Child Death Review

Improving our understanding of why children die taking action to prevent them

In a Nutshell: What is Child Death Review?

A Multi-disciplinary team of professionals that meet to share case information on fatalities in order to prevent other deaths.

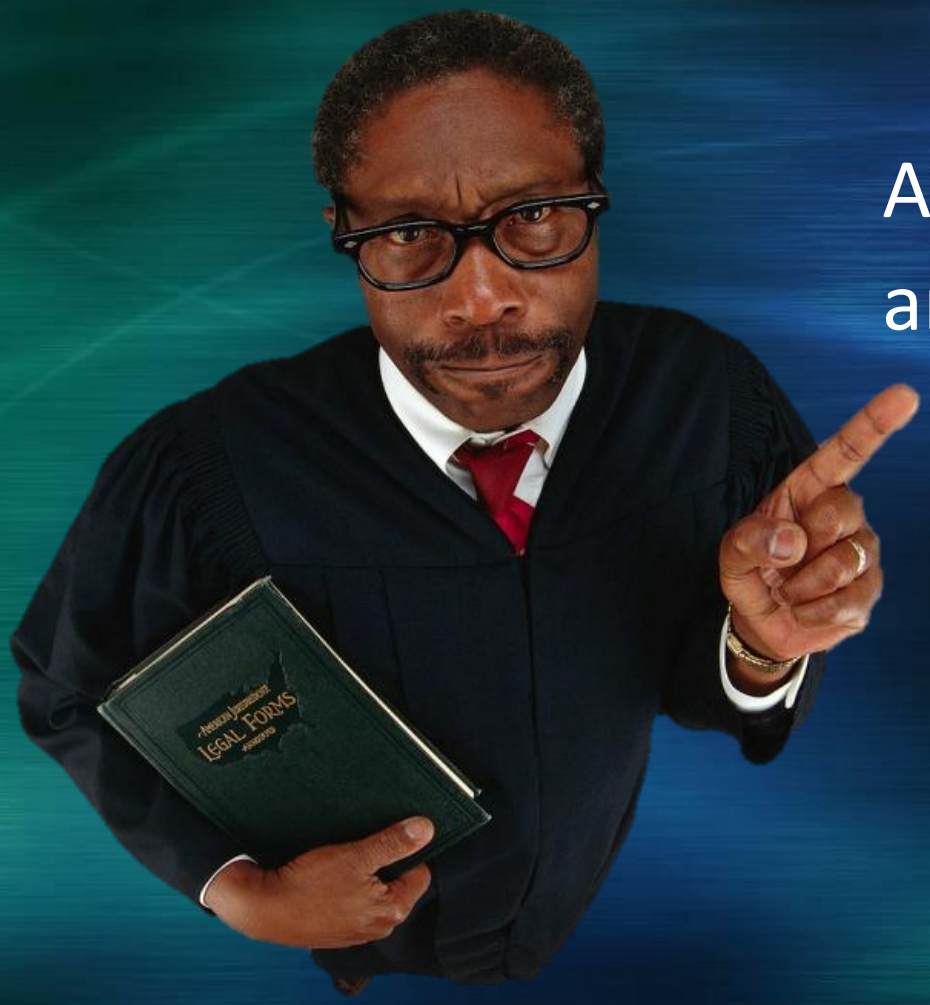
Sharing the Story to Keep Kids Alive

A simple process of sharing information

to understand the WHY

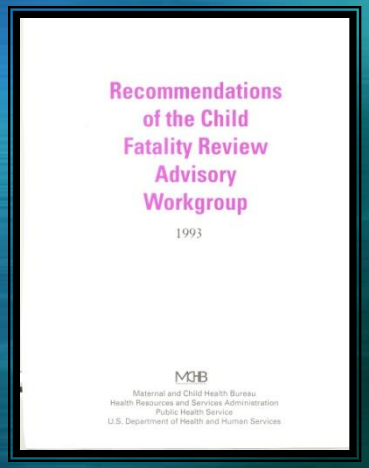
but a complex process of group wisdom and shared responsibility for getting it right to prevent other deaths

It is NOT



About Blame
and Shame

History of CDR


Recommendations of the Child Fatality Review Advisory Workgroup

1993

MCHB

Maternal and Child Health Bureau
Health Resources and Services Administration
Public Health Service
U.S. Department of Health and Human Services

Late 1970s Grass roots organization of local teams especially in Los Angeles, Oregon, S. Carolina.

Early 1990s: Following landmark Missouri study of fatal abuse deaths, national and state efforts lead to models of CDR to improve child abuse reporting and services.

Mid 1990s: U. S. Department of Justice and child welfare , and American Academy of Pediatrics endorse CDR. Government funds trainings and develops materials.

Federal government begins efforts to encourage review of all preventable deaths.

First National Symposium

Late 1990s	Most states with CDR but wide variation in process. Domestic Violence Review starts to organize.
2001	The State of the Nation study is completed and the CDC funds an assessment of CDR legislation.
2003	Federal government funds the National MCH Resource Center with a goal to support expansion of CDR to all preventable deaths.
2004-2008	States begin to standardize the review process, focus more on prevention, and enrollment reaches half of the states in the standardized Case Reporting System. British Columbia begins reviews of all deaths. England/Scotland/Wales requires local safeguarding boards to conduct reviews.
2013	Here we are today all states with CDR.

Guiding Principles

- Deaths and serious injuries are sentinel events: markers for the health and safety of people.
- Environmental, social, economic, health and behavioral factors impact the death or injury.
- These factors are so multidimensional that responsibility for a death or injury doesn't belong to any one place.
- Reviews focus on what when wrong and how can we fix it, not who is at fault and who should we blame?
- The best reviews are multi-disciplinary.

The Objectives of CDR

- Accurate identification and uniform reporting on every child death and serious injury.
- Improved investigative systems.
- Improved agency systems for children and families.
- Improved services for families and community.
- Improved communication and linkages among agencies.
- Understanding of risk and protective factors in child deaths and injuries.
- Changes in legislation, policy and practice, to prevent deaths and injuries and improve child health and safety.

