

State Child Death Review Advisory Boards: Strategies to make them effective in preventing deaths

May 10, 2017



About the National Center

- The National Center for Fatality Review and Prevention is a resource and data center that supports child death review (CDR) and fetal and infant mortality review (FIMR) programs around the country.
- Supported with funding from the Maternal and Child Health Bureau at the Health Resources and Services Administration, the Center aligns with several MCHB priorities and performance and outcome measures such as:
 - Healthy pregnancy
 - Child and infant mortality
 - Injury prevention
 - Safe sleep

The Center is funded in part by Cooperative Agreement Number UG7MC28482 from the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).



MCHB's Vision for the Center

- Through delivery of data, training, and technical support, the Center will assist state and community programs in:
 - Understanding how CDR and FIMR reviews can be used to address issues related to adverse maternal, infant, child, and adolescent outcomes
 - Improving the quality and effectiveness of CDR/FIMR processes
 - Increasing the availability and use of data to inform prevention efforts and for national dissemination

Ultimate goal: improving systems of care and outcomes for mothers, infants, children, and families



Webinar Goals

Participants will:

- Identify key partners necessary to have an effective state advisory board
- Gain a better understanding of how to structure state review boards to achieve outcomes



Speaker Panel



Diane Pilkey,
Health Resources
and Services
Administration



Heidi Hilliard,
Michigan CDR
program



Aretha Bracy,
Alabama CDR
program



Melissa Faul,
Nevada CDR
program

Housekeeping

- **Webinar is being recorded and will be available with slides in a few days on our website: www.ncfrp.org. The Center will notify participants when it's posted**
- All participants will be muted in listen only mode
- Questions can be typed into the Question Window. Due to the large number of participants, we may not be able to get to all questions in the time allotted. The Center will answer all questions and post the answers on the NCFRP web site:

<https://www.ncfrp.org/>



Alabama Child Death Review System

**Alabama Department of Public Health
Bureau of Health Promotion & Chronic Disease
Fatality Prevention Branch**

Statutes

- **Alabama Child Death Review Law signed in 1997**
- **At least one multidisciplinary LCDRT in each judicial circuit**
- **DA responsible for organization/coordination of the respective local review team**
 - **DA and/or designee, ME, Coroner, Law Enforcement, State Agencies, CACs, Probate/Family Court, Clergy**

Teams in Alabama

- ACDRS – Local CDR Teams
 - 42 Judicial Circuits / 53 multidisciplinary teams
 - District Attorney
 - County Health Officer
 - County Department of Human Resources
 - Medical Examiner/Local Coroner
 - Local Sheriff's Department
 - Local Police Department
 - Pediatrician or primary care physician
 - Local Children's Advocacy Center
 - Review all unexpected & unexplained deaths less than 18 yo
 - Required to meet annually and review assigned cases
 - Teams have 1 year to review each case
 - Most recommendations encourage existing outreach and educational efforts

Teams in Alabama

- ACDRS – State CDR Team
 - 28 member multidisciplinary team
 - State Health Officer
 - Jefferson County Coroner/Medical Examiner
 - Alabama Sheriffs Association
 - Alabama Department of Forensic Sciences
 - Department of Human Resources (CPS)
 - Department of Mental Health
 - Department of Public Safety
 - AAP, Family Physicians, CAN health professional
 - 5 association representatives (Coroners, Sheriffs, COP, DA, MA)
 - CACs,
 - 9 Governor Appointments
 - Chairs of Senate & House Committees

Teams in Alabama

- ACDRS – State CDR Team (cont'd)
 - Decrease the risk and incidence of unexpected and unexplained child injury and death by following the duties set forth in the CDR State Law.
 - Required to meet quarterly
 - Review and adopt team recommendations annually
 - Provide the Governor & Legislature an annual report
 - Legislation (Safe Place, Graduated Drivers License/enhancements, Child Passenger Safety, SUIDI, and Sports Concussion)
 - Education and Outreach (teen driver safety initiative, infant safe sleep campaign, and child passenger safety program)

Funding

- State Tobacco Settlement money
 - Director
 - Public Health Educator
 - Administrative Assistant
- State Medicaid Agency
 - Free print materials / Outreach

Strengths and Successes

- The level of confidentiality promotes engagement at all levels
- The longevity of the program and valuable relationships with partners
- Biennial training conference
- Staff, active LCDRTs, & engaging SCDRT
- Statute has little to no consequences for poor team performance

For additional information please contact:

