October 2019

Maryland's Child Maltreatment Fatality Review Plan

The following information outlines the initial plan for the Maryland Department of Human Services/Social Services Administration (DHS/SSA) in developing a centralized Child Maltreatment Fatality Review (CFMR) process, including tracking, and preventing child maltreatment deaths.

Maryland plans to implement a continuous quality improvement, trauma-informed, comprehensive, and centralized DHS/SSA-led review process for child fatalities that are due to maltreatment. The role and purpose of a centralized CMFR, the principles that will drive the reviews, the elements necessary to implement a statewide CMFR process, and outstanding considerations are detailed in this plan. Content is based on feedback and insight from SSA and Local Department of Social Services (LDSS) staff, stakeholders, and partners, including those represented in the Preventing Child Fatalities workgroup, all within the framework of a culture of safety.

A centralized CMFR process in Maryland will consist of a review of a representative sample of child fatalities. It will include efforts to understand the entire spectrum of factors that lead to a child's death due to maltreatment with the goal of preventing future deaths. The reviews will reinforce organizational values and shift the focus away from discussions of blame-worthy acts towards creating and supporting a culture of safety.

The comprehensive CMFR process will be two-fold in scope. First, it will be multidisciplinary in nature and lead to a broader understanding of the circumstances and risk factors that led to the child's death. The reviews will promote consistency in practice, workforce development, stakeholder, and community engagement, and will result in developing recommendations. Second, LDSS staff and supervisors will be engaged through a debriefing process that will explore critical decisions and interactions throughout the department's history with the child or family and provide an opportunity to share, process, and learn in a safe, non-punitive environment. This effort will be framed in a close review and understanding of available data as it relates to child maltreatment fatalities and prevention.

Elements of Maryland's Centralized Child Maltreatment Fatality Review Process

1. The CMFR will be DHS/SSA led and situated within Continuous Quality Improvement.
2. Quarterly reviews will include cases that are a minimum of 120 days from the report date and meet the following criteria:
    a. Maltreatment was a contributing factor to the child's death
    b. An active or recently closed child welfare case (within the past 12 months)
3. Further triage of these cases for inclusion in quarterly reviews will include the following criteria for the unexplained death of a child under age three:
    a. Sudden Infant Death Syndrome (SIDS)
    b. Sudden Unexpected Infant Deaths (SUID)
    c. Substance Exposed Newborns (SENs)
    d. Death of a child where parental substance use was a contributing factor
    e. Sudden Unexplained Death in Childhood (SUIDC)

4. A multidisciplinary team will contribute to the reviews. Core members of the team may be drawn from the following experts:
    a. LDSSs and SSA staff, including those with responsibilities for the investigation and/or prevention of child deaths;
    b. Continuous Quality Improvement representatives;
    c. DHS/SSA Medical Director;
    d. Workforce Development; and
    e. Additional representatives from agencies, providers, or professions involved in protecting children's health and safety will be considered on a case appropriate basis.
5. An automated system will be utilized to track and document all child fatalities, critical incidents, and serious physical injuries including alerts or notifications of cases as well as other characteristics (e.g., geographic location, age, gender, race/ethnicity, child welfare involvement, etc.) of all cases.
6. Available and relevant data (e.g., trend data, regional trends, ages for unexplained deaths and parental substance use, etc.) will be included in the review process to assure that there is a review and understanding of data as it relates to child maltreatment prevention.
7. A standardized tool will be used to guide reviews and record recommendations.
8. An annual report will be produced to include trends, themes, and recommendations for prevention efforts and changes to policy and/or practice.
9. The CMFR team will collaborate, coordinate, and share information with other child fatality reviews, teams, or councils (i.e. Department of Health State Child Fatality Review Team, Department of Health Local Child Fatality Review Teams, Citizen Review Board for Children, State Council on Child Abuse and Neglect, etc.).
10. The existing Policy Directive #10-05, Child Fatality/Serious Physical Injury/Critical Incident, will be updated to include the centralized CMFR process.
11. Needed revisions will be made to the DHS/SSA Forms 1080A: Initial Child Fatality/Serious Physical Injury/Critical Incident Report, 1080B: Follow-up Child Fatality/Serious Physical Injury/Critical Incident Report, and 2037 forms: Disclosure of Information.

