Louisiana State Child Death Review Panel

September 16, 2015 | 10-12p
7173-A Florida Boulevard, Baton Rouge, La
Large Conference room off of the lobby

Attendees: See attached list

Agenda Items and Meeting Notes

Welcome to new members/participants

This was the most well attended CDR meeting in the last year. Many new required members attended as well as colleagues of members, i.e. Social workers from LOPA. Welcome to the members from the Office of the Commissioner of Insurance and the LA Highway Safety Commission and the Office of Behavioral Health.

Purpose of Child Death Review

Jane reviewed charge and the guiding principles.

Membership Discussion

There are still a few members missing from the required legislative list, namely a Forensic Pathologist. There was also discussion about including a representative from Office of Behavioral Health (Danita LeBlanc) and Department of Education on an on-going basis. Given the issues with regular attendance, Jane discussed with the group how they wanted to move forward with meeting schedules. The group said quarterly was still OK. There was a comment that maybe legislation mandated quarterly meetings, but later investigation showed the legislation has no mention of the timing of meetings. The issue of how confidentiality can be assured with the public meeting format was brought up, and Bernadette (representing J. Waitz) explained a promising practice wherein one of her committees divides their meeting into a public part and a closed executive session. The group decided to explore further and move forward with the next quarterly meeting in December.

Updates & Recap from Previous Meeting

- SIDS/SUID Classification Performance Improvement project – Y. Guerin/J. Herwehe/D. George

  The project - designed to let coroners know the importance of correct classification of unexpected infant deaths – is ready to go. Yancy spoke with Dr. Thoma and the project can be introduced at the October Coroner's meeting

- Pool and Safety Regulation Review – K. Harvey/E. Andrews

  State law leaves it up to municipalities to set pool safety ordinances. It varies widely. If we want to target pool safety needs, we might have more sway with local governing councils or municipal bodies (suggested outreach to Municipal Associations, for example). We can look more closely at drowning details and figure out a way to communicate with those organizations. Also, Louisiana is not compliant with the Virginia Graham Baker Act so we are not eligible for Consumer Product Safety Commission grants for pool safety. RE: Insurance requirements – Korey reported that most insurance underwriting dictates rules on whether or not to insure. Most insurers include drowning as a risk automatically, so it is not part of the pricing mechanism. Insurance contracts/products are not all uniform, but most say the owner needs to follow the municipal code (and most require photos of pool and enclosure in contract file) or they will not receive liability coverage. If the municipal code doesn't have stringent rules there is nothing the Department of Insurance can do. Drew started to look to smoke free ordinances because they faced many of the same challenges and eventually constructed a good strategy. Dr. Mehta suggested maybe a good place to start would be recommending more stringent requirements for all new pools moving forward.

- Drug Screening of Caregivers – Bernadette for J. Waitz.

  District Attorneys think screening all members of the household for drug use whenever there is a child death is unconstitutional without probable cause, but will revisit and report back after their October meeting.

Overview of Most Common Causes of Child Death –

Motor vehicle accidents have surpassed sudden unexplained infant deaths **- preliminary data for 2014**

CDR Evaluation Findings – see attached one pager of key findings.

Case presentations and recommendations discussion - Annelle Tanner/Lisa Norman (Region 6) – Suicides

Annelle and Lisa provided a summary of case information for suicide deaths reviewed from Jan 2012-Aug 2015 and more in-depth review of 2 very similar cases from 2015 related to hanging. They recapped information from a CDC sponsored webinar that addressed recommendations for suicide prevention.

Recommendations:

- Danita emphasized the importance of changing the conversation around suicide, foster and empower connectedness, making sure law enforcement is in tune to the types of investigative information that the CDC needs to better understand youth suicide;
- Follow-up after suicide attempts with emergency rooms and acute care hospitals makes a difference
- Gun safety is very important as means restriction -85% of firearms used in youth suicide are from guns in the homes and the CDC estimates that 45% of LA households own guns.
- Overall means restriction is very important. Danita gave an excellent overview of all that is happening around suicide in LA and potential resources for organizations that she will forward to the group.
- Lt. Kolb mentioned that it might be a good idea to have a laminated sheet of the CDR investigative questions for all law enforcement.
- Group discussed the role of a crisis line. Under consideration was the possibility to partner with the 211 via link line, a connection that would connect callers to the crisis centers in New Orleans and Baton Rouge.
- Chief Lentz mentioned an application his department has used called "Media Sonar" to follow up on suicide-related postings on social media. He and his team were able to intervene with one youth's family.
- There were questions about what schools were doing (and what was mandated legislatively) and it reiterated the importance of having the Department of Education represented on the State Child Death Review Panel.

