Louisiana State Child Death Review Panel

June 28, 2016 | 1 PM – 3 PM
Bienville Building Room 173, Baton Rouge, La

Attendees: See attached list

Agenda Items and Meeting Notes

Welcome to members/participants
Jane welcomed the group and reviewed the meeting structure with an open meeting for the 1st hour then a closed (members only) final hour for specific case review and recommendations. Dr. Parham Jaberi, the new Asst. State Health Officer will most likely replace Dr. Davis as the State CDR Chair. Welcome Dr. Jaberi.

Update on HB 494

- Amendment to revise CDR legislation 40:2019– has been signed by Gov.
    - Establishes ability to bi-directionally share info between CDR and DCFS
    - Updates legislation required membership – Office of Behavioral Health, Pediatric EMS, and Department Of Education now officially has a place at the table, and MCH Coalition has been replaced by La Partnership for Children and Families

Water Safety

- A letter was presented asking partners to engage in water safety efforts along with another partner agency between April and August 2016. Each region and OPH BFH Central Office experienced favorable response from partners for education, community awareness activities, free swim lessons, safety tools, social media, etc.

Vital Records

- Vital Records sent a communication to coroners informing them of this project. All cases that are likely ASSB but are coded as SUID will be sent back for confirmation. Cara working with Regional MCH Coordinators now on tracking of these cases for feedback to VR which will in turn reach out to Coroners about the noted cause of death and if there is any need to amend the Death Certificate.

Region 2 CDR and Bluff Road Fatalities

- A safety study was requested of DOTD and there is no update, but it seems like there is an inclination to improve the roadway. Highway Safety Commission rep. still needs to follow up.

Child Death Investigation Protocol Update

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    - Issues/system failure points and recommendations are presented in the handout.
        - Issue 1 – Removal – EMS needs to weigh in on this 1 – putting a pin in it, but Emily will wordsmith to remove the "shall" wording.
        - Issue 2 – Who investigates? – more of an education point than a change, but Emily can see if the AG office will render an opinion if this becomes an issue between law enforcement entities, the opinion will be readily available.
        - Issue 3 – Notification of coroner

- Issue 4 – Unrecognized Child Abuse and Neglect – curriculum has been developed for first responders to train them on how to investigate investigators. Develop a continuing education process for folks who have a lot of experience. Edit to match language in Children's Code
- Issue 5- Importance
- Issue 7 – Incomplete
- Issue 8 – Timeliness
- Issue 9 – Interpretation – Strike "Given the length of time required for tox…"
- Issue 10 – Cause and Manner of Death – change to plain old pathologist
- Issue 11 – Case Tracking
- Issue 12 – Mandated Reporting
- Issue 13 – Some deaths aren't investigated because they seem accidental before other CODs are ruled out
- Jane will make changes and recirculate to the group for review. Once group is satisfied with the content, the members will bring to their organizations for any input then dissemination to identified agencies.

Other

- Child Death Review Report (2012-2014) is complete.
- Partner Updates:
  - Women's Hospital does an event in April where they invite families back, and there are around 700 families invited back – probably a great opportunity to do swimming outreach
  - Shoutout to Chief Lentz for Operation Angel – opiate problem is increasing in St. Tam, and rather than arrest and incarcerate users, they're treating it like a disease and give folks rides to recovery centers instead of jail. Around 30 folks have already sought trx in St Tam. New Orleans Mission (faith-based) is offering folks trx and case management services. Just purchased a facility on the N Shore and have a couple hundred beds

Closed agenda portion of the meeting – group reviewed 3 SUID Cases

- Recommendations:
  - Connect with Sheriff's Association to clarify responsibility of who's case it is when a child dies in a rural area and is brought to the city hospital to die
  - Emily will speak with someone to see if they can request an AG opinion on who's responsibility this is
  - Coroner might be a good point of this contact for this problem of investigation
  - Look at how families are able to access home visiting – all tied to child's drug screen. Are they testing the right samples? Are there resources for kids who test negative, but the parents have a SUD?
  - Look at how families get access to drug treatment and mental health supportive services – even if baby is negative for substances, positive moms with SUD should get care and family will need parenting support
    - If mom is positive for substances, continue care for moms after 30d
  - MDI log can be used to track deaths, especially to see if parents have multiple safe sleep deaths

        - Onboard siblings to safe sleep too! Babysitting classes?
        - Have difficult conversations to prevent deaths
    - Will be tapping into group for help with Safe Sleep Awareness month (October)
    - Point of clarification: DCFS does offer home visits to age 2 for babies that test pos, and they do education on safe sleep and cribs, toddler beds, etc.

Next steps

- Update membership now that legislation is amended – Jane
- AG office to look at possible opinion on jurisdictional issues with investigations of child fatalities – Emily
- Revise Death Investigations Protocol recommendations and circulate - Jane

Meeting adjourned

Next meeting: September 27th, 1 PM – 3 PM.

- LDH Bienville Building, 624 N. Fourth Street, Room 173, Baton Rouge, LA (The room is on the 1st floor and is the same room as the June meeting.)
    - Free parking is available in the Galvez Garage on the corner of North and Fifth streets for all legislatively mandated panel members.
    - Bring in parking ticket to the meeting for validation.

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Public Health

Child Death Review Confidentiality Agreement and Sign-in Sheet
June 28, *2016*
1:00 PM – 3:00 PM

All information and case summaries discussed as part of the State CDR Panel are to be held in the strictest confidence. I agree not to remove case summary reports from this room or to discuss aspects the cases after the conclusion of this meeting. All case reviews are to be anonymous with no identifying information presented or discussed. If I think I recognize the case, I will not allow any identifying information to enter the discussion. I agree not to release any information obtained by the Child Death Review Panel to anyone, including but not limited to, the family or representative of the family of any child whose death was the subject of review, governmental authorities, the courts, and law enforcement.

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