A Comprehensive Purpose

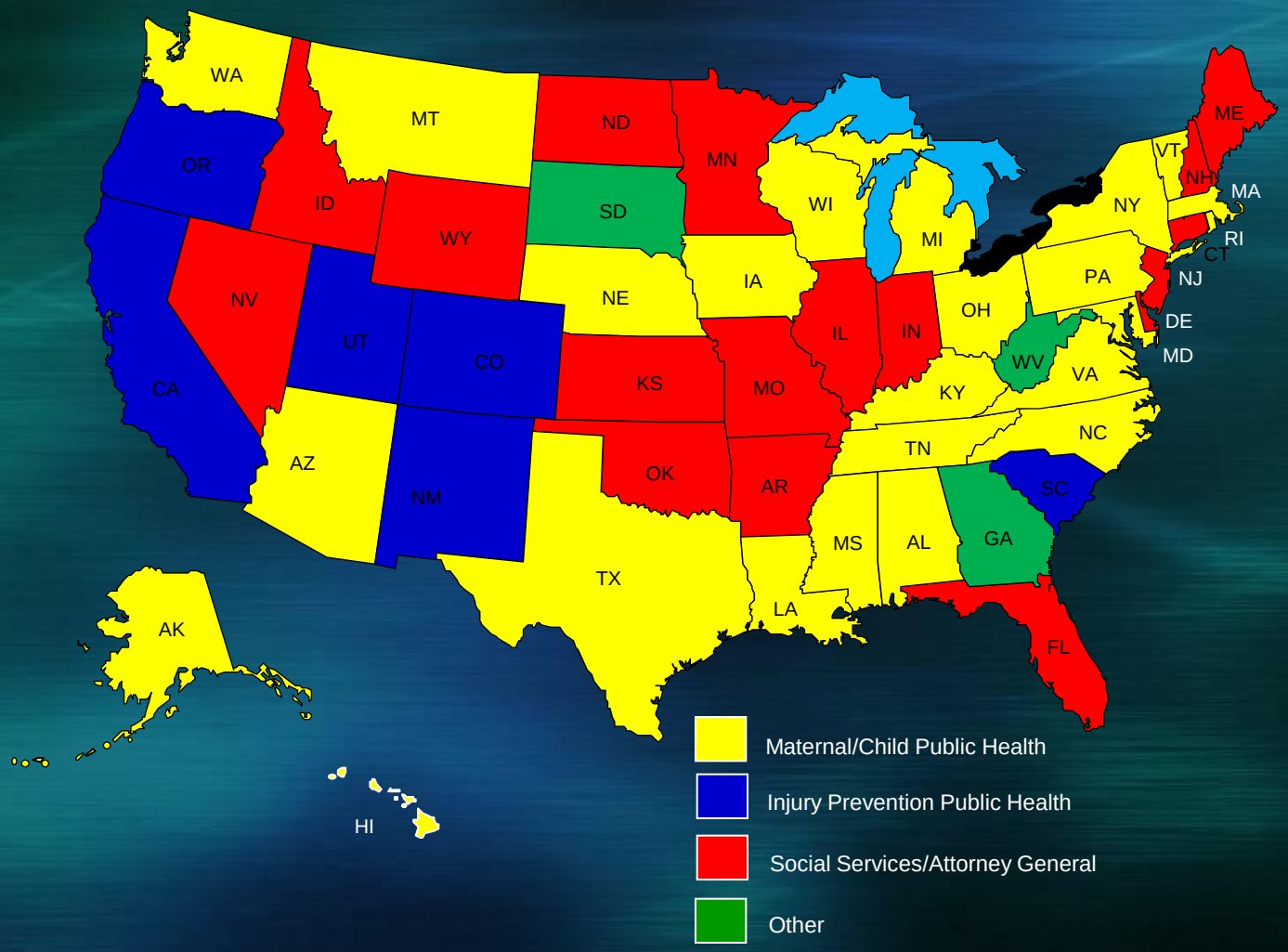
Systems Improvements	Prevention
Coordinated and Comprehensive Investigations	Risk Factor Analysis
Determination of manner and Cause	Effective Recommendations
Agency Actions	ACTION
Children's Justice	Policy, Programs, Services
Family Support	

Improving Interagency Communication, Coordination, &Collaboration

CDR in the U.S.

- All 50 states have well established CDR programs.
- State laws mandate/support CDR in 41 states.
- 23 based in State Health Departments.
- 37 states have community teams & state boards.
- Half review all causes; all review to age 18.
- 12 states review primarily child abuse.
- Vast majority focus on prevention.
- Most are funded with federal maternal and child health or child protection dollars.
- 40 states utilize the national CDR Case Reporting System.

Administrative Homes



Models Vary

- State and Local Teams: Local teams conduct intensive case reviews and state boards review findings of local teams and/or review cases. (37)
- State-only teams conduct case reviews of selected cases, usually fatal abuse and neglect. (12)
- Local teams review cases independently without any state-supported program or board. (1-SD) Three years ago 7 states had no state-level support.

Local Teams

- Conduct case reviews
- Adapt CDR protocols to meet local needs.
- Broad representation of local agencies
- Shared ownership
- Take local responsibility for action.
- Share findings with state for state-level analysis and action. Serve as other local groups, e.g. CAN Council, SAFEKIDS

What is Montana's FICMR?

- Fetal, Infant, and Child Mortality Review
- Established in May 1997 when HB 333 was signed into law
  - Fetal, Infant, and Child Mortality Prevention Act
  - MCA 50-19-401 through 50-19-406
- MCA 50-19-402 policy indicates:

  "it is the intent of the legislature to encourage local communities to establish voluntary multidisciplinary FICMR teams to study the incidence and causes of death to make recommendations for community or statewide change, if appropriate, that may help prevent future deaths."

FICMR Mission Statement

To identify, address, and potentially decrease the numbers of preventable fetal, infant, and child deaths in the State of Montana.

FICMR Statutes

What is required?

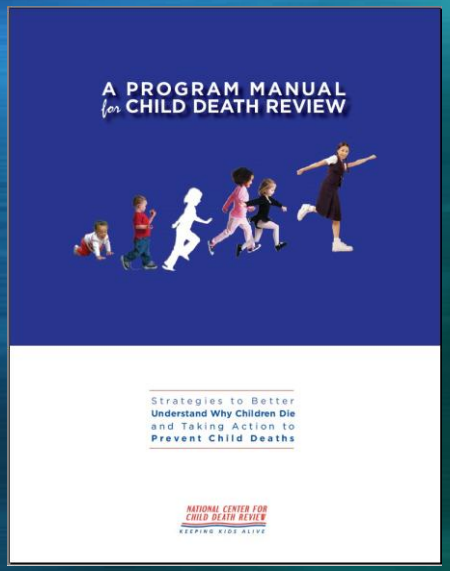
MCA 50-19-403

- Lead person has been designated
- Submit membership lists to the department annually
  - MCH BG Pre Contract Survey
  - Change in team members, need to notify DPHHS
    - Submitting new membership list (name, occupation, phone #)
- Operating policies
  - Include covering collection and destruction of information
- Maintain confidentiality

US Healthy People 2020

Increase the number of States and the District of Columbia where 100 percent of deaths to children aged 17 years and younger that are due to external causes and SUID are reviewed by a child fatality review team.

Creating a Team



- Designate a team leader-that would be you.
- Identify and contact core team members.
- Identify a chairperson and/or facilitator.
- Develop confidentiality and memorandum of agreement documents.
- Understand your local responses to a death: who does what when?
- Develop a process for identifying deaths.
- Decide on your time frame.
- Decide on the types of deaths to review.
- Select a meeting location.
- Set your first organizational meeting. Conduct a practice review(s) if necessary

Operational Plan for FICMR?

- Plan needs to be developed by the team.
  - Will need to include collection and destruction of information
    - Mission Statement
    - Purpose
    - List of Members
    - Responsibility of team members and lead coordinator
    - Meetings and notices
    - Amendments to guidelines
    - Signature and date
- Part of the MCH BG Attachment A
  - Template on FICMR Website
  - Email plan to DPHHS FICMR Coordinator
  - Due date of August 15, 2013
  - Smaller counties sharing teams, will need to email a copy of FICMR County MOU.

[Name of County]
FICMR Operational Plan
[Year]

Our Mission Statement: The mission of our FICMR Review Team is to reduce preventable fetal, infant, and child deaths by making recommendations based on the lessons learned from the review of FICMR deaths.

Purpose: To identify, address, and potentially decrease the number of preventable deaths by making recommendations for needed policy, system or legislative changes, examining community trends and issues, and facilitating prevention activities at the local level.

