



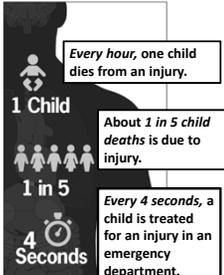

Local Child Fatality Review Teams

Presented by:
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Indiana State Department of Health



Why Child Fatality Reviews?

- >9,000 children died from unintentional injury in the United States in 2009
- Injury is still the # 1 cause of death among children
- All injury deaths are preventable!



1 Child Every hour, one child dies from an injury.

1 in 5 About 1 in 5 child deaths is due to injury.

4 Seconds Every 4 seconds, a child is treated for an injury in an emergency department.

CDC, Vital Signs: Child Injury, <http://www.cdc.gov/vitalsigns/childinjury/>

Why child fatality reviews?

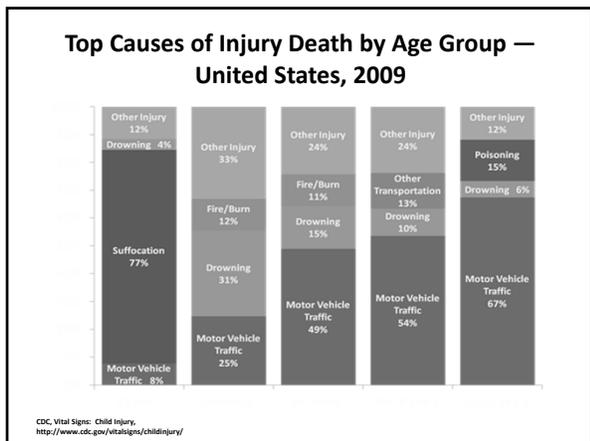
For every **1** child that dies there are...

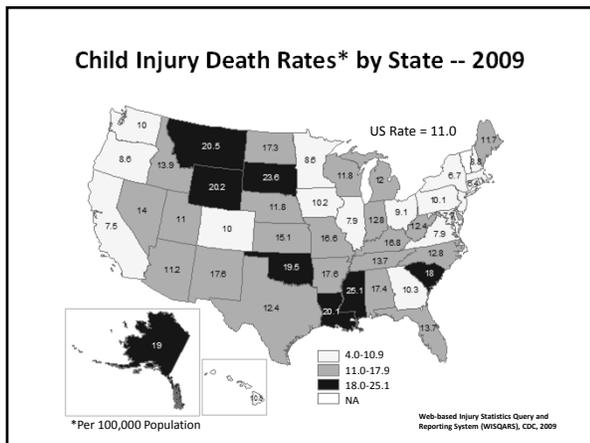
- 25** hospitalizations
- 925** treated in ER
- Many** more treated in doctors offices

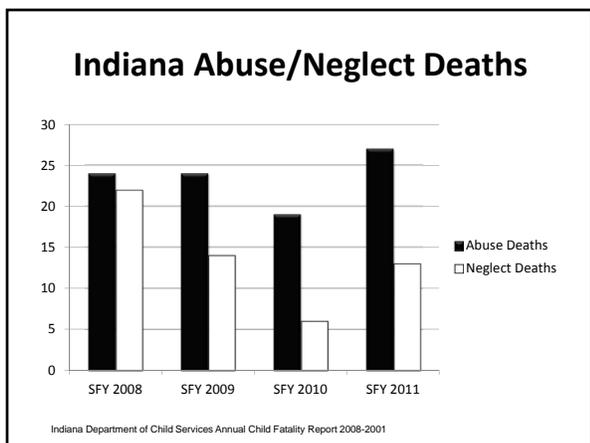
In 2005, injuries that resulted in death, hospitalization or an ED visit cost nearly \$11.5 billion in lifetime medical expenses.

SOURCE: Web-based Injury Statistics Query and Reporting System (WISQARS), CDC, 2009

Web-based Injury Statistics Query and Reporting System (WISQARS), CDC, 2009
National Health Interview Survey, 2009 data release, CDC, National Center for Health Statistics







Infant Mortality in Indiana

- Infant Mortality is the #1 indicator of health status in the World!
- Indiana:
 - In 2011(final data) Indiana had 7.7 deaths/1000
 - Indiana is 45th worst out of 51 states (includes DC) in 2011 (preliminary data)
 - IN consistently one of the worst in USA
 - Indiana **black IMR is 1.8x the rate of white** (12.5 vs. 6.9, respectively)
 - Indiana only <7.0 once in 113 yrs!!
 - 6.945 in 2008



Indiana Top 5 Causes of IM in 2011 (643 deaths)

