

Child Fatality Review Needs Assessment: Findings from Local Teams



June 2017

Acknowledgements

The Office of the Child Advocate (OCA) would like to thank the co-chairs of the Massachusetts State Child Fatality Review Team, Dr. Henry N. Nields from the Office of the Medical Examiner (OCME) and Leonard Lee from the Department of Public Health (DPH) for their support of this project. We also thank Lisa McCarthy-Licorish (DPH) and Justine Egan (DPH) for working with us on this needs assessment. The OCA thanks the Massachusetts District Attorneys Association for their support of this project. Finally, the OCA thanks all of the Assistant District Attorneys (ADAs) and team coordinators for participating in this assessment. We especially appreciate how quickly the ADAs responded to OCA requests for interviews and the depth of the conversations during the interviews. The OCA believes that this is one reflection of the great level of commitment that ADAs and coordinators have to strengthening child fatality review in Massachusetts.

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I. Background

The Massachusetts Child Fatality Review program was established in 2001 following the passage of MGL Ch. 38, Section 2A. According to the statute, the purpose of child fatality review is to “decrease the incidence of preventable child fatalities and near fatalities” in the Commonwealth. The law requires that Massachusetts must have two types of CFR teams; local child fatality review teams (CFRTs) and a state child fatality review team.

Per the statute, local child fatality review teams are county-based and are responsible for the following: collecting and reviewing information on child deaths and near fatalities, developing a better understanding of the causes of these incidents, and crafting recommendations to change current policies or practices that could reduce these types of incidents in the future. The district attorney’s office in each county heads the local CFRTs.¹

The state child fatality review team is responsible for receiving recommendations from the local teams, understanding the number and causes of child fatalities and near fatalities across the state, and advising the governor, the legislature, and the public about appropriate changes to policy and practice in order to reduce the rate of child deaths and near fatalities.² The Office of the Medical Examiner (OCME) is the chair of the state team, and in 2010, the Department of Public Health (DPH) became the co-chair of the team. DPH provides the majority of administrative support, including support for the state child fatality review coordinator.

Both the state and local CFRTs take an interdisciplinary approach to their work that relies on interagency cooperation and collaboration. This approach allows the teams to get the best understanding of child deaths in Massachusetts and make informed recommendations aimed at protecting the Commonwealth’s children.

In early 2016, the state team decided to conduct a comprehensive needs assessment of the CFR program to determine the best ways to improve CFR at both the state and local levels. Figure 1 on the next page lists the general purposes of the Child Fatality Review Needs Assessment. By the end of this assessment, it is the goal that the state and local teams will apply what they have learned to develop better systems and structures for the entire CFR process. The findings presented in this report will hopefully serve as a step forward for all CFRTs so that as a Commonwealth, we can more effectively prevent child deaths in Massachusetts.

¹ M.G.L Chapter 38, Section 2A

² *Ibid*

Figure 1: Purposes of the Child Fatality Review Needs Assessment

1. Improve understanding regarding how each local team conducts its child fatality reviews.
 2. Uncover the shared strengths and common challenges faced by both the state and local teams.
 3. Identify the ways in which the state team can best support the local teams based on local teams' common challenges and concerns.
 4. Identify any changes the state team may need to make to its structure and operations in order to address its own challenges and concerns.
 5. Determine short and long term action steps that all teams can take to improve the child fatality review process and strengthen its impact in the prevention of child deaths.
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II. Initial Research

The Office of the Child Advocate (OCA), a mandated member of the state team, agreed to lead the needs assessment, which began in November 2016. As a first step, the OCA researched and reviewed reports and guidelines on CFR from several model states, including Colorado, Wisconsin, Washington, and Michigan (Colorado Department of Public Health, 2014, Children's Health Alliance of Wisconsin, n.d., Office of the Family and Children's Ombuds, 2016, www.keepingkidsalive.org). The model states were identified through conversations with the National Center for Fatality Review and Prevention (NCFRP). This review provided the OCA with a greater understanding of many aspects of the review process in each state, such as which agencies chair the meetings, what the team member responsibilities are, and the specific processes for case selection and data collection. Learning from other states not only helped the OCA understand some of the best practices in child fatality review, but these materials also helped shape the key questions asked during this part of the assessment.

In addition to reviewing other states' procedures, the OCA also carefully reviewed the Program Manual for Child Death Review from the NCFRP, formerly the National Center for Child Death Review (NCCDR). This manual provides "strategies for developing or managing a state or local CDR program," and these strategies are based on best practices from around the country (NCCDR, 2005, p.2). The manual includes detailed information on the core functions of child fatality review teams, how to select cases for review, issues of confidentiality, and how to take

action based on information obtained from reviews. It also includes guidelines on how to evaluate a CFR program (NCCDR, 2005).

III: Methods

This needs assessment is being conducted in two phases. The first phase is the local teams' needs assessment, which is the basis for this report. The second phase will be the assessment of the state team. The OCA and DPH decided to begin the local needs assessment by interviewing all 11 local team leaders. In this report, the term "team leader" primarily refers to the Assistant District Attorneys (ADAs) who are in charge of their local CFRTs. In one case, the individual we interviewed was not an ADA, but served as one of the leaders of their team, so we count that person as a team leader for the purposes of this report. Team leaders' experiences in organizing and conducting reviews, as well as their on-the-ground knowledge about the issues facing their teams and communities, are critical to optimizing CFR throughout the state. In addition, conducting in-depth interviews with all teams would ensure that the OCA captured local teams' processes, strengths, challenges, and insights from across the Commonwealth.

The OCA, in collaboration with DPH, developed a comprehensive list of interview questions for local team leaders. These interview questions were designed to address the key questions for the local needs assessment, which are listed in Figure 2. Once complete, the OCA sent the questions to the Massachusetts District Attorneys Association (MDAA) for review.

