State Child Fatality Review and Prevention Team Meeting

Thursday, May 12, 2022
08:30 AM – 12:30 PM

Join ZoomGov Meeting
https://www.zoomgov.com/j/1606037072?pwd=eVo2SmV6RWROdzlDZ0tlQWR4ZnNHQT09

Call-in: 669-254-5252
Meeting ID: 160 603 7072
Passcode: 265515

Members attendance at May meeting					
Name	**Role**	**X**	**Name**	**Role**	**X**
Laura Chisholm, PhD, MPH, MCHES, co-chair	OHA, Public Health, Injury & Violence Prevention		Cate Wilcox	OHA, Public Health – Maternal & Child Health	
Deb Carnaghi, LCSW, CCISM, co-chair	ODHS, Child Welfare	X	Annette Lopez	OHSU – Toxicologist	X
Sherri Alderman. MD, MPH, IMH-E, FAAP	CDC Act Early Ambassador	X	Aileen Dulduao, PhD	Multco Health Dept	
Karen Ayers	Safe Kids / OCDC	X	Rachel Ford, MPH	OHA, Public Health, EMS for Children	X
John Casalino	Sr. DDA – Multnomah County	X	Heather Morrow-Almeida, MPH	OHA, Public Health – Maternal & Child Health	X
Meghan Crane	OHA, Public Health - Zero Suicide Coord.	X	Joanne Southey	DOJ – Deputy Chief Counsel / Child Advocacy	X
			Jennifer Vines, MD	Tri-county Health Officer - Multco	
Amber Kroeker, MPH, CPST	Legacy Health Systems – Injury Prevention Coord.	X	Tamara Grigsby, MD	OHSU – General and Child Abuse Pediatrics	X

Emily Taylor	Legal Assistant – Multnomah County	X	Robyn Marshall	Oregon Youth Authority – Foster Care Manager	
Dan Leonhardt, MD	Child Abuse Pediatrician—CARES NW/Randall Children's Hospital		Jill Baker	OHA, Health Systems Division, Behavioral Health	
Kathleen McDonough	Washington County - Child Abuse MDT & CFR Coordinator		Kara Boulahanis, PhD	Oregon Department of Education - Community Engagement and Wellness Specialist	X
Robin Reimer	DOJ – CAMI Fund Coordinator	X	Captain Jay Bates	Portland Police Bureau, Child Abuse Team (CAT)	
Rachel Howard	Child Welfare, CIRT and Suicide Coordinator	X	Sgt. Davis Kile	Portland Police Bureau, Child Abuse Team (CAT)	
Thomas Valvano, MD	Doernbecher - CARES NW – Child Abuse Pediatrician		Chelsea Holcomb	OHA, Health Systems Division, Behavioral Health	X
Sean Hurst, MD	State of Oregon - Chief Medical Examiner	X	Jay Messenger	Early Learning Division	X
Lt. Rachel Andrews	Portland Police Bureau, Child Abuse Team (CAT)				
Guests					
State Technical Assistance Team					
Amanda Couch, MDI	OHA, Public Health, SCFPRT Ops Support	X	Robyn Ellis	OHA, Public Health, Injury & Violence Prevention	X
Agenda for May meeting					

8:30am-8:40am	**Welcome and Introductions** 1. Read grounding statement: We bring to this discussion a beautiful mosaic of experiences, lenses, cultures, passions, and energy. We must also acknowledge those who are not represented and those who our system has excluded. We are not a true representation of the Oregon families we serve. Let's welcome the challenging and uncomfortable path to change this and use this acknowledgment as a foundation from which to act. 2. Introductions: Share name, pronoun if you choose, and role in chat. Also send corrections to how your name and affiliation appear in the agenda.
8:40am-10:30am	**State Team Business** 1. Review notes and action items from prior meeting 2. Updates (suicide and injury prevention data, potential legislative change and funding request, SUIDI/doll re-enactment training, Medical Examiner subgroup, action plan, prevention recommendations) 3. Child maltreatment fatality data from FFY 2020/2021 4. Charter subgroup update
10:30am-10:45am	**Break**
10:45am-12:10pm	Charter review
12:10pm-12:25pm	Member updates
12:25pm-12:30pm	Wrap up Next Meeting Date: Thursday August 11th, 2022, 8:30am – 12:30pm Adjourn

Notes from February meeting:

- Gratitude to Chelsea for reading the grounding statement
- Charter subgroup met once to develop outline for charter content. Content developed and meeting scheduled for review. Goal to have draft to state team two-three weeks prior to May meeting for review at May meeting.
- County needs assessment is complete, and the executive summary was reviewed by the team. The resulting draft action plan was discussed and input from members collected. Action plan will be revised based on input and distributed (see action items below).
- Discussed having role specific state team members create a process to support professionals in the same role that serve on county teams.
- Community of practice for peers discussed.
- Reviewed and discussed prevention recommendations. Suggestion to organize by issue moving forward.