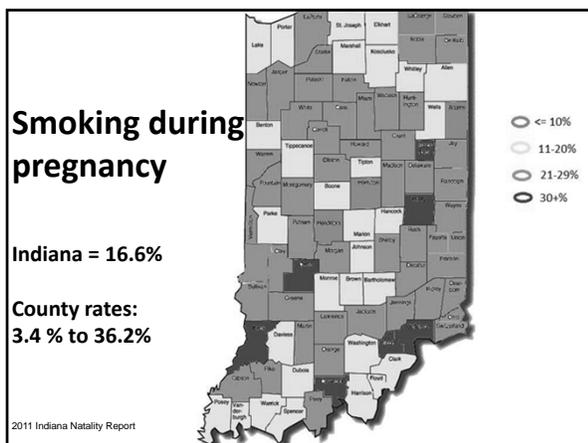
1. Perinatal Risks=45.7% (294 deaths)
 - Examples include: Pre-term, LBW, VLBW, placental complications, premature rupture of membranes, bacterial sepsis, respiratory conditions, etc.
2. Congenital malformations=26.3% (169)
3. SIDS/SUIDS/Accidents=15.6% (95)
 - SIDS =51
 - accidental suffocations=28
 - other accidents= 16
4. Assault/Neglect=1.4%
5. All Other=11% (71)



Infant Mortality Factors

- Prematurity and Low Birth Weight
 - Smoking
 - 16.6% pregnant mothers smoke
 - 30% Medicaid Moms smoke!!!
 - Indiana has 6th highest smoking rate in US
 - Obesity
 - Obese=25% chance prematurity
 - Morbidly Obese= 33% prematurity
 - Indiana is 8th most obese state in US
 - Elective deliveries before 39 weeks gestation





What is child fatality review

- Multidisciplinary team seeking to understand the risk factors surrounding the death of a child
- A professional process aimed at improving system responses to child deaths
- An opportunity to improve the health and safety of our children

Children's Health Alliance of Wisconsin,
www.chawisconsin.org

Child fatality review is not...

- A peer review
- Designed to examine individual performance
- An opportunity to second guess agency policy or practice

Children's Health Alliance of Wisconsin,
<http://www.chawisconsin.org>

IC 16-49

- Effective July 1, 2013
- Moved local child fatality review teams and Statewide Child Fatality Review Committee from Title 31 to Title 16—from DCS to ISDH
- Coordinator position created under the Indiana State Department of Health
- Requires each county, at the local level, to establish either a county or regional review team

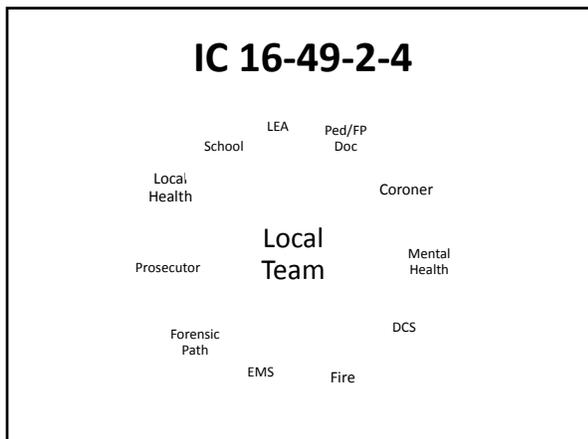


IC 16-49, cont.

- Deaths reviewed
 - Sudden, unexpected, or unexplained
 - Assessed by DCS
 - Determined to be the result of
 - Homicide
 - Suicide
 - Accident
 - Undetermined
 - Essentially, any death that is not medically expected!

Prosecutor's Implementation Responsibilities

1. Call meeting of the Local Child Fatality Committee (Prosecutor, LEA, DCS, Coroner, and Local Health Dept)
2. Fatality Committee decides
 - County or Regional Team
 - Team Membership
3. Prosecutor files report with State Coordinator specifying
 - Team selection (county/regional)
 - Team members
 - Any assistance needed from the Coordinator
4. Prosecutor calls first meeting of the Local Child Fatality Review Team/Chairperson is selected



Barriers and Roadblocks

- Representative from each profession not available
 - Forensic Pathologist, Pediatrician
- Not many deaths
- Regional v. Local v. Local + written agreement

Expectations of team members

- Contribute information from agency records
- Serve as a liaison to respective professional counterparts
- Provide definitions of professional terminology
- Interpret agency procedures and policies
- Explain the legal responsibilities or limitations of his or her profession