Figure 2: Key Questions for the Local Needs Assessment

1. How are local teams conducting their child fatality reviews? What are the steps that team leaders and coordinators must take to prepare for the meeting, conduct the review, and craft recommendations?
2. How do local team leaders and coordinators describe their team's strengths?
3. What are some of the common challenges that local teams are facing?
4. From the local perspective, how can the state team better support the local teams in their efforts?

The OCA then contacted team leaders via email to request their participation in the interview. The interview questions were attached to the email for their review, as well as a short survey that the OCA asked team leaders to complete and return prior to their interview. Both the interview questions and the pre-interview survey can be found in the appendix.

Team leaders were invited to ask other staff members to participate in the interview if they might be able to address some of the interview questions. The OCA completed 10 out of 11 interviews between February 1, 2017 and April 30, 2017. The same two OCA staff members were present for 9 out of 10 of the interviews. Most of the interviews were conducted in person, with two conducted via conference call. The OCA spoke with a total of ten team leaders and six team coordinators. Team coordinators are the administrative assistants, paralegals, and other staff members who provide administrative support for their local CFRTs. In most cases, the OCA conducted joint interviews when both the team leader and team coordinator were participating. The interviews lasted between 45 minutes to 1 ½ hours, with most interviews lasting about an hour.

At the beginning of each interview, OCA staff members explained the purpose of the needs assessment to all interview participants and explained the confidentiality procedures. After each interview, the two OCA staff members debriefed to determine if we captured and understood participant responses in a similar way. We also used this time to identify any gaps in knowledge and check for any discrepancies in what was reported during the interview compared to what we had observed at local team meetings. While the OCA is not a statutorily mandated member of the local CFRTs, staff members regularly attend team meetings for all active local teams.

Debriefing after each interview and comparing how participants' interview responses compare with observations both serve as checks on the validity of a study (Mertens and Wilson, 2005). Validity means "the correctness or credibility of a description, conclusion, explanation, interpretation, or other sort of account" in a research study (Maxwell, 2013, p. 122). Peer debriefing is one way to help ensure that researcher bias and other issues are not interfering with the interpretation of participants' responses (Mertens and Wilson, 2005, Maxwell, 2013). One OCA staff member also wrote entries in a research journal after each interview to note any major themes or issues that came out of the discussion (Maxwell, 2013). The research journal served as an additional data source and validity check on the conclusions drawn in the analysis.

After the debriefing, participants' interview responses were entered into a data matrix for analysis. A data matrix is a tool which helps organize data by important categories (Maxwell, 2013). The findings in this report are based on the analysis of the data matrix, entries from the research journal, and the OCA's observations at local team meetings.

IV: Findings

Local team snapshot

Based on the pre-interview survey, this snapshot provides highlights about local teams and their leadership. First, the survey showed that seven of the local teams held their last CFRT

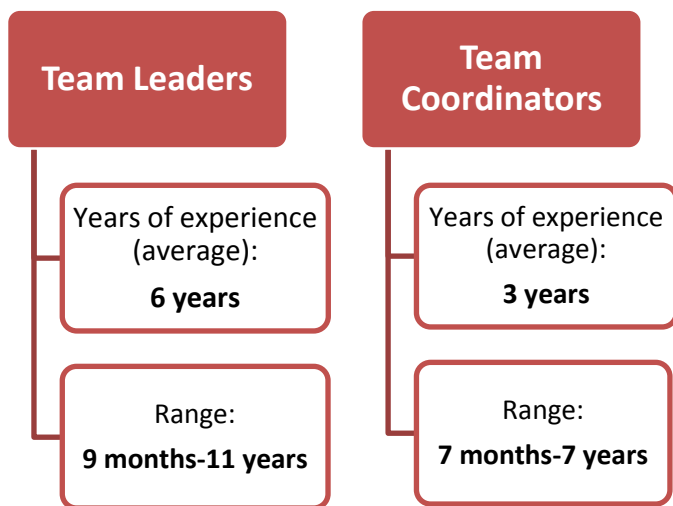
meeting within the past year. However, there were two teams that had not met since 2015, and one that had not met since 2014. In these cases, the OCA asked team leaders to answer the survey and interview questions to the best of their ability. After their interviews were complete, two of these three local teams scheduled a meeting in the spring of 2017, which was a very positive outcome this needs assessment.

The OCA wanted to know how often local CFRTs met in a given year. The statute requires that local teams meet at least four times a year. However, the survey showed that the teams have different meeting schedules, as shown in Table 1. Half of the teams are or were meeting on a quarterly basis, but three others aimed to meet between two and four times a year. In these cases, team leaders explained that they have fewer meetings because sometimes there are no cases available for them to review. Finally, when it was active, one team was meeting once a month.

Table 1: Frequency of Local CFRT Meetings

Frequency of Meetings	Number of teams
Quarterly	5
2-3x a year	2
Monthly	1
Bimonthly	1
3-4x a year	1

Figure 3: Experience in Leading Local CFRTs



Lastly, the survey showed that local team leaders and coordinators have significant experience in managing and organizing CFRTs. As Figure 3 shows, team coordinators have an average of three years of experience, and team leaders have an average of six years of experience.

Learning by Doing

At the beginning of each interview, the OCA asked team leaders and coordinators to explain how they became involved with child fatality review. The majority of team leaders (8) said they were responsible for leading their teams because of their roles in the District Attorney’s office. Team leaders are often the Chiefs of the Child Abuse Unit in their office, and the person in this

role has traditionally been assigned to lead the county's CFRT, among their other responsibilities. Team coordinators are often administrative staff or paralegals, but in rare cases, they are other ADAs. In half of the cases (5), the coordinator's child fatality review responsibilities are a part of their job description, but in other cases, the coordinator responsibilities are added on top of other responsibilities. Finally, several team leaders mentioned that they personally selected their coordinators based on the person's strong organizational skills.

