller	X	Hellers	X		
Deance	✓				
CHAIR: <i>Adrian Taylor</i>	✓	CHAIR:			

**NEW FISCAL NOTE(S):**

Department	Date	Zero	Fiscal

**PREVIOUS FISCAL NOTE(S):\***

Department	Date	Zero	Fiscal
HSS-STATE LICENS SVCS.	3-13-98	✓	

APPROPRIATION -- no fiscal note

\*include fiscal notes accompanying Governor's bill

What parts of the bill are required by federal law?

1. Foster parents and relatives who provide care for children get notice of hearings, and an opportunity to be heard at hearings.

AS 47.10.030 (b)

AS 47.10.070(a)

AS 47.10.080 (f)

2. Permanency hearings 12 months after a child is removed from home and annually thereafter

AS 47.10.080 (f)

*sect. 26 on p. 24,  
sect. 28 p. 25/26*

3. Judges must make specific findings at the permanency hearing about whether a child will return home or go into some other permanent safe home

AS 47.10.080 (l)

4. The health and safety of the child shall be the paramount concern.

AS 47.10.082

*sect. 31 p. 28*

5. Reasonable efforts to return the child home once removed, will not be required in all cases. In cases where there has been a homicide of a child in the family, felony assault on a child, abandonment of a child, sexual abuse, torture, chronic abuse or neglect, the state will be required to find a permanent safe home for the child.

AS 47.10.086 (c)

*sect. 33 p. 29  
Page 29*

*p. 30  
see notes*

6. The state must file a petition to terminate parental rights in some cases: abandoned children younger than 6; children who have been in foster care for 15 of the most recent 22 months; siblings of children who were killed by a parent; children who were seriously injured by the parents. The state must have a compelling reason not to proceed to termination in certain cases.

AS 47.10.088 (d) and (e)

*p. 33 L 15*

7. States are required to do concurrent planning for children: have a plan for reunification with the parents and also develop an alternative permanent safe plan for the child.

AS 47.10.086 (f)

AS 47.10.088 (i)

*see  
5 & 6 above*

8. States must offer families community-based family support services on a time-limited basis, not to exceed 15 months, whenever the plan is to prevent removal from the home or to return the child to the family home.

AS 47.10.086 (a) and (b) *see reasonable efforts pgs 39 & 40 L.5*

9. States must have a preference for kinship care with relatives.

AS 47.14.100 (e) and (i) *P. 43 sect 49 - P. 44 L. 12*

10. States are required to conduct thorough criminal background investigations on any licensed home or facility where children are placed.

AS 47.35.017(b) *sect 64 P 50-53*  
AS 47.35.022  
AS 47.35.023 (b)

11. States are required to define abuse and neglect at a minimum, to include acts by caretakers that result in: death; serious physical harm; serious emotional harm; sexual abuse or exploitation; imminent risk of harm. AS 47.10.011 (a) (8)

*Fed. Floor P. 17 L. 13-29*

12. States are required to expedite the permanent placement of abandoned infants.

AS 47.10.088(d) (2) *P. 33 - L. 21-22*

*Permissio*

13. States are allowed to create child fatality review teams and must set up a "public disclosure provision for the team." AS 12.65.005 - 12.65.140.

*P. 6 L. 8 P. 11 L. 119*

*Permissio Fed.*

14. States are allowed to provide respite care to foster parents for temporary stress relief.

AS 47.14.100 (d) *P. 42-43 sect 48*

15. States are allowed to create Multidisciplinary Teams as investigative resources

AS 47.14.300 *P. 45 sect 54 - P. 47 L. 14*

*Permissio*

**What parts of the bill did the courts want changed?**

1. Children can only be declared abandoned if they have no parent willing or able to care. Willing is enough even if a parent is not able to care.

AS 47.10.011 (a) (1)  
AS 47.10.013

*L*

2. The law does not provide the state with the authority to intervene in cases of emotional neglect.

AS 47.10.011 (a) (8)

17-215-79

**What parts of the bill are state-initiated changes?**

1. Providing a policy, purpose, and legislative findings section in statute that gives courts guidance in making decisions about children.

AS 47.05.065

2. Clarifying in statute that parents have important rights, especially the right to use reasonable corporal discipline.

AS 47.05.065

3. Redefining the situations where the state may get involved and seek services for a family to include domestic violence, substance abuse, and parental conduct that results in serious mental injury to children.

AS 47.10.011 (8) (10)

4. Definitions should allow workers to consider the family's full history and address the problem comprehensively. Workers should no longer look at isolated incidents when making conclusions about children.

AS 47.14.300

AS 47.17.033

5. Creating a separate "Termination of Parental Rights" statute.

AS 47.10.088

6. Allowing the state to intervene before children are severely damaged because problems are severe or chronic.

AS 47.10.011 (8) (9)

7. Eliminating multiple and repeated moves of children by preparing foster parents and creating procedural barriers to moving children.

AS 47.10.093(b)

AS 47.12.310(b)

AS 47.10.080 (s)

AS 47.14.115