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Michigan Child Death Review

The Child Death Review Process in Michigan

National Center for Fatality Review and Prevention

Webinar: State Child Death Advisory Boards

May 10, 2017



**Keeping
Kids
Alive[©]**



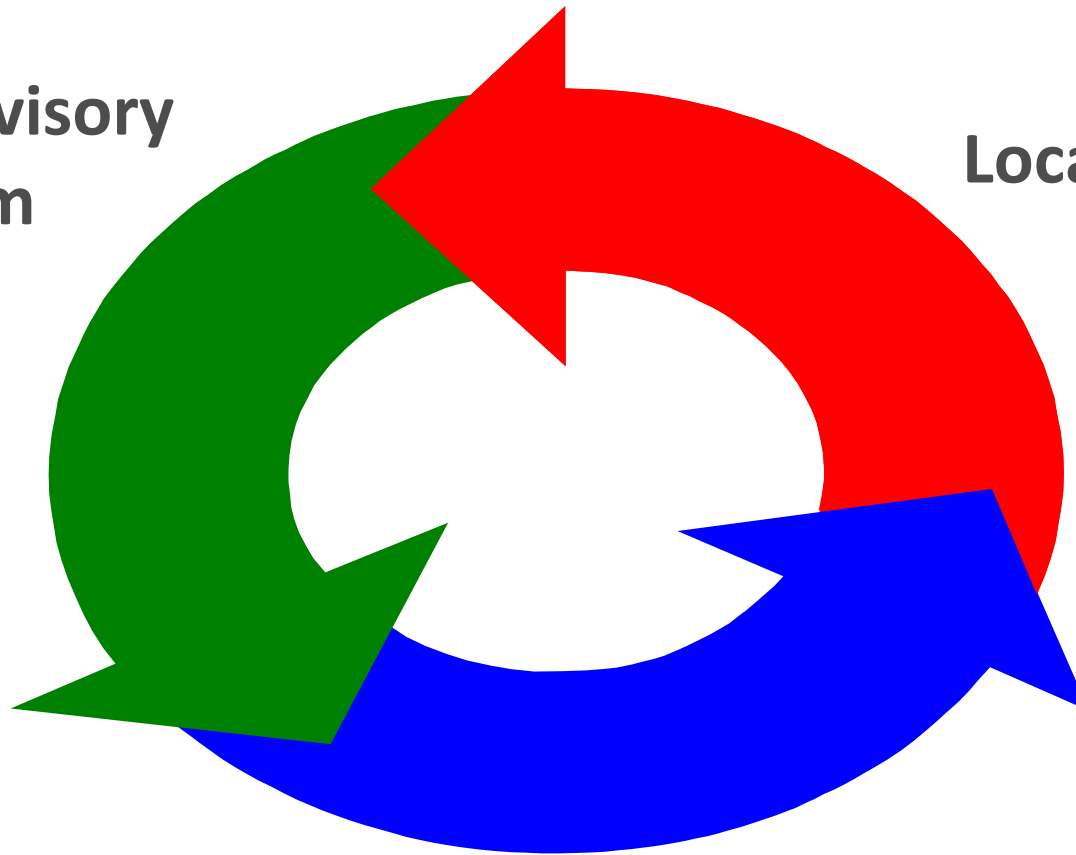
Michigan Child Death Review

The CDR Process in Michigan



State Advisory
Team

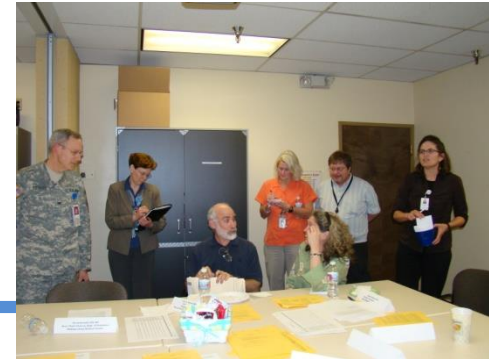
Local Teams



Program Staff

Michigan Child Death Review

Local Teams



- ❖ Review cases to put together the entire picture
- ❖ Use findings to make changes at local level
- ❖ Submit findings and recommendations to SAT
- ❖ Composition: **PH, ME, LE (state/local/county), PA, CPS, Courts, CMH, Hospitals, Physicians, Education, EMS, Fire Depts and other local human service reps**

Michigan Child Death Review



Local Teams

- ❖ 77 teams, covering all 83 counties
- ❖ Over 1,400 volunteer team members
- ❖ Review about 500 cases per year
- ❖ Reviewed over 12,000 since inception
- ❖ Teams report into Nat'l CDR database