Next Steps/Assignments

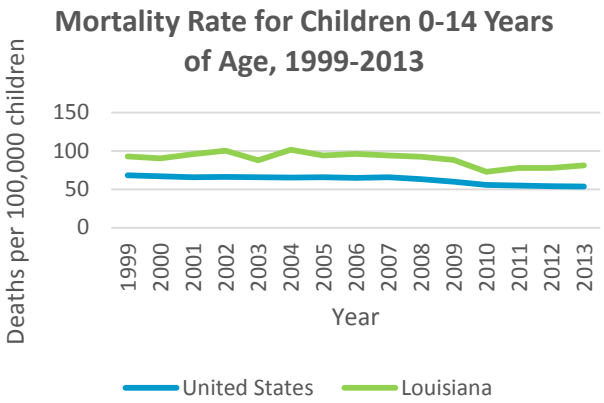
- Joe Waitz – final determination from the District Attorneys about the constitutionality of drug screening of caregivers in SUID cases
- Danita – forward resources for suicide prevention
- Drew – look into legislation on what schools are doing around suicide prevention training; also any laws around information sharing prohibitions with Child Death Review and any legislation around training of healthcare professionals on suicide assessment and training.
- Yancy and Cara/Devin/Jane: SUID Cause of Death classification project – Bureau of Family Health and Vital Records reps can attend Oct 10th Coroner's conference to present and introduce the project prior to kick off. Yancy will find out about agenda.
- Robin and Coordinators – will look into the development of laminated cards for suicide investigation questions for law enforcement – needs further exploration on content and process.
- **Next Meeting – December 9th, 2015, 10–12p -** Same location – Different Room

The Louisiana Child Death Review Program

A State-Level Evaluation

History and Need

The Louisiana Child Death Review (CDR) program was established in 1992 following the initiation of several CDR programs nationwide. Since its inception, CDR has not been reviewed. Although Louisiana has followed the national trend of an overall decrease in child mortality, the mortality rate has consistently remained above the national average, emphasizing the continued need for the CDR.



Key Evaluation Questions

Inputs

- Are CDR meetings effective?
- Is the performance of the CDR database adequate to support the CDR panel's duties?

Outputs

- Is CDR fulfilling its duty of producing an annual report for the state legislature?

Outcomes

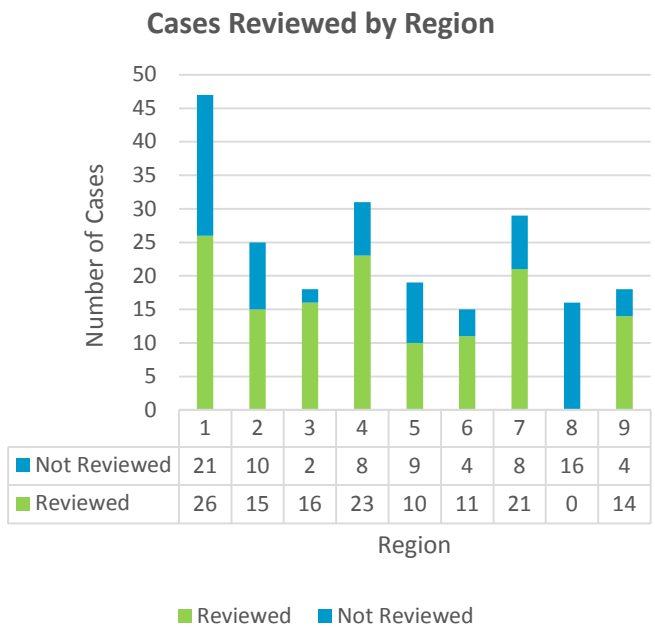
- What actions at the state level have resulted from the CDR program?

Findings and Recommendations

Inputs

- Meeting membership and attendance are incomplete
- The database is not capturing all cases

Keep an updated roster of panel members, update legislation to reflect appropriate membership, adjust the code used for CDR case identification, and ensure that the CDR panel is aware of the proportion of total cases that they are reviewing.



Outputs

- Data covered in annual reports are not up-to-date

Update legislation to reflect that reports should be completed using the most recent available data and presented to the state legislature prior to the next legislative session. In addition, assign a liaison from the CDR panel tasked with ensuring that the legislature is informed of the release of the report.

Outcomes

- No traceable outcomes found through review of all available meeting minutes

Employ a tracking form for action items established at state CDR meetings

Amanda Pereira, 2015 Graduate Student Epidemiology Program

Prepared by: Bureau of Family Health, Office of Public Health, Louisiana Department of Health & Hospitals

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals

Office of Public Health

Child Death Review Confidentiality Agreement and Sign-in Sheet
September 16, *2015*
10 AM – 12 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, law enforcement agencies or the media.

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