FICMR Team Members: [County Name] FICMR team will consist of 5 core team members as stated in statute MCA 50-19-403. The lead FICMR team member for [county name] is [name of person]. Each core member and other team members will sign a confidentiality statement annually, which will be kept on file at the health department.

- [Core member's name and position]
- [Core member's name and position]
- [Core member's name and position]
- [Core member's name and position]
- [Core member's name and position]
- (List other members that are on your FICMR team include their name and position)

FICMR Team Members Responsibility: (Feel free to add or remove items listed)

1. Attend all FICMR Team meetings and be on time.
2. Bring pertinent records and documents to review for the FICMR Team meeting.
3. No copies of records should be made for distribution for FICMR Team meetings. If copies are made, that team member is responsible for collecting documents and destroying copies immediately after the meeting.
4. All members must maintain strict confidentiality of all information disclosed during the death review process.
5. All members must be respectful of deaths being reviewed and cultural differences.
6. Members need to participate in discussion, analyze, and determine if a fetal, infant, or child death could have been prevented.
7. Recommend measures to preventable deaths.
8. Would like all members to contribute and participate in community prevention recommendations and activities.

Administrative Responsibilities: (Feel free to add or remove items listed)

1. Develop and maintain relationships with FICMR Team members and ensure that the team membership is adequate to effectively review cases.

Created March 2013: H: /FCH/Lori R/FICMR County Plans/ Template for FICMR Operational Plan

Template

Decide on your Leadership

You – the local FICMR Team Coordinator.

Your meeting facilitator/chair

Your team reporter

These can be different people

Team Review Members

- Must have 5 core members at team meetings.
  - Serve as liaisons to their agencies
  - Case reports considered incomplete
- Recommend you have more than 5 members
  - Avoid cancelled meetings
  - More information to share
  - Better discussions

- Encourage members to commit for at least a year.
  - Attendance is an issue, may ask member to step down.
- Uncomfortable discussing details of a case
  - Lead Local Coordinator should adjust accordingly

Core Team Members: MCA 50-19-403

- Must have 5 multidisciplinary core team members:
  - County Attorney
  - Law Enforcement Officer
  - Medical Examiner/Coroner
  - Mental Health Professional
  - School District Representative
  - Public Health Nurse
  - Tribal Health (appointed by the tribal government) and IHS
  - Forensic pathologist
  - Pediatrician or Obstetrician
  - Family Practice Physician
  - Nurse Practitioner
  - Local Trauma Coordinator
  - Etc

Submit membership lists to the department annually

MCH BG Pre Contract Survey

ETC: Other Team Members

- Community Hospital
- Juvenile Division of court
- Child Care Licensing
- Clergy
- Advocacy Centers
- SIDS Services
- Domestic Violence Representatives
- Tribal councils

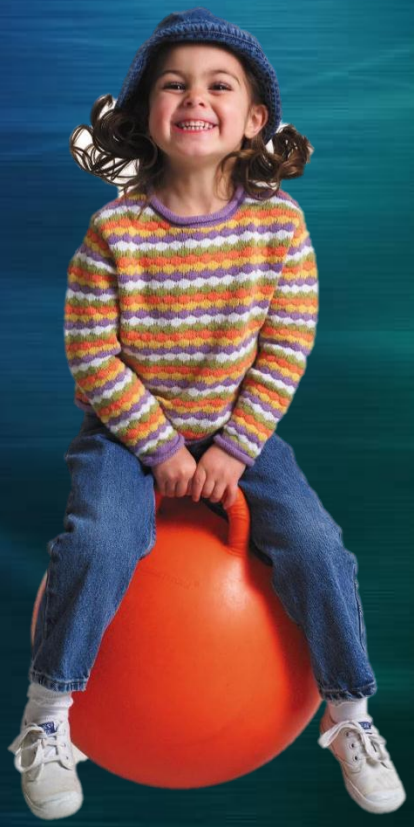
Members should represent your children, and must be set up as a standing member

Managing a CDR Team

- Identifying deaths
- Obtaining records
- Recruitment of members
- Meeting logistics
- Case reports
- Follow up and tracking of actions
- Liaison with state

Decide On Your Time Frame

- Rapid Response
  - Designed to aid in investigation.
  - May only need smaller number of team members
- Retrospective
  - Investigation should be near completion.
  - Focus is on systems improvements and prevention.

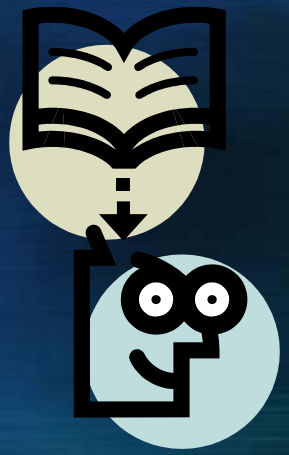


Most teams are hybrids

Identifying Death Cases

- Counties should find the deaths
  - Establish connections with registrar/clerk and recorder.
    - Monthly, Quarterly call regarding deaths
    - Have them notify you
  - Relationship with local hospital records, case manager, or social worker
  - Obituary notices in the newspaper or internet.
- Monthly Updated Death Lists
  - Identify county of resident and death
  - Name (First, Middle, and Last)
  - Date of Death
  - Age
  - Death Certificate Number
  - Occasionally cause of death

Death Certificates, Tools, and Definitions



Death Certificates

- Public Record (MCA 50-15-121)
- Fetal
  - FICMR Program receives from Vital Stats
  - Local FICMR Coordinators will receive copies from FICMR Coordinator
  - Parents can request Certificate of Still Birth for fetal death occurring or after 20 weeks gestation.
- Child and Infant
  - Obtain from your registrar or clerk recorder
  - FICMR Coordinator has access to Vital Stats Death Records
- Out of state
  - Hard to obtain
  - Fees
  - Vital Stats does receive some death certificates from other states
    - Incomplete
    - Not available for distribution

Trouble Obtaining Out of State Death Certificate?

- Local FICMR Coordinator should:
  - Ask for “Unofficial or Noncertified” copy
  - Cost or fee--- use MCH BG Funding
  - Make a couple of attempts
- Contact FICMR Coordinator
  - Contact person
  - Official letter
  - State to State agreement
- No success! Send email to FIMR Coordinator
  - Short attempted explanation
  - Case will be closed, no review needed.

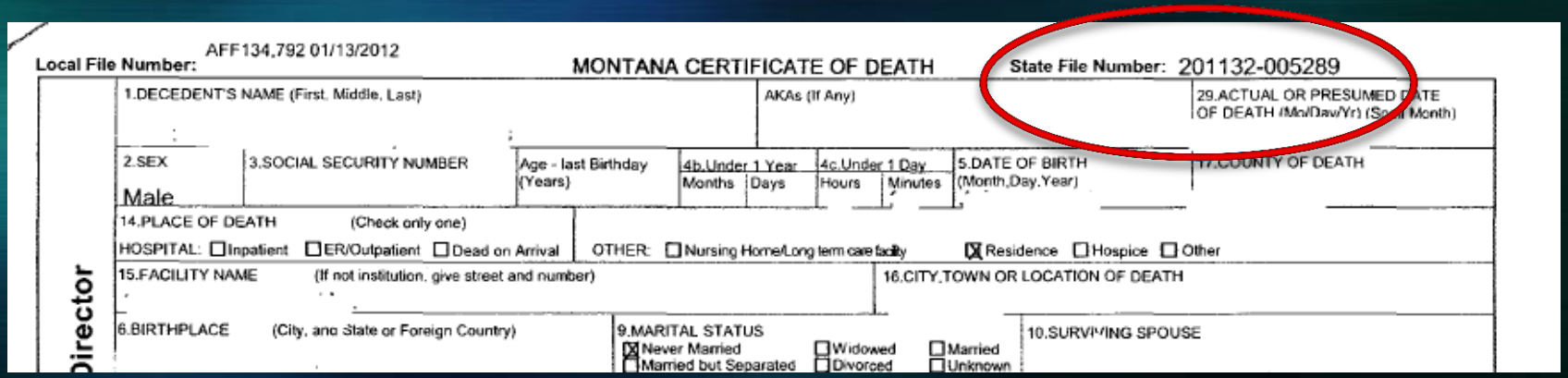
Death Certificate Number

What is a DCN and is it required for FICMR?