Michigan Child Death Review

Local Results



- ❖ Teams identify local health/safety issues through review of specific cases
- ❖ Local information is used to propose and implement prevention initiatives
- ❖ Lead for initiative may come from the team or another local agency/organization
- ❖ Pro: changes can occur quickly; Con: limited reach

Michigan Child Death Review

State Advisory Team



- ❖ Meets quarterly; members appointed by DHHS Director
- ❖ Develop recommendations based on findings and publish annual report
- ❖ Serve as a conduit by bringing perspective and information to the table and taking information back to agency/organization
- ❖ Composition: **PH, ME, LE, PA, CPS, Courts, Ombudsman**, CA doc, Hospitals, Education, EMS, DV, NA Affairs, Child Advocacy

Michigan Child Death Review

State Results



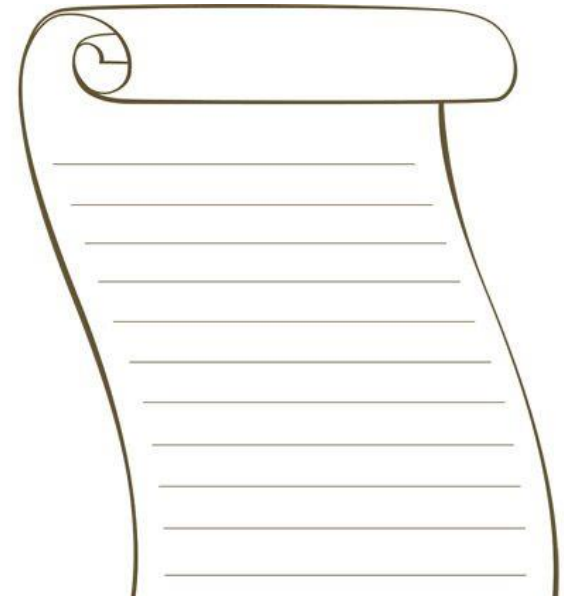
- ❖ Team identifies state health/safety issues through review of aggregate data
- ❖ Statewide information is used to propose prevention initiatives in annual report
- ❖ State Team reviews recommendations each year
- ❖ Pro: initiatives affect a larger population
- ❖ Con: change may take longer to occur

Michigan Child Death Review



Legislative Requirements

- ❖ Local teams “may” exist
- ❖ State Advisory Team “must” exist
- ❖ Team membership for both
- ❖ State Team purpose: “...to identify and make recommendations on policy and statutory changes pertaining to child fatalities and guide statewide prevention, education, and training efforts.”
- ❖ Dept to provide team member training
- ❖ Annual report from State Team
- ❖ Confidentiality of meetings, exemption from FOIA and Open Meetings Act



Citizen Review Panel Process



- ❖ Case files are requested on previous year fatalities to DHHS where:
 - ❖ The death occurred while child was in foster care or had an open CPS case
 - ❖ The family had significant prior contact with CPS
- ❖ Each State Team/Fatality CRP member receives and reviews full case files four weeks prior to the panel meeting
- ❖ Four-six workgroup meetings convened annually, conducting 18-25 full case reviews
- ❖ Workgroup meetings last all day and each select case is discussed at length among panel members
- ❖ Group consensus on findings and recommendations for every case
- ❖ An annual report is submitted to DHHS with the year's compilation of findings and recommendations

Michigan Child Death Review

Policy, Practice and Protocol Reform as a Result of CRP



❖ Birth-Match System

- ❖ State Child Welfare/Health Dept Cooperation
- ❖ Statewide automated system that notifies CPS Centralized Intake when a child is born to a parent who had:
 - ❖ Prior termination of parental rights
 - ❖ Caused death to a child as a result of abuse or neglect, or
 - ❖ Had perpetrated egregious abuse to a child, such as sexual abuse or life-threatening injury
- ❖ CPS data system automatically generates a complaint to the local office supervisor
- ❖ The complaint is assigned for investigation
- ❖ Threatened harm must be determined prior to filing a petition with the court requesting termination
 - ❖ Harm is likely to occur based on:
 - ❖ A current circumstance **OR**
 - ❖ A historical circumstance absent evidence that past issues have been successfully resolved

Results of the CRP Process in Michigan

“We identified a number of problem areas in our state’s child welfare system by reviewing child maltreatment fatalities using a citizen review panel. Most of these problem areas identified were addressed by the state child protective services agency with changes in law, policy, or practice, and there was a later reduction in the number of findings and in the number of deaths associated with those findings over time. While further research is needed to assess the impact of CRPs on child welfare practices, child fatality reviews by federally mandated citizen review panels offer the potential to reduce CM deaths by improving child protective service practices.”



COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

The Commission traveled around the country starting in the spring of 2014 to hear from a variety of professionals in a representation of states who work on child safety and protection issues in order to learn from their experiences. The written testimony I submitted to the Commission on behalf of our State Team/CRP focused on:

- 1) Unmet mental health needs
- 2) Self-medication, often due to #1
- 3) Lack of affordable child care
- 4) Pervasive domestic violence
- 5) Family instability created by poverty



Tips to Success



- ❖ Program staff facilitate the activities of the State Team
- ❖ Program staff write the bulk of the annual report and facilitate its production
- ❖ Well-rounded, diverse membership with varying perspectives
- ❖ Appointments have remained apolitical
- ❖ Case review process in CRP contributes to team cohesion
- ❖ Close working relationship with DHHS, who values their participation on the team

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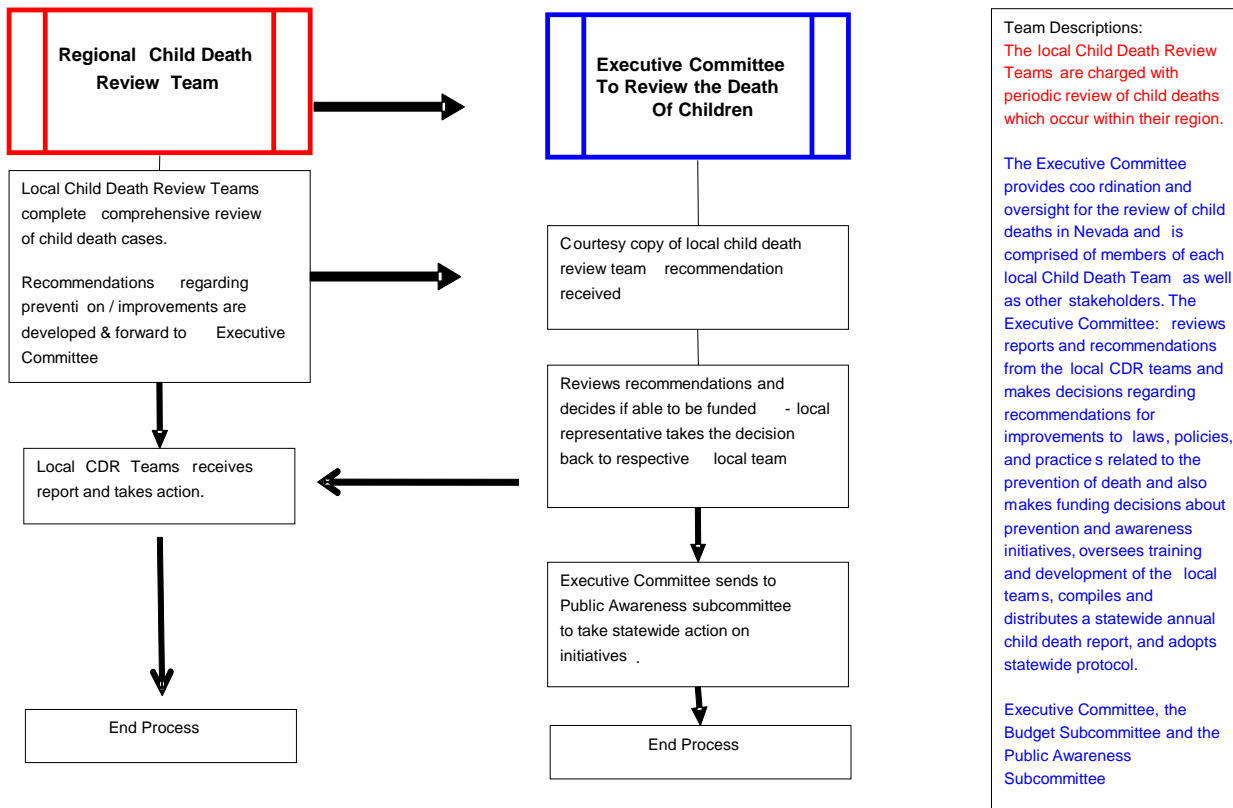