The OCA also asked leaders and coordinators if they were given any background materials about the CFR process before taking on their leadership roles. We found that coordinators tended to receive more information than team leaders. Two coordinators said that the previous coordinator organized materials for them to review, and four others reported that they received direct training on their CFRT responsibilities from the person who previously held the position.

In contrast, only one team leader said that they had received any background materials, which was a memo from the previous leader. The majority of team leaders (9) reported that they had not received any kind of background information on the CFR process when they started. In these instances, team leaders used a variety of methods to learn about CFR, including referencing the statute, attending other local team meetings, and reviewing existing documents in their office. Some team leaders served as team members before assuming their leadership position, so in these cases, they used their experience as a team member to inform how to run the meetings. Finally, for those team leaders who were involved in the creation of the legislation, they reported that being involved in that process helped them learn how CFRTs should function before they began the task of building their own teams. In short, most of the current team leaders have taken the initiative to train themselves on how to build and manage CFRTs.

What Teams Have in Common: Administration/Operations

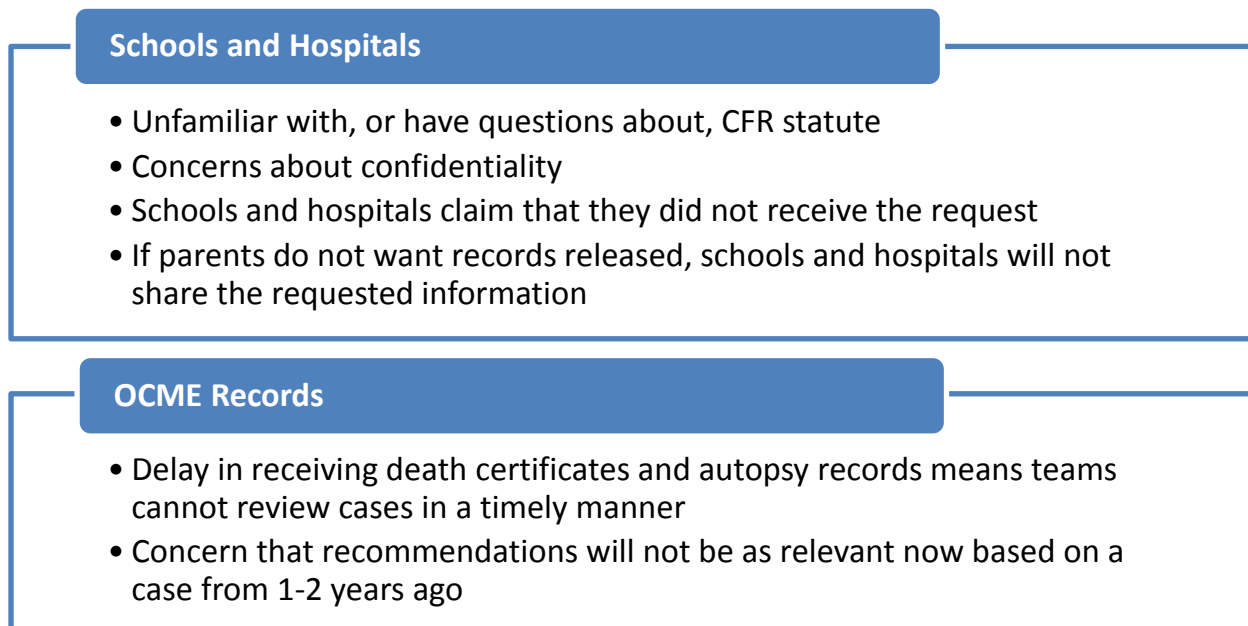
The OCA asked team leaders and coordinators to describe their team's CFR process. Overall, we found that local teams have many administrative similarities in terms of how they prepare before the meeting, what happens during the meeting, and what follows after the meeting.

Before the Meeting

Once teams select the cases that they are going to review, the next step for all teams is to collect relevant records for each case. The most common records used in CFR include the death certificate, autopsy report, medical records, Department of Children and Families (DCF) records, police reports, school records, and ambulance records. The team coordinator requests the records by mail, email, and/or phone calls. In addition to collecting similar records, team

leaders and coordinators also identified some common challenges in obtaining certain records, as can be seen in Figure 4.

Figure 4: Common Challenges in Record Collection



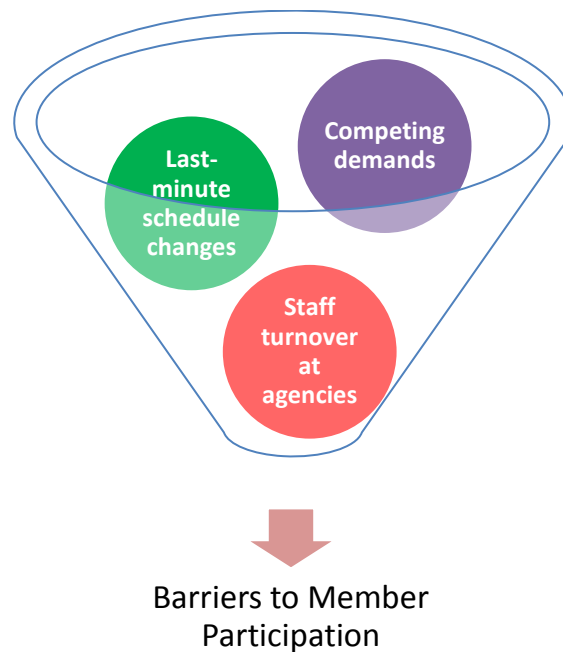
Schools and hospitals’ confusion about the law, including questions and concerns about confidentiality, can mean delays in obtaining relevant records. Sometimes team coordinators are not able to access the records at all. This confusion also adds additional work for coordinators as they have to repeatedly follow up to explain the reason for the records request in order to get the information they need for the review. In rare cases, two team leaders said that they have gone to court to obtain records or are willing to go to court if necessary, which is permissible per the statute.