- A death number assigned to death certificate by Vital Stats
- Located at the top of a death certificate.
- Vital stats about a month behind
- DCN number is required on case reports and screening tools
  - Identify cases

What if my death certificate doesn't have a number?

- Death List
- Contact FICMR Program Coordinator


AFF134,792 01/13/2012

Local File Number:

MONTANA CERTIFICATE OF DEATH

State File Number: 201132-005289

1.DECEDENT'S NAME (First, Middle, Last)

AKAs (If Any)

29.ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month)

2.SEX Male

3.SOCIAL SECURITY NUMBER

Age - last Birthday (Years)

4b.Under 1 Year Months Days

4c.Under 1 Day Hours Minutes

5.DATE OF BIRTH (Month,Day,Year)

17.COUNTY OF DEATH

14.PLACE OF DEATH (Check only one)

HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ Dead on Arrival

OTHER: ☐ Nursing Home/Long term care facility ☒ Residence ☐ Hospice ☐ Other

15.FACILITY NAME (If not institution, give street and number)

16.CITY,TOWN OR LOCATION OF DEATH

6.BIRTHPLACE (City, and State or Foreign Country)

9.MARITAL STATUS

☒ Never Married ☐ Widowed ☐ Married

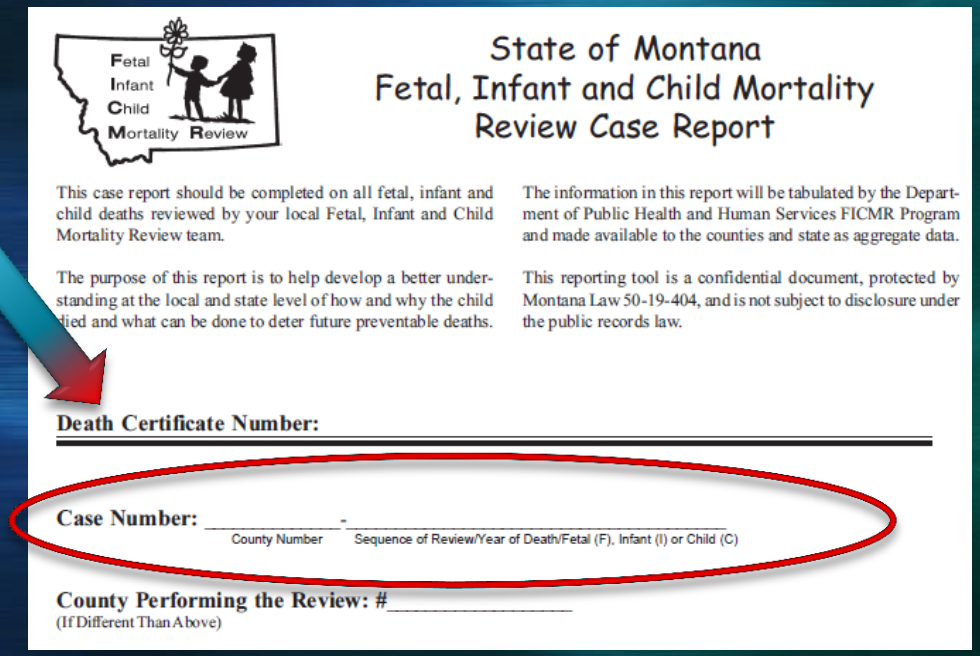
☐ Married but Separated ☐ Divorced ☐ Unknown

10.SURVIVING SPOUSE

Director

Case Number

- County number where the death occurred
  - Sequence of the review
    - # of Fetal, Infant, or Child deaths reviewed
  - Year of death
  - Category (Fetal, Infant, or Child)
- Implementation of CDR Case Number will no longer be needed.



Fetal Infant Child Mortality Review

State of Montana
Fetal, Infant and Child Mortality
Review Case Report

This case report should be completed on all fetal, infant and child deaths reviewed by your local Fetal, Infant and Child Mortality Review team.

The purpose of this report is to help develop a better understanding at the local and state level of how and why the child died and what can be done to deter future preventable deaths.

The information in this report will be tabulated by the Department of Public Health and Human Services FICMR Program and made available to the counties and state as aggregate data.

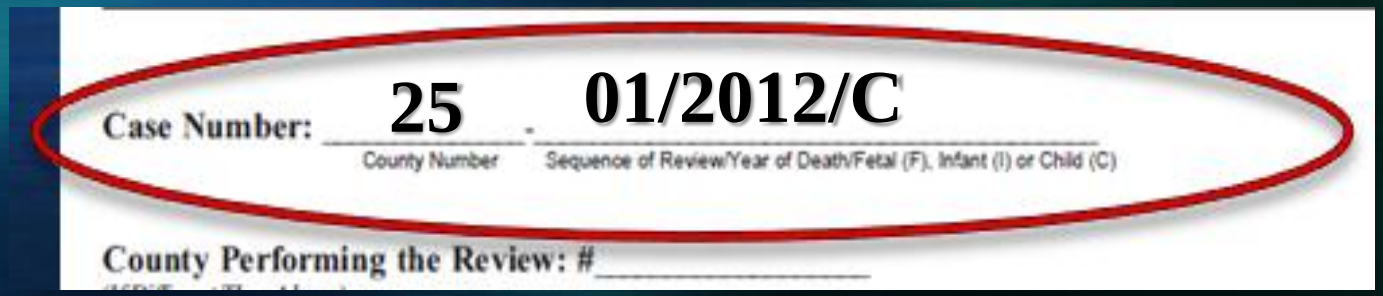
This reporting tool is a confidential document, protected by Montana Law 50-19-404, and is not subject to disclosure under the public records law.

Death Certificate Number: _____

Case Number: _____-_____
County Number — Sequence of Review/Year of Death/Fetal (F), Infant (I) or Child (C)

County Performing the Review: #_____
(If Different Than Above)

EXAMPLE:



Case Number: 25 - 01/2012/C
County Number — Sequence of Review/Year of Death/Fetal (F), Infant (I) or Child (C)

County Performing the Review: #_____

Types of Deaths to Review

What
Deaths are You Going
to Review?

Why?

- Age
- Cause of Death
- Residence
- Cases under investigation or litigation

AGE: Definitions:

- Fetal Death– birth of a fetus without any signs of life that weighs at least 350 grams or if the weight is unknown, has reached 20 weeks of gestation.
- Infant Death—death of "an individual less than 365 days (one year old).
  - Any signs of life at birth regardless of gestational age or weight are considered an "infant death".
- Child Death—death of and individual between the age of 1 year through the end of the 17th year.