State of Nevada

Department of Health and Human Services
Division of Child and Family Service

Family Programs Office
Child Fatality Program

Child Fatality Oversight Process



Child Death Review Teams

Local Child Death Review Teams (CDR)

- ▶ Conduct State mandated child death reviews within their counties/region per Nevada Revised Statutes (NRS) chapter 432B, sections 403 through 4095:
 - ▶ All child deaths within the local region
- ▶ 6 Regional Child Death Review Teams, with some sub-groups within Rural areas throughout the state
 - ▶ Rural community teams meet quarterly
 - ▶ 2 urban area teams
 - ▶ Washoe County meets every other month
 - ▶ Clark County meets monthly
- ▶ Teams comprised of representatives from:
 - ▶ Child Welfare
 - ▶ Medical Personnel
 - ▶ Coroner's Office
 - ▶ Law enforcement (involved with case under review)
 - ▶ District Attorney's Office (where the case is reviewed)
 - ▶ School (involved with case under review)
 - ▶ Others as deemed appropriate by team
- ▶ Make recommendations to Executive Committee to Review the Death of Children for improvements laws, policies, practices and prevention efforts

Child Fatality Review Teams

The Executive Committee to Review Child Death

- ▶ Provides oversight of the local teams and receives the reports and recommendations from local multidisciplinary teams for review
 - ▶ Meets quarterly
 - ▶ Responds back to the local Child Death Review Teams
- ▶ Team comprised individuals from:
 - ▶ Vital Statistics
 - ▶ Public Health
 - ▶ Public Safety
 - ▶ Office of Attorney General
 - ▶ Mental Health
- ▶ Child Welfare Agencies and chairs from local Child Death Review Team
 - ▶ Division of Child and Family Services
 - ▶ Clark County Family Services
 - ▶ Washoe County Department of Social Services

Child Fatality Review Teams

Executive Committee Continued

- ▶ Responsibilities:
 - ▶ Oversight of annual budget that was created from a fee attached to death certificates, \$1 per death certificate
 - ▶ makes funding decisions about prevention and awareness initiatives
 - ▶ oversees training and development of the local multidisciplinary teams
 - ▶ compiles data through the National Case Reporting system and distributes a statewide annual child death report
 - ▶ adopts statewide protocol
 - ▶ Make recommendations for improvements of law, policies and practices to support the safety of children

Child Fatality Review Teams

Prevention Efforts/Campaigns

Total proposed amount of funding this year, which was \$70,000 and was split evenly between suicide prevention and safe sleep prevention.

- ▶ Crisis Call Center-Text4Life
- ▶ Nevada Coalition for Suicide Prevention- Reducing Access to Lethal Means
- ▶ Upstream Strategies for Injury Prevention
- ▶ Social Emotional Learning in Nye County Schools for Upstream Suicide Prevention
- ▶ Safe Sleep

Nevada Revised Statutes (NRS)

Chapter 432B, sections 403 through 4095

- ▶ **NRS 432B.405**- Organization of Child Death Review teams
- ▶ **NRS 432B.406**-Composition of child death review teams
- ▶ **NRS 432B.407**-Information available to child death review teams, sharing of certain information, subpoena to obtain information; confidentiality of information.
- ▶ **NRS 432B.4075**-Authority of Administrator to organize multidisciplinary team to oversee review conducted by child death review team; access to information and privileges.
- ▶ **NRS 432B.408**-Executive Committee to Review the Death of Children to review report of child death review team.
- ▶ **NRS 432B.409**-Establishment, composition and duties of Executive Committee to Review the Death of Children; creation of and use of money in Review of Death of Children Account.
- ▶ **NRS 432B.4095**-Civil penalty for disclosure of confidential information; authority to bring action; deposit of money.

Where to find State of Nevada Child Fatality Information

- ▶ DCFS Child Fatality Website

<http://dcfs.nv.gov/Programs/CWS/CPS/ChildFatalities/>

- ▶ Fatality Disclosures Page

<http://dcfs.nv.gov/Programs/CWS/CPS/ChildFatalities/FatalityDisclosures/>

- ▶ Child Fatality Policies

<http://dcfs.nv.gov/Policies/CW/0400/>



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QUESTIONS

**Recording of webinar and slides will be posted within a week on
National Center website: www.ncfrp.org**



Save the Date!

Social Determinants of Health

June 7, 2017

2:00 pm - 3:00 pm EDT

<https://attendee.gotowebinar.com/register/7876393709280591107>

Facebook and Twitter



Thank you!

Additional questions can be directed to info@ncfrp.org

