Attachment 6

Supporting Information for the Workgroup Recommendations

Child Death Data Review Workgroup

Report and Recommendations to Florida's Children and Youth Cabinet

The Child Death Data Review Workgroup is an ad hoc committee of Florida's Children and Youth Cabinet established to

- evaluate existing child death review processes among organizations within the state;
- improve communications, data sharing and collaboration across agencies regarding the investigation of child deaths; and
- recommend ways to improve the response to the investigation of child deaths.

The following workgroup recommendations are intended to directly address these goals.

Recommendation 1: Expand the state child death review process to allow review of all deaths of children up to 18 years of age and participate in the US National Child Death Review case reporting system.

Background: Florida's statewide child death review process is limited to child deaths that are reported to the Florida Child Abuse Hotline, subsequently investigated by the Department of Children and Families and formally "verified" by DCF as stemming from abuse. This limits the capacity of the Committee to both understand and identify trends in child deaths and construct strategies to prevent future fatalities. As most other states have found, the child death review process works best when the determination of trends and prevention strategies comes from the review of all child deaths. In addition, allowing the review of all child deaths would eliminate the time-consuming step where the Department of Children and Families, law enforcement, and medical examiners must complete their investigative activities before the case can be reviewed by the Committee. This frequently means a year or more passes before a child death can be reviewed.

We recognize that the DCF verification process provides an important service by prepping cases so that the statewide Child Abuse Death Review (CADR) Committee can receive cases in a consistent manner and format. However, national efforts have now produced a consensus child death dataset through the US National Child Death Review Case Reporting System. This system provides a form that can be easily implemented and used to log every child death in the state. The system also provides a secure national repository for the data that can yield vital information on state and national trends. This uniform dataset/form is currently available for use in Florida and would greatly streamline the review process. This uniform and universal data would help make the centralized review of all child deaths feasible and cost effective.

This recommendation requires statutory amendments to make the proposed "universal review" possible. This would include changing the statutory responsibilities of the Department of Children and Families in the child death review process. Current inter-departmental data-sharing agreements would also need to be changed. Permissive language that allows rather than requires the review of all child deaths would enable local communities or specialized statewide groups to examine potential trends as resources allow.

Recommendation 2: Endorse the Protect Our Kids Act as filed in the US Senate.

Background: The Protect Our Kids Act would create a commission to develop a national strategy and recommendations for reducing fatalities resulting from child abuse and neglect. This initiative represents a crucial step in the creation of an effective national child death review process. The identification of evidence-based best practices for all child death reviews would strengthen the implementation of the strategies discussed in Recommendation 1.

The bill has already received the formal endorsement of several child protection teams and organizations in the state. The act is jointly sponsored by Senator John Kerry (D-Mass.) and Senator Susan Collins (R-Maine), displaying the bipartisan nature of the initiative. The filing of a companion bill in the US House of Representatives is expected.

Recommendation 3: Support the reinstatement of the Sunshine Law exemption that allows child death case reviews to be conducted without being subjected to video or audio recording.

Background: Case reviews are confidential and not subject to Sunshine Laws, allowing information of a critical but sensitive nature to be shared candidly among committee members. Several years ago, Florida statute was changed to require the recording of committee case reviews. While these recordings may remain confidential, they limit the candor of participants when cases that are subject to criminal or civil court proceedings are discussed. The resulting lack of disclosure impedes the case reviews. The statutory recording requirement adds costs to the child death review process while providing little benefit and should be removed.

Recommendation 4: Support joint meetings of the state Child Abuse Death Review Committee, the Fetal and Infant Mortality Review program, the Pregnancy-Associated Mortality Review program and the Domestic Violence Fatality Review team at least annually to further discuss ways to better share data and information to prevent state resident deaths.

Background: The CDDRW received overviews of Florida's other three death review programs; the Domestic Violence Fatality Review, the Fetal and Infant Mortality Review and the Pregnancy-Related Mortality Review.

Florida's domestic violence fatality review process consists of 15 local domestic violence fatality review teams. Representatives from the teams from attend a statewide review meeting, and report on the types of cases they review. The local teams are autonomous and their reports often reflect differences in their operations as well as funding. For example, the Miami-Dade team is funded by the county with a full-time staff while other teams rely on volunteers from the various agencies to conduct the review.

Local fatality review teams are governed by Chapter 741, Florida Statutes. The statutes define a

domestic violence fatality review team, and provide guidance on membership and the types of cases reviewed by the team.