During the Meeting

Agendas for the CFRT meeting typically include the child’s name, date of birth, and date of death. Two teams include a summary of each case, and two other teams also include the immediate cause of death. On the day of the meeting, almost all teams require members and guests to sign in, and the sign in sheet serves as the confidentiality agreement. Most team leaders (7) reported that they had “consistent” or “constant” attendance by their core members, meaning the members that are required to attend by statute. Most team leaders (7) also reported that at some point, their teams had invited experts to their meetings to speak on specific subjects, including maternal health and suicide prevention. Finally, based on OCA observations, sometimes teams invite others who knew the deceased, such as guidance counselors or responding police officers.

Even with generally good attendance, there are some common challenges in ensuring consistent member participation. First, half of the team leaders reported that they did not have any representation from the juvenile courts, which is required per statute. Several team leaders also reported less consistent attendance from the medical examiner's office, attributing this to changes in staff and scheduling challenges. In addition, two leaders noted that sometimes doctors could not attend because of their schedules with patients, and two others team leaders said that sometimes they could not attend CFRT meetings due to their trial schedules. In these cases, the coordinator would facilitate the meeting. As shown in Figure 5, competing demands, last-minute schedule changes, and staff changes within agencies combine to create barriers to consistent member participation.

Figure 5: Barriers to Local Team Member Participation



Once team members are signed in and are ready to begin reviewing cases, some differences between the teams start to emerge. The first difference is in regards to the availability of case records. Half of the teams make copies of the records for each case for every team member. Two other teams make a single copy of records available for team members to review if they wish, and one team does not make copies of the case records at all.

At the beginning of each meeting, three teams spend the first part of their meeting asking members to review the records for each case. Reviewing the records can take between 30-45 minutes, and once team members are finished, two of these teams immediately begin the discussion about the cases. Three other teams begin with the team leader or coordinator

presenting a summary of each case before the discussion. Finally, four teams rely on other team members to introduce each case. This member is typically a police officer or a doctor, and the police officer may or may not be the responding officer for the case. However, one team asks team members to select a case when they arrive, and once each team member has reviewed the records for their case, each member summarizes their case to the team. While some of these differences may stem from leadership styles and the history of each team, it is important to remember that team members' understanding of each case will depend, at least in part, by how cases are initially presented.

Once the introduction of the case is complete, the remainder of the meeting generally proceeds the same way across teams. Team members contribute additional information about each case based on their area of expertise and/or agency involvement in the child's case. Team members ask questions about the different cases, and ideas for recommendations are developed during the discussion. Finally, teams decide by consensus which of their recommendations will be sent to the state team.

After the Meeting

After the meeting, recommendations are sent to the state team by either the coordinator or the DPH representative, and about half of the teams say that they send these to the state within one to two weeks. When the OCA asked leaders and coordinators how teams decide which recommendations go to the state, over half (6) said that all of their recommendations were sent to the state. The remaining teams made some distinction between which recommendations could be implemented at the local level and which should be sent to the state, but implementation at the local level is challenging due to limited resources. While some individual team members have engaged in local actions (e.g. a team member distributes safe sleep information at a health fair), only two teams have taken action as the local CFRT.

For most teams, sending recommendations to the state is the last step in their CFR process. However, for three teams, there is one more component, which is entering case information into the National Child Death Review Case Reporting System database. The coordinators from these three teams reported similar challenges with the database. One, entering information into the system is extremely time-consuming. Two, the system requests a lot of information that is often not available. Finally, one coordinator reported not being able to retrieve information from the database, and another question the system's ability to produce meaningful reports, especially in places that review relatively small numbers of child deaths.

Where Teams Diverge: Case Selection

In terms of case selection, local teams have two things in common. First, teams are not regularly reviewing near fatalities, as there is no system in place for identifying these cases. Second, most teams do not review a child death that is, or could ever be, subject to prosecution. Despite the confidentiality provision of the CFR statute, team leaders feel that a CFR might result in discovery obligations to a defendant. Some teams will review a child death if the prosecution is complete and the defendant has died or there is very little likelihood of an appeal. Other teams will never review a child death for which there was, or could be, a prosecution. This means that there are many cases, including most child abuse and neglect cases, which are never reviewed and are therefore missing from CFRTs' understanding of how children die in Massachusetts. Massachusetts is the only state in the country that restricts case reviews in this way.

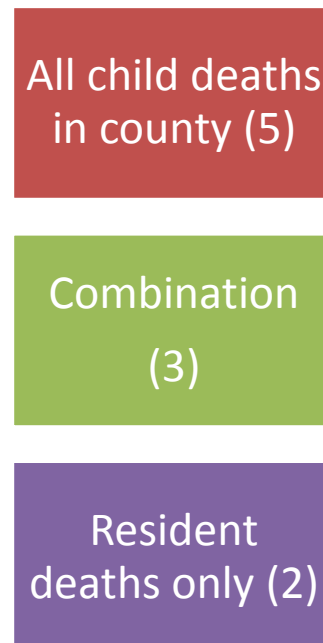
Beyond these two similarities, there are major differences in how, and why, teams choose which cases to include for review, and these differences have important implications for the CFR process.