Fetal Screening Tool

How does this work?

- Review the death list.
  - Fetal deaths are reviewed by the county where the mother resides.
- Local FICMR Coordinator to screen all fetal cases.
  - Identify major risk factors
- Recommended that a full review should be done due to the following risk factors:
  - Smoking
  - Alcohol or illicit drugs
  - History of preterm delivery
  - Late or no prenatal care
  - Pre-existing chronic conditions (hypertension, diabetes, or obesity)
  - Lack of information or presence of risk factors

MONTANA
Department of Public Health & Human Services

FETAL DEATH SCREENING TOOL

Date of Death: ___-___-_____ (MM DD YYYY) Death Certificate Number: _____-_____

County of Maternal Residence: _____ County of Death: _____

Environmental Factors-Maternal	Please circle best answer
1. **Mother smoked/used tobacco products during pregnancy**	Yes No Unknown
2. Non-smoking mother exposed to second hand cigarette smoke during pregnancy	Yes No Unknown
3. **Maternal use of illicit drugs or any prescription-type psychotherapeutic medication used non-medically during pregnancy**	Yes No Unknown
4. Maternal use of alcohol during pregnancy	Yes No Unknown
5. Homeless during pregnancy	Yes No Unknown
6. Mother experienced domestic violence during pregnancy	Yes No Unknown
Prenatal or Maternal Medical History	
1. **Maternal history of previous preterm delivery**	Yes No Unknown
2. Maternal history of difficulty conceiving	Yes No Unknown
3. Maternal history of previous fetal loss	Yes No Unknown
4. Was labor induced in this pregnancy?	Yes No Unknown
5. Was this a C-section delivery?	Yes No Unknown
6. **Late entry or no prenatal care?**	Yes No Unknown
7. **Maternal hypertension before pregnancy (chronic hypertension)**	Yes No Unknown
8. **Pregnancy induced maternal hypertension**	Yes No Unknown
9. **Maternal diabetes before pregnancy**	Yes No Unknown
10. **Developed gestational diabetes with this pregnancy**	Yes No Unknown
11. **Maternal obesity**	Yes No Unknown
12. Maternal age <19 or >35	Yes No Unknown
Pregnancy Outcome	
1. Multiple birth	Yes No Unknown
2. Congenital Anomaly not compatible with life	Yes No Unknown
3. Placental or cord problems	Yes No Unknown
4. Fetal gestational age 20-24 weeks	Yes No
5. Fetal gestational age 25-31	Yes No
6. Fetal gestational age 32-37	Yes No
7. Fetal gestational age >37 weeks	Yes No

Complete FICMR team review indicated? Yes No

Note: A complete review is recommended if the answer to any of the bolded items is "Yes."

03/2012

Fetal Screening Tool Continued…

- Submission
  - No full review needed
    - Mail or fax to 444-2606
    - Death Certificate Number
  - Full review needed
    - Keep a copy of the screening tool with your case report.

- Where can I find this form?
  - FICMR Website: http://www.dphhs.mt.gov/publichealth/cdrp/index.shtml

Topic of Discussion

Prematurity deaths in infants should be reviewed by:

1. County where the death occurred

-or-

2. County where the mother resides

When should you conduct reviews?

Average 3-6 months from death;
Depends on your meeting schedule

Do not review cases under litigation

When are case reports due?

- Recommend that case reports be submitted within a week of being reviewed.
  - FICMR Review Team tables a case.
  - 2012 death reviews due **December 31, 2013**
    - Don't recommend waiting a year to complete reviews.
  - Notify FICMR Program Coordinator if:
    - Not going to meet December deadline
    - Litigation

Who is Responsible for Completing the Review?

- Fetal cases will be reviewed by the county where the mother resides
- Infant and Child cases will be reviewed by the county where the death occurred.
  - Infant prematurity: Topic of discussion results
- Out of state deaths will be reviewed by county where the child resided in.
  - Screening tool in development
  - Completion goal is Jan 1, 2014

Confidentiality:
What Does Montana Law Allow/Require?

MCA 50-19-404

- Information obtained not subject to disclosure under public law
- Information and materials are not subject subpoena

What can I do so confidentiality isn't breached?

- No note taking
- No photocopies
- No discussion of cases reviewed with non team members
- Sign in sheet at review meeting with confidentiality statement
- Sign confidentiality statement annually
- Completed case reviews should be locked up

Access to Information

- MCA 50-19-402 and 50-16-252:
  - Health care provider may disclose information without a patient's or representative's authorization
- MCA 41-3-205
  - Receive child protection records
- MCA 44-5-303 :
  - Receive criminal justice information through the county attorney or a person designated by the county attorney.

Records Needed for Review

- Scene Investigation Information
- Medical Examiner/Coroner reports
- EMS Run reports
- CPS Histories
- Public Health Visits/Immunizations
- Medical records from hospitals/physicians
- Fire Marshall Reports
- Suicide Notes sometimes shared
- Some Mental Health
- Child care licensing
- Prenatal care records
- School Histories
- Court and Juvenile Histories

It Will Help if You Know Who Does What When a Child Dies?

- The 911 Call or Family at Hospital
- The Emergency Response: EMS, Fire, Police
- Health Care: Hospitals, physicians, public health
- The Investigation: Police, ME/Coroner, CPS, Day Care
- Notification and Death Certification
- Bereavement Services: public health, non profit groups
- Critical Incident Debriefing
- Services for the Family and Community
- Burial
- Prosecution/Adjudication
- Follow Up Services

The Steps in Case Review

1. Share the story
2. Investigation?
3. Services?
4. Modifiable risk factors?
5. What agency policies and practices need attention?
6. What should be done to change behavior, technology or laws?
7. What is our best recommendation(s)?
8. Next steps: who will take the lead?

At Every Meeting

- Bring data or information related to past meeting recommendations.
- Review past meetings' recommendations.
- Ask for reports from persons taking responsibility.
- Document and review actions periodically.
- Celebrate successes.

The Review Meeting

1. Reviewing the Cases
   a. Share all information.
   b. Ask questions
   c. Discuss investigation, services, agency practices, prevention.
   d. Complete a case report

2. Updates on past case

3. Tracking recommendations and actions
   a. Bring data or information related to past meeting recommendations.
   b. Ask for reports from persons taking responsibility.

4. Education on causes of deaths

A Comprehensive Purpose

Systems Improvements

- Coordinated and Comprehensive Investigations
- Determination of manner and Cause
- Agency Actions
- Children's Justice
- Family Support

Prevention

- Risk Factor Analysis
- Effective Recommendations
- ACTION
  - Policy, Programs, Services

Improving Interagency Communication, Coordination, &Collaboration

Improving the Investigation

- Who is the lead agency?
- Was the investigations coordinated?
- Was there an autopsy? Was it comprehensive?
- Was there a scene investigation?
- Was there a scene recreation with photos?
- Were there other investigations?
- What were the key findings?
- Was the investigation adequate?
- Is the investigation complete?
- What more do we need to know?
- What can be done to help our investigators and the system?

Services

- Were there any services that the family was accessing prior to the death?
- Were services provided to family members as a result of the death?
- Were services provided to other children (schoolmates, etc.)?
- Were services provided to responders, witnesses or community members?
- Are there additional services that should be provided to anyone?
- Who will take the lead in following up on these service provisions?
- Does the team have suggestions to improve our service delivery systems?