Principles of Maryland's Centralized Child Maltreatment Fatality Review Process

1. The multidisciplinary review process will engage LDSS and state agency leadership, frontline staff, and other key child welfare stakeholders such as public health officials, law enforcement, and the courts. Ownership for the process and the findings will be shared across agencies.
2. The CMFR process will be move toward a safety culture oriented around a proactive response to child fatalities and a response system dedicated to learning and system change. It will support a focus on identifying underlying systemic issues to improve prevention efforts and response by child welfare.
3. The output of the review will consist of recommendations to improve outcomes for all children and families within, and outside of, the child welfare system in an effort to prevent future child fatalities.
4. Intentional partnering with agencies around prevention efforts will occur through identifying proximal areas of needed improvement.
5. Training and support for staff, including needed tools and resources, will be central to supporting the advancement of a safety culture.

Additional Considerations for DHS/SSA's Centralized CMFR Process

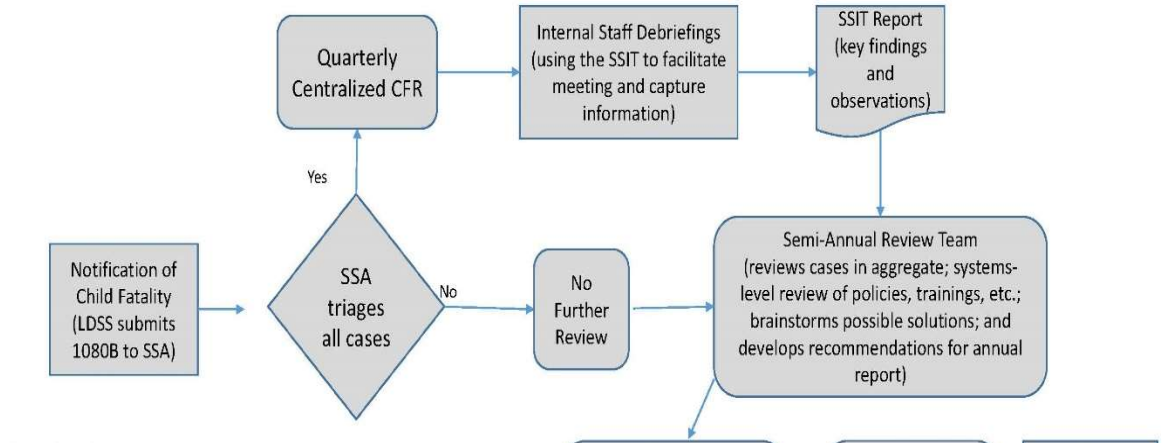
This plan includes additional considerations for DHS/SSA as it begins preparation for implementation of a centralized CMFR process.

- The CMFR team may want to consider including reviews beyond where maltreatment was a contributing factor to a child fatality. This could include a triage of Critical Incident and Serious

Physical Injury cases that rise to the attention of SSA (per Policy Directive 10-05). This triage would include a brief case summary and a determination of which cases require a full review. Ideally this would be an electronic case review and criteria would be established to determine which cases require a full review (e.g., cases outside the identified criteria which appear to indicate non-adherence to policy or practice, media exposure, near fatalities, etc.)

- A standard tool to support and guide the comprehensive CMFR process will be considered. This may entail the use of a case information checklist to organize the collection of records, reporting forms for partner agencies, and/or templates for detailing the circumstances that led to the fatality. DHS/SSA plans to review any existing templates or tools being used by the local Department of Health Child Fatality Review teams.
- Inclusion of debriefings with staff and supervisors as part of the CMFR process will be explored. A "debriefing" is a voluntary opportunity for staff to join with a facilitator to process, share, and learn from child fatalities in an effort to best support quality case management practices and influence increasingly safe outcomes for children. It captures rich information and data for use in quality improvement and prioritizing improvement opportunities.
- The inclusion of families and feedback from families in the review process is important. Assuring these voices and perspectives are heard throughout the review process is an element that DHS/SSA plans to consider in implementation.
- Explore the Safe Systems Improvement Tool (SSIT) as a resource to be modified or enhanced for DHS/SSA's CMFR. This specific tool is a communication tool that is completed and scored at the culmination of the review, centered on all aspects of the review and debriefings when rating the items. The tool helps to synthesize and organize all information gleaned from debriefings and any other components of the review.
- Explore a regular process to review hotline data, specifically data for calls to the hotline for children under age three as research indicates this is an indicator for increased risk for a fatality for the indicating child as well as other children in the home.

Potential Flow Chart for a Centralized CMFR Process



Considerations:

- Triage cases will include cases where maltreatment was a contributing factor and will include a record review of other case criteria
- Quarterly centralized CFR team will review a small portion of cases, increasing over time
- Debriefings will be voluntary for staff
- SSIT will be used and scored at the culmination of the review