Case Selection by Residency

Teams have very different processes for deciding which cases they will review based on the child's residency, which can be found in Figure 6. Five team leaders reported that they review all child deaths that happen in their county. Three of these leaders describe this as having an incident-based system, meaning that if the incident preceding the death happened in their county, then they will review it, regardless of whether or not the child lived in their county.

Three team leaders said that they select a combination of cases based on residency, such as reviewing residents and nonresidents in the county and residents who die outside of the county. Finally, two team leaders reported that their teams only review resident deaths, even if the death occurs in another county. If a child dies in their county who is not a resident of their county, they will not review it.

Figure 6: Case Selection by Residency



Half of the teams reported that they are in contact with other teams if there is ever confusion about who should review which case, and sometimes teams have conducted joint reviews. While it is good that teams are in communication with one another, in order to clarify roles, save time, and ensure no cases are missed, there should be a common understanding regarding residency for all teams. During a conference call with the National Center for Fatality Review and Prevention team, NCFRP said that all teams in the state should operate under the same set of residency guidelines, and that the best practice is for all teams to work under an incident-based system. The Massachusetts CFRTs must decide whether or not we should move to an incident-based system, keeping in mind that one potential challenge of this may be ensuring that death certificates are sent to the correct team for review.

Case Selection by Purpose of CFR

Local teams are including different kinds of cases in their CFRs. For instance, some teams review medical cases while others do not, and some review newborn deaths and others do not. Prior to this needs assessment, it was not clear why the local teams were so different from each other in this regard, but there was hope that this process could shed some light on this issue. The interviews with leaders and coordinators ultimately revealed that the differences in local teams' case selection appear to be driven by different understandings of the purpose of child fatality review.

The OCA asked each team leader and coordinator to describe how they viewed the purpose of conducting child fatality reviews. The responses fall into four categories, and the important elements of each group's understanding of purpose are listed in Figure 7. Half of the teams fall into the "General Prevention" category, and the rest of the teams are distributed between the remaining three groups. These differing philosophies shape important aspects of case selection and the key questions team leaders are trying to address during each review.

Figure 7: Purpose of Child Fatality Review for Local Teams

General Prevention	Identify Patterns	Prevent Patterns	Team-Member Focused
<ul style="list-style-type: none"> • Review child deaths • Make policy/program recommendations to prevent future child deaths 	<ul style="list-style-type: none"> • Review <i>every</i> child death • Identify trends • Make recommendations • Improve collaboration between agencies 	<ul style="list-style-type: none"> • Review <i>every</i> child death • Team members contribute based on areas of expertise • Identify how to prevent future deaths • Identify problems <i>before</i> they become patterns 	<ul style="list-style-type: none"> • Bring people together who are best suited to discuss children's issues • Come to a consensus on trends or on recommendations for the state.

First, teams in the “General Prevention” category see prevention as the primary purpose of CFR, and therefore focus their energy on preventable deaths. As can be seen in Table 2, these team leaders and coordinators collectively identified the most restrictions on the types of cases that they will review. These teams also review a sample of cases instead of all child deaths that occur in their jurisdiction, and these samples do not necessarily include all preventable deaths. Cases are chosen based on a number of factors, including the likely availability of records and trying to selecting those cases where the local CFRT can have the most impact. Some teams also choose cases by topic, meaning one meeting may focus on suicide cases while another focuses on safe sleep. Finally, the key questions that these teams address during the reviews align closely with their stated mission, and therefore focus on whether the death was preventable and what interventions may prevent similar deaths in the future.

Teams in the “Identify Patterns” category all state that the purpose of CFR is to review *every* child death, which is the primary difference from the “General Prevention” group. These team leaders and coordinators identified fewer restrictions on case selection, with one team reporting no restrictions at all. As such, these teams tend to review both preventable and non-preventable deaths, such as complex medical cases. Finally, these team leaders and coordinators identified additional key questions that align with their purpose, including not just questions about prevention and interventions, but also if there were any risk factors present in

Table 2: Differences in Local CFRT Case Selection by Understanding of Purpose

Purpose Category	Case selection restrictions	Review all cases?	Key questions addressed
General Prevention	No obvious medical deaths or limited medical deaths No premature newborns No children under 1	No - select a sample based on different factors (e.g. topic, availability of records).	Was the death preventable? What can we recommend to prevent future deaths?
Identify Patterns	Limited medical deaths No premature newborns	Review almost all cases	Was the death preventable? Are there any trends? What risk factors are present? What recommendation can we make?
Prevent Patterns	None	Review all cases	What are the circumstances of the child's death? Identify issues before pattern emerges
Team-Member Focused	No premature newborns No children under 1	Review almost all cases	What does the case tell us? Is the death preventable?

the case and/or are any trends emerging in their county.³ Trends or patterns tend to be identified through institutional memory.

³ This is not meant to imply that teams outside of the “Identify Patterns” group do not consider risk factors or look for trends in their reviews. Many of them do. However, the analysis above is based on team leaders/coordinators’ responses to two specific interview questions aimed at identifying both purpose and priorities during the CFR process. Some teams identified trends as a priority, while others identified other aspects of CFR as most important, which is what is being described here.

In the “Prevent Patterns” category, there are no restrictions on case selection, which aligns with their stated purpose of reviewing every child death. In addition, since the goal is to identify patterns before they emerge, that additional key question is added to their reviews. Finally, in the “Team Member Focused” category, since their purpose focused more on collaboration between agencies, there was less of a connection between purpose and case selection process. Their restrictions are similar to those in the “Identify Patterns” group, but their key questions align more with the “General Prevention” group.