Agency Policies and Practices

- Did agencies follow acceptable practice/policies in meeting the needs of the child before, at time of and after death?
- Are there gaps in delivery of services to family/child?
- Are there specific agency policies or practices that should be changed, improved on, implemented?
- How can we best notify the agenc(ies) about our findings?

Michigan Example Statistically significant decrease in deaths

Finding	Problem Area	System Changes
Failure among medical professionals to diagnose and report suspected abuse or neglect.	Non-Compliance	-Statewide training for physicians
Poor medical follow-up by families and medical professionals after hospitalization.	Poor Practice	
Unaddressed mental health needs lead to the death of a child.	Inadequate policy	-New protocol for family assessment by foster care agencies
Lack of accuracy or consistency by Medical Examiners in categorizing cause or manner of sudden, unexpected deaths in children	Poor Practice	-New state protocol to determine cause and manner of sudden child deaths

Finding	Problem Area	System Changes
Inappropriate screening-out of complaints and delay in acceptance of complaints and case assignment.	Non-Compliance	-New CPS peer review program
Incomplete and insufficient complaint investigation by MDHS staff. (“Incomplete” refers to concluded investigations, but no supervisory sign-off; “insufficient” refers to the apparent omission of required tasks	Non-Compliance	-New training at CPS training institute for new hires
Unacceptable time lapses between assignment and contact with families	Non-Compliance	-New CPS peer review program
Failure of CPS supervisor to sign off on child abuse/neglect assessments and/or properly review the case materials, in accordance with established procedures.	Non-Compliance	-New mandatory CPS supervisor training
Poor communication among law enforcement and MDHS and failure to perform joint investigation resulted in the whole picture of the child and family’s condition not being properly investigated	Poor Practice	-New protocol for joint investigation -Development of Child Advocacy Centers

Failure to remove subsequent children after a finding of preponderance in infants with positive toxicology results	Non-Compliance	-New mandatory CPS supervisor training
Improperly returning a child to a home that had lost its foster care license	Non-Compliance	-Data system upgrades
Criminal history check was not done; if done, was not complete.	Non-Compliance	-New terminals for criminal history checks placed in CPS offices

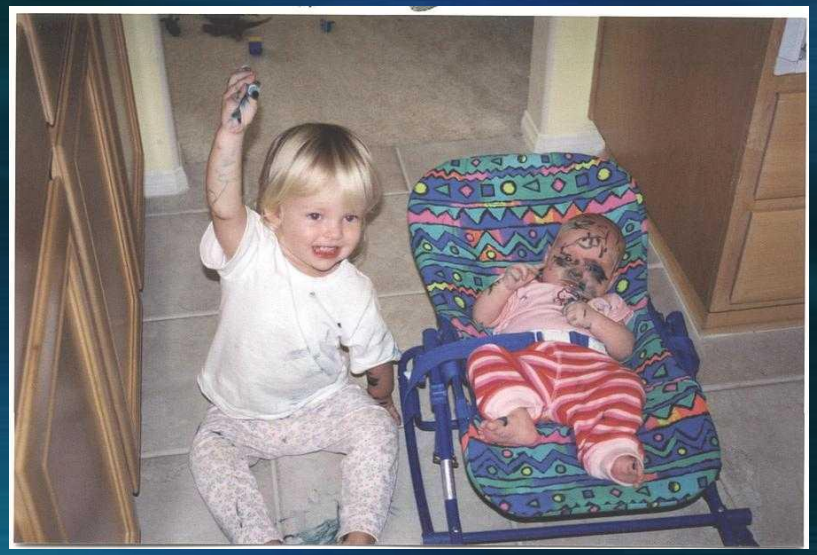
Making Systems Changes: Example-Las Vegas

- 79 deaths identified by state as possibly due to abuse or neglect. Deaths from many types.
- Only 6 were coded on death certificates as maltreatment-from physical abuse. Only 9 has been substantiated as maltreatment by CPS.

Looking for Systems Problems

1. Identification of and the reporting to CPS, of suspected child abuse and child deaths.
2. Investigation by law enforcement of suspected abuse and of child deaths.
3. Investigations of child deaths by the Coroner's Office.
4. Case intake and investigation by CPS of suspected child abuse and of child deaths.
5. CPS substantiation of child abuse.
6. Provision of Services by CPS.
7. Actions taken by the civil and criminal divisions of the District Attorney's Office and the Courts.

In 13 deaths, a report was not made to CPS in which actions by the caretakers contributed to the children's deaths, but in which there were no surviving siblings. 64 of the children who died had surviving siblings, but CPS interviewed only two sets of siblings.



Change: new state law requiring notification even when there are no siblings and CPS must interview children.

Finding: Reports of neglect due to poor supervision and or inadequate care were usually screened out and…

Almost all deaths with safety assessments in the case record were incomplete, incorrect or dated long after the event.

Change: 144 new CPS worker positions were funded for Clark County.

Using Your Review to Take Action to Prevent Other Deaths

114,000 deaths
48,000 recommendations
11,000 interventions

New or amended laws to protect children from harm.

- Teen driver graduated licensing laws.
- Safe Haven laws to stop infant abandonment.

New child health, safety and protection programs.

- Smoke alarm distribution programs.
- Intensive home visiting services for new parents.
- National drowning prevention campaign.

New or revised agency policies and practices.

- Coordinated interagency scene investigations.
- Improved reporting for child abuse and neglect.

Environmental modifications to eliminate hazards.

- Changing dangerous intersections and roadways.
- New signs warning of water hazards.

New partnerships with local, state and national groups.

- Collaborations with Safe Kids USA injury coalitions.
- Partnerships with SIDS bereavement support services.

The Excuses

- It’s not my job.
- I don’t have time.
- We don’t have resources.
- It’s hard to do.
- We don’t know what to do.
- We’ll send in our report to the state.
- Nothing works anyways.
- It was a bad accident and will probably never happen again.
- You can’t prevent stupidity.

WHY ME?

- All team members have a lot to contribute.
- You are often the very folks who have standing in the community.
- Prevention is not just for the public health and school nurses.
- It’s good P.R.

KEY POINTS

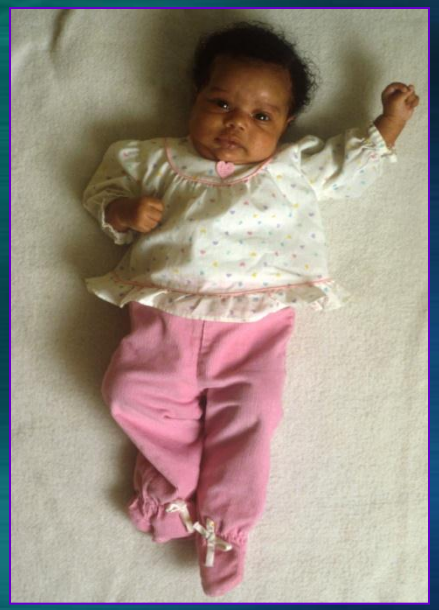
- It is not necessary to reinvent the wheel.
- There are often no quick and easy longterm solutions but…
- Quick action can inspire others.
- One person *can* make a difference.

Risk Factors

- Medical
- Social
- Economic
- Behavioral
- Environmental
- Systemic (Agency Policies)
- Product Safety

Example: SIDS/Suffocation Risks

She's on her back!