• Agreement to have assigned state team members reach out to county team contacts to acknowledge recommendations.
• Decision to respond to issues that impact multiple counties, with a "packaged" response to all county teams with what resources and supports are available. Note the plan is to have an implementation team, but this ensures a consistent response in the interim.
• Safe sleep and substance use recommendations were impacting multiple counties, and the team agreed to send a packaged response to all counties on each of these issues (see action items below).
• Suggestion to develop a presentation, possibly video, showing the entire death review process, from county review to state team role, through implementation of prevention recommendation and subsequent change in data/outcomes. This can support county team buy in, understanding of their impact and clarity about process.
• Shared specific examples of positive impact from county team support program. Plan to continue having a state team member assigned to a county team with no plan to end program. State team member volunteers needed and welcome, reach out to Deb if interested. Lots of support provided to volunteers.
• Discussed possible approaches when there are differing medical opinions between medical examiner and designated medical professional. Issue is generally discrepancies in information known by providers. This can be exacerbated by involvement of multiple counties when a child is life flighted outside of the county where they reside/injury occurred. Agreement to draft some brief guidance suggesting (1) designated medical professionals attend autopsy when possible. Metro area most likely location for this to occur but can check with county medical examiner. This approach supports the added value of information exchange (2) Asking for a meeting to bring people together. Bringing together those who evaluated the child and those partners who may be unable to make planning decisions. This approach is aimed at getting questions asked and answered to provide sufficient confidence in planning and decision making.
• Discussed telemedicine for autopsy. Oregon State Medical Examiners does not have equipment to support this. Offers to explore funding. Dr. Grigsby offered to connect Dr. Hurst to a resource for an estimate. Telemedicine for autopsy could reduce travel for medical examiners and support attendance by designated medical professionals.
• Consistent, quality county death investigation results in more information/context for medical examiners. This would include every county having one or more dedicated medical legal death investigators. Current system is inequitable. A quality approach was developed by the Oregon State Medical Examiners and implemented in Clatsop County.
• Discussed the Child Death Investigation training modules from the National Center for Fatality Review and Prevention and benefit of having team members individually watch the training. This will also inform what resources the team promotes.
• Discussed Linn County interest in doll re-enactment training for law enforcement, district attorneys, designated medical professionals, Child Welfare. Decision to look at statewide training and consistency. Use funding from CAMI or Child Welfare or Oregon Health Authority to potentially fund purchase of trauma informed dolls for each county. Training curriculum/content through CDC, National Center for Fatality Review and Prevention, American Board of Medical and Legal Death Investigators, Multnomah County District Attorneys' office PowerPoint, and Oregon State Medical Examiner annual training course. Review resources to establish standard for state team to promote. Then send communication to county teams identifying resources. Consider a roll out of a training that is followed by a Q&A with experts.
• Subgroup developed to focus on efforts to support the Oregon State Medical Examiners. Additional state team volunteers are encouraged and welcome. Contact Deb.
• Agreement to use a state team meeting this year (not May meeting) to present to state team on medical examination system in Oregon.
• Next meeting agenda to focus on charter review and FFY 2021 child maltreatment data

Action Items from February meeting:		
Item	**Assigned to**	**Status**
Charter subgroup to meet, review content, revise draft and submit to state team prior to May meeting.	Charter subgroup	Done
Update action plan to reflect input and distribute executive summary, draft action plan, and cover letter in the following order (1) via email to coordinators and leads, (2) via Department of Justice newsletter to team members, (3) Children's Justice Act taskforce and others identified as needing the information. Solicit feedback on the prioritization of the action items as well.	Deb, Robin	Done
Prevention recommendation template to be updated to reflect issue, with additional column for applicable counties.	Amanda	Done
Outreach to Josephine County team with offer to connect to Oregon Department of Transportation	Laura	Done
Outreach by state team contacts to Clackamas, Josephine, Union, and Washington county team contacts to acknowledge recommendations and next steps where applicable	Assigned state team members and Deb (to get specific information to state team members	Done
In response to infant sleep related death prevention recommendations: Safe sleep package to be distributed to state teams, sharing self-study resource, and identifying Safe Kids, home visiting, and Oregon Parenting Education Collaborative as resources. Offering sleep surfaces and safe sleep display kits while available through Child Welfare. Also asking teams to consider who is at the table that may contribute to prevention discussion regarding sleep related infant death. Also address language of co-sleep vs bedsharing to support consistency in messaging.	Deb	Done
Contact with Cross Agency Safe Sleep Workgroup, to request a listening session with county teams be set up to provide an opportunity to hear about what is occurring in Oregon's communities.	Deb	Done
In response to substance use prevention recommendations: Contact Oregon Health Authority overdose coordinator to discuss opportunities to connect county teams with county/regional Overdose Prevention Coordinators and Tribal and County Alcohol & Other Drug Prevention coordinators. Request a phone call/virtual meeting with county teams and Overdose/Alcohol & Other Drug Prevention Coordinators to provide information and listen to the needs of the communities.	Laura, Kathleen, Emily	Partially complete. Send info to Robin for DOJ newsletter.

Draft guidance to support information sharing between medical examiners and designated medical professionals at autopsy when possible and when differing conclusions impact decision making for partners.	Deb	Incomplete
Gather and review doll re-enactment/death investigation Training curriculum/content through CDC, National Center for Fatality Review and Prevention, American Board of Medical and Legal Death Investigators, Multnomah County District Attorneys' office PowerPoint, and Oregon State Medical Examiner annual training course. Suggested to use pictures to support the education/training. Review resources to establish standard for SCFRT to promote.	Deb and other state team members	Done
Follow up with Linn County regarding doll re-enactment to update on state team discussion	Deb	Done
Watch the National Center for Fatality Review and Prevention Child Death Investigation training modules. Access here: https://ncfrp.org/center-resources/child-dsi-learning-series/	All state team members	Incomplete
Document a list of state medical examiner needs and barriers to effectively function in the child safety system.	Dr. Hurst	Partially complete
Subgroup for strategizing how to support Oregon State Medical Examiners	Heather Morrow-Almeida, Amanda Couch, Jill Baker	Partially complete
Pursue information from lab re: possible modification to rush toxicology process. *Carry over from 11/2021 meeting	Dr. Hurst, Dr. Leonhardt	Incomplete
Obtain data on number of rush toxicology requests and those that are specific to pediatric fatalities (define pediatric). *Carry over from 11/2021 meeting	Dr. Hurst	Incomplete