These differences in understanding of purpose, and the ways in which they affect case selection, are important for a number of reasons. First, differences in case selection can shape the kinds of patterns or trends that teams are able to identify, and these trends may or may not reflect the most important child safety issues in the community. Second, differences in case selection and the key questions addressed in reviews can shape how teams craft their recommendations. These different types of recommendations may or may not align with how the state team understands the purpose of CFR and/or the state team’s desired impact on policy change. Finally, the ways in which team leaders and coordinators see their purpose may be linked to the pervasive issues of limited time and limited resources. For instance, some teams with an overwhelming number of cases to review may focus on prevention in their purpose, and select smaller samples for review, because they do not have the time to review every case. Meanwhile, some teams that see the purpose as reviewing all child deaths may be able to do so due to having fewer cases and/or more resources available for reviews.

It is critical that state and local teams come together to identify a common purpose for CFR in the Commonwealth. It will be very difficult for the state team to create any new guidelines for local teams without articulating a clear purpose that will drive guidance on many aspects of CFR, from case selection to crafting recommendations. Developing this common purpose will involve answering two different types of questions. First, the legal question asks what the purpose of CFR is according to the statute. Second, the philosophical questions ask us why we are doing child fatality reviews beyond what is required in the statute. In other words, at the state and local level:

- What goals are we trying to achieve through child fatality review?
- What are the different steps all team should take to take to achieve those goals?

Having all teams, state and local, in agreement on our purpose will help us accomplish our shared goal of preventing child deaths in the Commonwealth.

V: Strengths and Challenges

Strengths

The OCA asked team leaders and coordinators to describe their teams' strengths and share what their teams do well. Two common responses stood out: the ability to sustain themselves, and the high level of engagement and commitment from their local team members. Over half of the teams (6) reported that one of their greatest successes is the fact that they have been able to meet consistently despite a lack of resources. In addition, the majority of team leaders (8) said that one of their greatest successes is that their team members are engaged and have good working relationships with one another. There is good attendance and strong support from core team members, and team members are invested in improving the CFR process. Team leaders, coordinators, and members have worked together to create environments where everyone feels comfortable expressing their opinions. Even when there are disagreements, the end result is still positive in that everyone on the team is learning from one another.

Challenges

When asked about challenges in CFR, team leaders and coordinators identified three interrelated challenges that their teams face, which can be seen in Figure 8. First, the amount of time that it takes to prepare for a CFRT meeting is one significant challenge, including the time it takes to obtain the necessary records for review.

Figure 8: Common Challenges for Local CFRTs



Another common issue is competing priorities. For team leaders and coordinators, CFR is competing with other priorities in their District Attorney's office. These priorities primarily include prosecution, but also involve other projects like CSEC (child sexual exploitation cases) that are top priorities and consume office resources. There is often not enough time to focus on CFR given other priorities in the office. For team members, they are participating in CFR in addition to their regular job responsibilities and on top of their own competing priorities. As noted earlier, this can make it challenging for team members to attend meetings, especially for those who participate on multiple teams.

Finally, the biggest challenge for local teams is the issue of staffing. Team coordinators are doing an incredible amount of work to prepare for CFRT meetings, and they are a critical part of sustaining CFR in the Commonwealth. To paraphrase several team leaders, without the dedication and organizational skills of the team coordinators, CFRT meetings would not happen at all. However, many of the coordinators are taking on these responsibilities as just one part of their job, even if it is not officially in their job description. Given how time-intensive this process can be, several team leaders expressed an interest in having a full-time coordinator for their team. While many District Attorneys show their support of CFR by funding a part-time position, there is often not enough available to fund a full-time person, especially given the aforementioned competing priorities.

Though only one team specifically mentioned that CFR is an unfunded mandate, the threads that tie all three of these challenges together are time limitations and a lack of resources for local CFRTs.

VII. Recommendations and Action Steps

Local Team Recommendations for State Team

Despite these challenges, team leaders and coordinators are generally happy with their CFR process and believe that their teams are doing well. However, team leaders also report feeling unsure as to whether or not their teams are meeting the state's expectations. This is a difficult issue for team leaders to address because it is not clear what the expectations are from the state team's perspective.

In addition, there is recognition from several team leaders that the state team is also not funded and will not be able to help with certain kinds of challenges, like granting money for staff support. However, leaders and coordinators had many other ideas for recommendations, including about how the state team could help them manage their time more effectively and ensure that the results of their reviews are meeting the state's expectations. These recommendations can be found in Figure 9.

Figure 9: Recommendations for the State Team from Local Team Leaders and Coordinators

Provide information and resources on common issues

- Create a list of resources that local teams can use to address common issues (e.g. safe sleep, suicide prevention).
- Develop a list of experts that local teams can contact if they want a guest speaker on a specific topic. This list should include which experts are willing to travel to different parts of the state.
- Share best practices, both from other local teams and from across the country.

Improve communication with local teams

- Give feedback and updates to local teams, especially in regard to the status of their recommendations
- Provide the local teams with information and updates on the state team's activities.
- Assign state team members to serve as liaisons to the local teams. State liaisons would attend local team meetings to share any news from the state team, and then would share any information or questions with the state team.