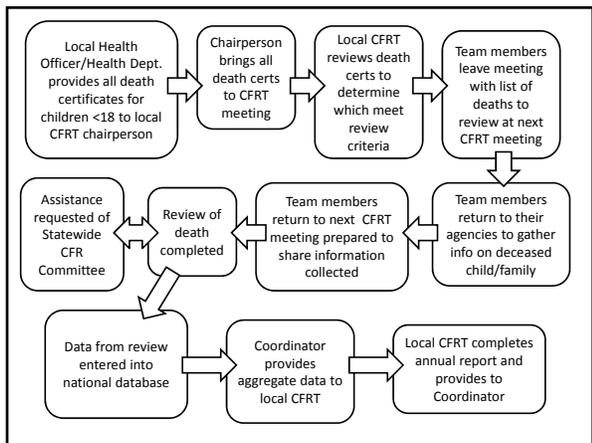


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Role of Team Chair

- Schedule and set agenda for meetings
- Distribute death summary information to members prior to the meeting
- Facilitate the meetings and maintain professional decorum
- Ensure data reports are submitted to NCRPCD
- Ensure team operates according to statute
 - Confidentiality forms for team and invitees
 - Posting agenda and meeting time/location
 - Memoranda

Children's Health Alliance of Wisconsin,
http://www.chawisconsin.org



Objectives of CFR

- Ensure the accurate identification and uniform, consistent reporting of cause and manner of death of every child death
- Improve agency responses in the investigation of child deaths
- Improve criminal investigations and the prosecution of child homicides



The National Center for the Review & Prevention of Child Deaths, A Program Manual for Child Death Review, <http://www.childdeathreview.org/Finalversionprotocolmanual.pdf>

Objectives of CFR, cont.

- Identify significant risk factors and trends in child deaths
- Identify and advocate for needed changes in legislation, policy, and practices and expanded efforts in child health and safety to prevent child deaths
- Increase public awareness and advocacy for the issues that affect the health and safety of children

The National Center for the Review & Prevention of Child Deaths, A Program Manual for Child Death Review, <http://www.childdeathreview.org/Finalversionprotocolmanual.pdf>

Operating Principles of CFR

- The death of a child is a community responsibility
- A child's death is a sentinel event that should urge communities to identify other children at risk for illness or injury
- CFR requires multidisciplinary participation from the community
- A review of case information should be comprehensive and broad
- A review should lead to an understanding of risk factors
- A review should focus on prevention and should lead to effective recommendations and actions to prevent deaths and to keep children healthy, safe and protected

The National Center for the Review & Prevention of Child Deaths, A Program Manual for Child Death Review, <http://www.childdeathreview.org/Finalversionprotocolmanual.pdf>

Order for Conducting a Review

- Coroner/M.E. reviews death investigation
 - Autopsy findings
 - Cause and manner of death
- EMS presents run report
- Hospital representative presents ED/inpatient info
- CPS reports any previous contacts
- Public health reports any previous contacts
- Prosecutor reports on investigation, and prior info
- Others may have input as well

During the review...

- Share, question and clarify all case information
- Discuss the investigation
- Discuss the delivery of services
- Identify risk factors
- Recommend system improvements
- Identify and catalyze community action



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<http://www.chawisconsin.org>

Discussion Questions

The following questions should be asked:

- Is the investigation complete, or is the team missing critical information?
- Does the family need services?
- Has DCS determined safety for other children?
- Should we recommend any changes to agency practices or policies?
- What risk factors were involved in this child's death?

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Discussion Questions, cont.

- Could this death have been prevented?
- How do we prevent another similar death in the future?
- Is our review of this case complete or do we have need to discuss it at our next meeting?
- Who should take the lead in implementing our recommendations for prevention?

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<http://www.chawisconsin.org>

Why collect data?

- Provides ability to track trends at county, regional, state, and national level
- Captures the risk factors and circumstances contributing to the death of a child
- Allows prevention to be targeted to specific groups or risk factors



Children's Health Alliance of Wisconsin,
<http://www.chawisconsin.org>

What do we do with the data?

- Drowning—not enough to know that [this many] children died from drowning
- Did they drown in...
 - A pool
 - A retention pond
 - A bathtub
 - A bucket
- Must have circumstances/factors for effective prevention

How is the data collected?

- The National Center for the Review & Prevention of Child Deaths: Case Reporting System
 - Internet based, confidential database used by 45 states
 - Web-based form can be completed during the meeting
 - Takes about 15 minutes



Prevention...Prevention...Prevention



Statewide Child Fatality Review Committee

- Appointed by the Governor
- Help to standardize forms/procedures for local teams
- Can assist with, or conduct, a review for a local team
- Identify death trends for Indiana based on local team data
- Recommend statewide strategies for prevention
- Advise and educate legislature/public on status of health and safety of Indiana's children

Barriers and Roadblocks

- Sharing confidential case info in a secure way
- Incident occurs in one county, death in another
- Money \$\$\$



“Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.”
-- Margaret Mead

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