Florida's Fetal & Infant Mortality Review (FIMR) is a Department of Health-sponsored process of community-based fetal and infant mortality reviews aimed at identifying and addressing factors and issues that affect infant mortality and morbidity. The state FIMR program is based on the National FIMR model spearheaded by the American College of Obstetricians-Gynecologists. The knowledge gained through the reviews of fetal and infant deaths is used to empower local communities to lower fetal and infant mortality rates.

The FIMR process works through infant mortality committee of the local Healthy Start Coalition which provides an analysis of the basic statistical and epidemiological aspects of fetal and infant mortality, and then selects objectives, plans, and manages the review process. An expert review panel reviews and analyzes the findings of the interviews and record abstractions. A community review panel of local experts, representatives of the health department, hospital, and health professional groups, community leaders, school, civic and business leaders, and consumers work to implement the recommendations of the review panel.

The Pregnancy-Associated Mortality Review (PAMR) is a statewide review process created to improve the Department of Health's surveillance and analysis of pregnancy-related deaths in Florida. The program works to identify gaps in care and service delivery in order to improve the overall systems of care for pregnant women in Florida. PAMR's primary goal is to assure that all deaths identified as pregnancy-related deaths are reviewed.

The PAMR process identifies all deaths to women in Florida, from any cause, while she is pregnant or within 1 year of termination of the pregnancy regardless of duration and site of the pregnancy. Such pregnancy-associated deaths are identified utilizing linked data files from Healthy Start screens, birth certificates, death certificates, and fetal death certificates. Once pregnancy-associated deaths are identified, they are sorted by a physician/nurse subcommittee and initially deemed "pregnancy-related," "possibly pregnancy-related" or "not pregnancy-related." Through the utilization of a broader definition, as well as the increased sources of linked data, PAMR is able to assess more accurately the causes of pregnancy-related deaths in Florida.

Representatives of the statewide Child Abuse Death Review Committee, the FIMR program, the PAMR program and the Domestic Violence Fatality Review team currently meet jointly each year. Future discussions should focus on ways to better share data and information to prevent state resident deaths.

Recommendation 5: Identify additional funding sources for public-private partnerships to assist Florida's death review teams accomplish their identified goals.

Background: The Traffic Records Coordinating Council (TRCC) is a potential model for the administration of Florida's death review process. The TRCC provides a forum for the creation, implementation, and management of an omnibus traffic safety information system that provides accurate, complete, and timely traffic safety data is collected, analyzed to those agencies and individuals that need the information.

To accomplish this goal of data integration and availability, the TRCC maintains the authority to review Florida's highway safety data and traffic records systems while providing a forum for the discussion of highway safety data and traffic records issues. The TRCC representatives then report any issues back to the agencies and the organizations that create, maintain, and the data. The TRCC reviews and evaluates new technologies to keep the highway safety data and traffic records systems up-to-date.

Both the Department of Health and the Agency for Health Care Administration were represented on the TRCC Executive Committee. TRCC staff have offered assistance to the death review teams should they wish to pursue the establishment of a similar organization.

Recommendation 6: Seek assistance from Florida's medical licensing boards in the education of medical examiners of the needs of the various death review processes.

Background: Vital statistics data from death records can help child death review committees identify potentially suspicious deaths. For example, deaths of toddlers with drowning listed as the cause are often signs of neglect. Additionally, the child death review process has traditionally focused on the review of investigative findings of particular deaths. Effective child death review committees should be actively using this data and using it to identify and examine any suspicious cases. These types of examinations can further help the committees identify emerging trends in child deaths focus state and local resources in areas that can lower death rates.

These two issues form a persuasive argument for the adoption of the US National Child Death Review Case Reporting System of the review of all child deaths through the Statewide Child Abuse Death Review Committee. (See Recommendation 1)

However, different medical examiners often describe identical deaths very differently. However, inconsistent recording of cause of death by local medical examiners limits investigators' ability to capture all suspicious deaths through a data-based approach. The problem is exacerbated by lack of sensitivity or understanding on the parts of medical examiners to the fact that death records are being used in this manner. Medical examiners should be informed and educated about the needs of the death review process.

The advent of ICD-10-CM may help address these concerns as well. ICD-10-CM, the standard for describing and coding diseases and injuries in the rest of the world, is hyper-specific relative to the current ICD-9-CM system. ICD-10-CM should therefore provide significantly more information and, at least theoretically, force greater consistency in death records. ICD-10-CM is currently scheduled to be implemented in the US sometime in 2013 or 2014.

Recommendation 7: Pursue linkages with state university programs that share common or parallel goals to Florida's death review teams.