Identify the Risk Factors

SUID: SIDS/Suffocation Risks

- Place where child was sleeping or playing.
- Position of child when found.
- Type of bedding, blankets and other objects near child.
- Faulty design of cribs, beds or other hazards.
- Number of and ages of persons sleeping with child.
- Obesity, fatigue, or drug or alcohol use by persons supervising or sleeping with child.
- Quality of supervision at time of death.
- Family's ability to provide safe sleep or play environment for child.
- Prior child deaths or repeated reports of apnea episodes by caregiver.

SIDS/Suffocation Interventions

- Provider Training and Education
- Home Visiting
- Parent Training and Education
- Community Education
- Provision of Safe Cribs
- Child Care Provider Training and Education
- Prenatal Drug and Alcohol Treatment Services
- Prenatal Smoking Cessation

‘Cribs for Kids®’

Six deaths were reviewed in Pittsburgh in Nov. 1998 in which babies died in unsafe sleep and none of them were in cribs.

Members of the Allegheny County CDRT and SIDS PA formed a steering committee of public health, political and business leaders.

Cribs for Kids PA was formed to give out free Cribs to needy families.

As of today all 6,500 high-risk infants who received cribs in Allegheny County lived to celebrate their first birthdays.

Babies Need Cribs, Make Them Safe

After several studies the Graco Pack n' Play was chosen as the best crib for our program because of its size, convenience, portability and ease of assembly.

Your baby's crib should have:

- Railings that are not more than 2⅜ inches apart (you can't fit a soda can through them.)
- A firm mattress that fits snugly in the frame.
- A fitted sheet that is tight around the mattress.
- No quilts, comforters, duvets, heavy blankets, stuffed animals, bumper pads, sheepskins, etc. They can obstruct the baby's breathing.

For more information, go to the Consumer Product Safety Commission's website at www.consumer.gov/productsafety.htm or call toll free at 1-800-638-2772.

CRIBS FOR KIDS ...it's for the babies

To reduce the risk of SIDS and accidental suffocation, the Consumer Product Safety Commission, 'Cribs for Kids®', and the American Academy of Pediatrics recommend that infants sleep on their backs on a firm mattress in a safety-approved crib, with no soft bedding or comforters, with no exposure to cigarette smoke, and with a room temperature that is comfortable to adults.

Since 1998, the National 'Cribs for Kids®' Campaign, has provided cribs and educational materials about ways to reduce the risk of SIDS and accidental suffocation to families throughout the United States thanks to the generosity of foundations, corporations, special event fundraisers, and partnerships with Graco Children's Products and Pitt Ohio Express.

Babies are safest sleeping alone in an uncluttered crib on their back, never on their front or side. If you need a crib... we can help.

'Cribs for Kids®' is an initiative of SIDS of PA For more information or to make a donation, please contact us:

'Cribs for Kids®'
Suite 250, Riverfront Place
810 River Avenue
Pittsburgh, PA 15212
1-888-721-CRIB
www.cribsforkids.org

safe sleep for your baby

CRIBS FOR KIDS ...it's for the babies

Outcomes from Case Reviews

FOR EXAMPLE: YOUTH SUICIDES

- School Policies and Practices
- Community and State Task Forces
- Anti-Bullying Legislation
- Suicide Ideation Training
- Revisions to Mental Health Service Plans
- Family and Community Support
- PTSD Services

Spectrum of Prevention

Influencing policy and legislation

Mobilizing neighborhoods and communities

Changing organizational practices

Fostering coalitions and networks

Educating providers and
training people who can make a difference

Promoting community education

Strengthening individual knowledge and skills

Use Best Practice Websites

Intervention-Decision Matrix

Intervention	Option 1	Option 2	Option 3
Effectiveness			
Feasibility			
Affordability			
Sustainability			
Political Acceptability			
Unintended Consequences			
Final Priority			

*Adapted from Carolyn Fowler, Johns Hopkins University Injury Research Center

CDRT Recommendations Project

- Based our study on public health planning model
- Sampled written reports from 75 CDRTs throughout the United States
- Developed Guidelines for Writing Effective Recommendations
- Reviewed and assessed over 1,000 recommendations

CDRT Recommendations Project

- **Findings**:
- Quality of recommendations varied widely
- CDRTs did best on front end
  - Problem statement
  - Best practices
- CDRTs scored lowest on follow up activities
- Written recommendations showed moderate specificity and awareness of Spectrum levels, but lacked clarity on who was to take action

A Strong, Action Oriented Recommendation:

Parents should put their babies to sleep in safe cribs.

Sunnyside Hospital and the County Health Department should design, implement and manage an education campaign for new parents, using prenatal classes and hospital discharge educators, to teach comprehensive infant safe sleep practices according to the AAP guidelines, by the end of December.

A good recommendation:

Refers to local data and contexts
Applies knowledge of best practices
Identifies incremental next steps
Is specific and actionable
Is made with accountability and follow-up

Role of Effective Recommendations

- Recommendations come after
  - Defining the Problem and
  - Identifying Risk and Protective Factors
- But Before
  - Developing and Testing Interventions
- They are part of developing solutions

Beware

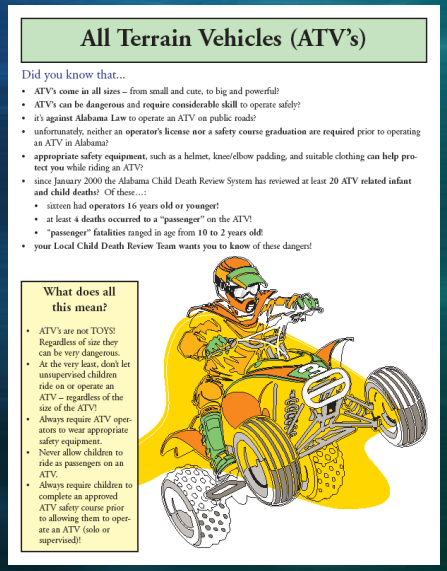
- Too many dilutes effectiveness
- Pay attention to timing
- Put then in writing
- Let people know ahead of time they are coming
- Make sure you follow up
- Hold people accountable

West Virginia ATV

Team worked hard to pass legislation.

But….it may have done more harm than good…

- 250 deaths from 2001-2006
- Rate increased 14%
- Average 26 deaths a year, 46 in 2006



All Terrain Vehicles (ATV's)

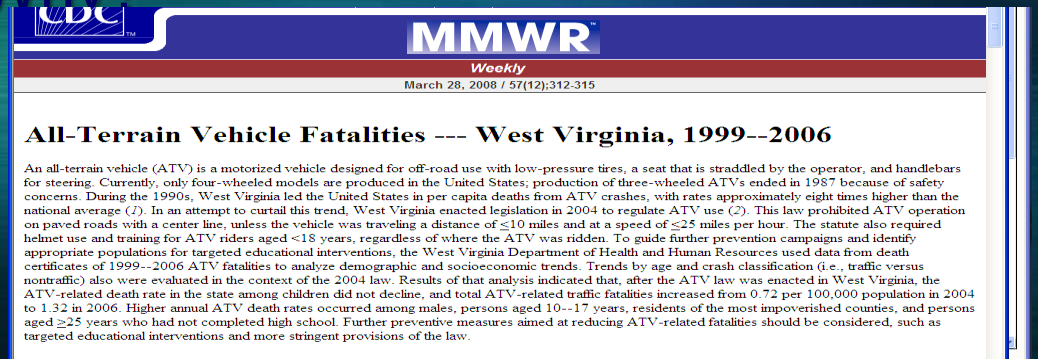
Did you know that...