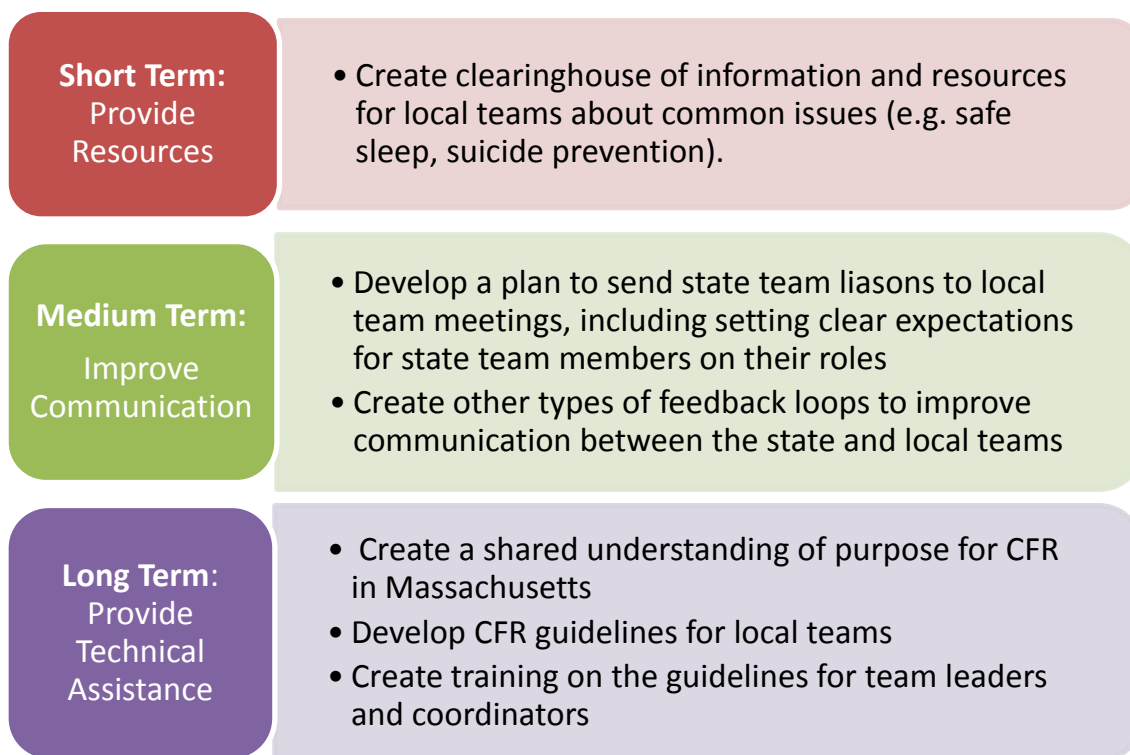
Provide technical assistance for local teams

- Develop guidelines for local teams that clearly articulate the state team's expectations in terms of case selection, case review, and desired outcomes.
- Develop training opportunities and tools for local teams, including training on any new guidelines to ensure consistency across teams.

The recommendations from team leaders and coordinators address some of the key issues identified in this report. For instance, developing lists of resources and experts can build local teams' capacity to take action at the county level. In addition, these resources will also save teams time, as team leaders and coordinators will not have to look for information on their own. Providing technical assistance and clear lines of communication between the state and local teams will help clarify questions of purpose, questions regarding residency, and expectations regarding desired outcomes. Open lines of communication, guidelines, and trainings will also save teams time in the long run, as they will be better able to manage their time knowing what they should and should not focus on for their reviews.

Based on these recommendations and the other findings in this report, there are several action steps that the state team should take based on the recommendations of the local CFRTs. Figure 10 divides these steps into short term, medium term, and long term actions.

Figure 10: Action Steps Based on Local Team Recommendations



The most immediate step the state team can take is to develop a clearinghouse of information on common issues that local teams face, such as sudden unexpected infant death and suicide prevention. All teams will begin this process at the Massachusetts State Child Fatality Review conference in June 2017. State and local team members will be asked to share information on resources that they have used or are aware of, and will also ask team members to share information on experts that may be willing to visit local teams to talk about different issues. This information will be collected by the state team and serve as the foundation for this clearinghouse. Future resources could include standard documents for use by all local teams, such as form letters for requesting records from hospitals and schools.

In the medium term, the state team should discuss how state team liaisons might operate. This may take more time than the clearinghouse, as the state team will have to determine what the expectations would be for state team members in this role, how to assign state members to different teams, and potential challenges for state team members. It will also take time to generate ideas about other ways to improve communications between the state and local teams.

Finally, the state team will need additional information before it can begin addressing the long term steps. This will begin in the next phase of the needs assessment, which will be to conduct surveys and interviews with state team members. This part of the assessment will ask similar questions regarding state team members' understanding of the purpose of CFR and how they understand their roles as team members. Once all of this information is collected, responses from the state and local teams can serve as a basis to develop an overarching purpose statement for CFR. The state team will also have to consider how to get feedback on any proposed purpose statement.

Once the purpose is finalized, the state team can begin to develop CFR guidelines and trainings for local teams based on best practices and findings from the needs assessment. Driven by the purpose statement, these guidelines can provide specific information regarding how teams should select their cases, the key questions they should address, best practices on how to conduct CFR meetings, and the state's expectations for crafting recommendations. The state team will have to make decisions along the way regarding certain issues identified in this report, including how local teams should select cases by residency and whether or not all teams should participate in the National Child Death Review Reporting System. It will be a delicate balance to develop guidelines that provide more structure for local teams while also allowing them the flexibility to run their meetings in a way that best suits local needs. As such, communication between state and local teams will be critical in this process.

As with any research project, this needs assessment has its limitations. For instance, the OCA was not able to interview all 11 teams, so we do not have all teams' experiences included here. In addition, not all coordinators were included in the interviews, so we have not captured the full experience of those who are managing the administrative aspects of CFR. Finally, due to time limitations, the OCA was not able to interview other local team members, who may have different perspectives regarding the strengths of their teams, the challenges they face, and the best ways for the state team to support the local teams. That said, this needs assessment is ongoing, and the OCA welcomes any feedback on progress and the findings thus far, which we can then incorporate into the final report once the entire needs assessment is complete.