- **ATV's come in all sizes** – from small and cute, to big and powerful?
- **ATV's can be dangerous** and **require considerable skill** to operate safely?
- it's **against Alabama Law** to operate an ATV on public roads?
- unfortunately, neither an **operator's license nor a safety course graduation are required** prior to operating an ATV in Alabama?
- **appropriate safety equipment**, such as a helmet, knee/elbow padding, and suitable clothing **can help protect you** while riding an ATV?
- since January 2000 the Alabama Child Death Review System has reviewed at least 20 ATV **related infant and child deaths**? Of these…:
  - sixteen had **operators 16 years old or younger!**
  - at least 4 **deaths occurred to a "passenger"** on the ATV!
  - **"passenger" fatalities** ranged in age from **10 to 2 years old!**
- **your Local Child Death Review Team wants you to know** of these dangers!

What does all this mean?

- ATV's are not TOYS! Regardless of size they can be very dangerous.
- At the very least, don't let unsupervised children ride on or operate an ATV – regardless of the size of the ATV!
- Always require ATV operators to wear appropriate safety equipment.
- Never allow children to ride as passengers on an ATV.
- Always require children to complete an approved ATV safety course prior to allowing them to operate an ATV (solo or supervised)!

Why?



MMWR Weekly

March 28, 2008 / 57(12);312-315

All-Terrain Vehicle Fatalities --- West Virginia, 1999--2006

An all-terrain vehicle (ATV) is a motorized vehicle designed for off-road use with low-pressure tires, a seat that is straddled by the operator, and handlebars for steering. Currently, only four-wheeled models are produced in the United States; production of three-wheeled ATVs ended in 1987 because of safety concerns. During the 1990s, West Virginia led the United States in per capita deaths from ATV crashes, with rates approximately eight times higher than the national average (*1*). In an attempt to curtail this trend, West Virginia enacted legislation in 2004 to regulate ATV use (*2*). This law prohibited ATV operation on paved roads with a center line, unless the vehicle was traveling a distance of ≤10 miles and at a speed of ≤25 miles per hour. The statute also required helmet use and training for ATV riders aged <18 years, regardless of where the ATV was ridden. To guide further prevention campaigns and identify appropriate populations for targeted educational interventions, the West Virginia Department of Health and Human Resources used data from death certificates of 1999--2006 ATV fatalities to analyze demographic and socioeconomic trends. Trends by age and crash classification (i.e., traffic versus nontraffic) also were evaluated in the context of the 2004 law. Results of that analysis indicated that, after the ATV law was enacted in West Virginia, the ATV-related death rate in the state among children did not decline, and total ATV-related traffic fatalities increased from 0.72 per 100,000 population in 2004 to 1.32 in 2006. Higher annual ATV death rates occurred among males, persons aged 10--17 years, residents of the most impoverished counties, and persons aged ≥25 years who had not completed high school. Further preventive measures aimed at reducing ATV-related fatalities should be considered, such as targeted educational interventions and more stringent provisions of the law.

Lesson: Know the issue, do your homework and bring in the right advocates!

Writing Effective Recommendations

- Problem Assessment
- Written Recommendation
- Action on Recommendation

Written Recommendation

- Who will Take Action
  - Identifies the persons and organizations (doers) to take action in a manner consistent with the problem assessment
- Who will Benefit
  - Identifies the recipient (e.g., person, agency, policy, law) of the intended action in a manner consistent with the problem assessment

Written Recommendation (Cont'd)

- Specificity
  - The plan of action described in sufficient detail to allow follow up consistent with:
    - Issues identified in problem assessment
    - Actions appropriate for recipient
    - Places/institutions identified where changes will occur
    - Timeframe for action identified

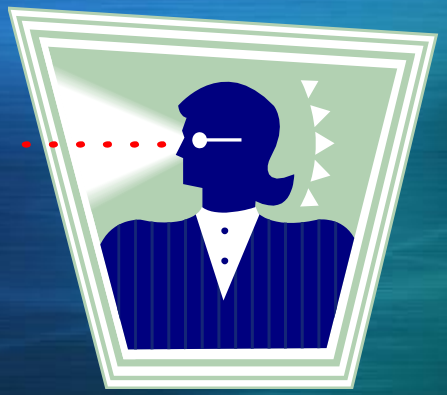
Written Recommendation (Cont'd)

- Accountability
  - Assigns and obtains buy-in of someone (i.e., team member or other individual) to be accountable for follow up and tracking of progress on actions taken within timeframe identified
- Spectrum of Prevention
  - Demonstrates awareness of levels of intervention and identifies appropriate level(s) given issues identified in problem assessment

Action on Recommendation

- **Dissemination**
  - specifically states who will receive the recommendation, and includes not only the potential actors and recipients but also appropriate decision makers, funders, and potential supporters.
- **Outcomes/Impacts**
  - identifies a mechanism/procedure to document the impacts and outcomes that result from action on team recommendations.

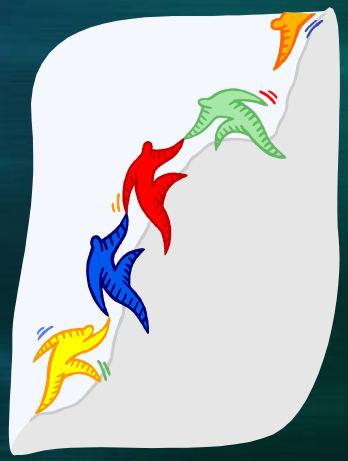
Writing Effective Recommendations: Activity - One



- Identifying components of written recommendations
- Identifying limitations of written recommendations

Writing Effective Recommendations: Group Activity - Two

- Break into small groups of 3-5
- Take one example for each group
- Assume team has done its problem assessment
- Re-write recommendation using Guidelines
- Think of which levels of the Spectrum might be relevant
- Report back



Make recommendations knowing full well they have to be implemented

Lessons Learned

- Make prevention a priority
- Value the recommendation process
- Be realistic – take small steps
- Identify existing partners & champions
- Keep track of what you recommend
- Follow up
- Let people know what happens
- Celebrate successes

Enlist Partners to Move from Recommendations to Action and Hold Them Accountable

House Bill 28 Maternal Mortality Review

Hearing Rumors on HB28?

What was HB 28?

- Amendment of the FICMR Act to include Maternal Mortality
  - Passed on January 31, 2013
  - FICMMR
  - Added Language:
    - Perform in-depth analysis of maternal deaths
      - within one year of delivery
    - A team reviewing a maternal death needs to include at least one obstetrician, family practice physician, or physician assistant whose duties and delegation agreement includes obstetrical care.
- Effective - October 1, 2013
  - Maternal Reviews do not need to start in Oct.
  - Development of questionnaire and guidance manual.
  - Average about 12 deaths per year statewide.
    - Some counties may have 1 death every few years.
    - Larger counties may encounter 1 death per year.

Questions

Contact Information:
Lori Rowe—FICMR Program Coordinator
lrowe@mt.gov
406-444-3394

FICMR Website:
http://www.dphhs.mt.gov/publichealth/cdrp/index.shtml