Moving forward, the OCA, with assistance from DPH, will focus on data collection and analysis for the needs assessment for the state team. A second report will combine the recommendations from this report with the results of the state team assessment to develop a comprehensive list of actions that all teams can take to improve and strengthen child fatality review in the Commonwealth. The assessment of the state team will begin in the summer of 2017.

Appendix

I: Massachusetts Child Fatality Review Team Members

Mandated State Child Fatality Review Team

- Chief Medical Examiner (Co-Chair)
- Commissioner of Dept. of Public Health, or designee (Co-Chair)
- Attorney General, or designee
- Commissioner of Dept. of Elementary and Secondary Education, or designee
- Commissioner of Dept. of Mental Health, or designee
- Commissioner of Dept. of Developmental Services, or designee
- Commissioner of Dept. of Children and Families, or designee
- Commissioner of Dept. of Youth Services, or designee
- Representative of Mass. District Attorney's Association
- Colonel of Mass. State Police, or designee
- Director of Mass. Center for Sudden Infant Death Syndrome (SIDS), or designee
- Representative of the Mass. Chapter of the American Academy of Pediatrics with experience in child abuse and neglect
- Representative of the Mass. Hospital Association
- Chief Justice of the juvenile division of the trial court, or designee
- President of Mass. Chiefs of Police Association, or designee
- The Child Advocate, or designee
- Other individuals with information relevant to cases under review

Mandated Local Child Fatality Review Team Members

- District Attorney of county (Chair)
- Chief Medical Examiner, or designee
- Chief Justice of the juvenile division of the trial court, or designee
- Commissioner of Dept. of Public Health, or designee
- Commissioner of Dept. of Children and Families, or designee
- Director of Mass. Center for Sudden Infant Death Syndrome (SIDS), or designee
- Pediatrician with experience in child abuse and neglect
- Local police officer from the community where the fatality occurred
- State law enforcement officer
- Other individuals with information relevant to cases under review

II. Interview Questions

Background:

1. How were you chosen for this role? (If team leader doesn't specify: Did you volunteer or were you asked to lead the team by a colleague/supervisor?)
2. When you first started, were you given any background materials about Child Fatality Review Teams in general, or any specific information about how to run a local meeting?
 - a. If yes - what kind of information were you given?
3. How would you describe the purpose of holding local CFRT team meetings?
4. On your team, are all of the statutorily-required positions filled?
5. Has your team added any additional positions based on local needs (e.g. substance abuse experts, school resource person, etc.)?
6. Are there additional expert roles that are needed on your team? If so, which ones?

Meeting Process – Before the Meeting

1. How does your team decide which cases it is going to review?
2. Has your team ever considered reviewing near fatalities in addition to fatalities?
 - a. If yes, what have been some of the challenges in reviewing near fatalities?
3. What kinds of records do you collect for each case?
4. How do you collect records for each case?
5. Do you share case information prior to the meeting or do you wait to share case information during the meeting?
6. How do you manage confidentiality agreements? Do you ask each team member to sign one per year, sign a document at each meeting (e.g. on the sign-in sheet), or do you have some other process?

Meeting Process – During the Meeting

1. Does everyone on the team typically attend meetings, or have you noticed that there are representatives from certain agencies who tend to attend more consistently than others?
2. What types of cases does your team review? (e.g. deaths only occurring in your county, non-resident deaths occurring in your county, residents of your county whose deaths occurred elsewhere)
3. Can you walk me through the process of how you review each case?
4. Are there particular questions about each case that you try to address in the review?
5. How does the group decide on local recommendations?
6. Have you ever had outside experts come in to talk to the group? If so, who and how often?

Meeting Process – After the Meeting

1. What is the process for deciding which recommendations should be sent to the state team?
2. How long does it typically take to provide recommendations from the most recent local meeting to the state team?
3. Does your local team have a signed data use agreement to participate in the National Child Death Review (CDR) case reporting system?
4. Do you, or does someone on your team, enter any data from your local meetings into the National CDR case reporting system?
 - a. If so, what do you see as the benefits of using this system?
 - b. If not, what are some barriers to using this system?
5. Have you ever searched for resources on the NCCDR website?
 - a. What kinds of resources were you looking for?
 - b. Where you able to find the information that you needed?
6. Do you implement any recommendations at the local level? If so, how?

Assets/Challenges

1. What do you see as your team's biggest accomplishments or successes?
2. What are some things that you think your CFRT does well?
3. What would you say are the primary challenges facing your CFRT team?
4. Has your team taken any steps to meet some of these challenges?
5. Do you have any ideas about the ways in which the state level team can assist you in addressing those challenges?

Wrap-Up

1. As we move forward, are there other members of your CFRT team you think we should talk to?
2. Do you have anything else about your CFRT, or the state CFRT, that you would like to add that we didn't ask about?

III. Pre-Interview Survey

Instructions

Please fill out this questionnaire *prior* to your interview for the needs assessment. When identifying which team members are responsible for certain tasks, please be sure to include the team member's name and their agency. If you have any questions regarding this questionnaire, please contact Lindsay Morgia at the OCA (lindsay.morgia@state.ma.us). The OCA will gather your questionnaire on the day of your interview.

Questions

Local leader name: _____ County: _____

1) How long have you served as the leader of this CFRT? _____

2) How often does your team meet? _____

3) When was the last time your team met? _____

4) Who writes the agenda for each meeting?

5) Who sends out the agenda for each meeting?

6) Who facilitates the team meeting?

7) Who serves as the note-taker for each meeting, if you have one?

8) Who reports a summary of the meeting to the state team?

9) Who sends the recommendations and action items to the state team?

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