CDSIRP 2022 Report Summary

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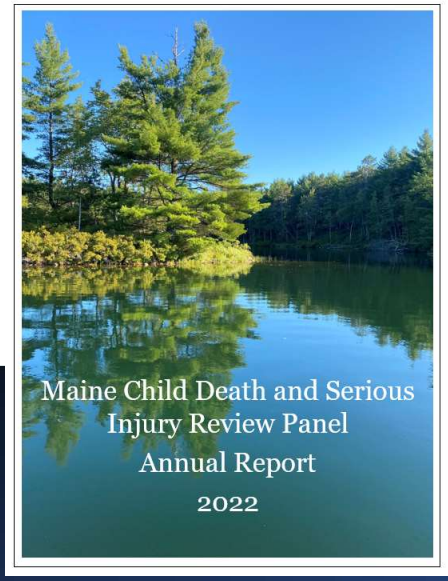

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2022 Case Reviews and Panel Activities

- Panel met 9 times in 2022
- Level 1 reviews: summary reviews of all reports to OCFS from October 2021 through September 2022
- Level 3 reviews: five cases
- Educational presentations- pediatric ingestions, Safety Science
- Quarterly HHS presentations- June, September
- New England Regional Child Fatality Review Meeting

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Data Trends

- Serious Injury Reports: Increased 23% year over year (continuing multi-year upward trend)
- Ingestion Reports: Increased 114% year over year (4 yr downtrend, now 2 yr uptrend)
- Child Death Reports: Stable (54 in CY21, 54 in CY22)

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Injury Specific Observations

- Ingestions: 42/90 reports in 2022 were marijuana, 7/90 fentanyl
- Naloxone: focus of use and availability should no longer be solely on adults at risk of OD, but kids in those environments
- Tendency of OCFS staff to view ingestions as “accidental” vs “intentional” rather than focusing on potentially neglectful environment or circumstances in which incident occurs
- No comprehensive data collection/monitoring of total ingestions
- Unsafe sleep- potential return toward more traditional annual average
- Similar seasonal pattern injuries as in prior years (drowning, recreational vehicles, window falls)

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Systemic Observations- OCFS

- Workforce- Support for establishing after hours units statewide
- Practice
  - Support for Safety Science
  - Management of chronic low/mod severity maltreatment
  - Lack of effective CODE system
  - Cultural barriers to maltreatment evaluation/intervention

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Systemic Observations- Multidisciplinary

- Law Enforcement- good coordination/relationships at high levels, more challenging dynamics locally
- Medical Care- importance of Well Child Care for anticipatory guidance, primary and secondary prevention

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Recommendations (Injury Specific)

1. All HC facilities and lab service providers ensure ability to detect fentanyl and other synthetic opioids

2. ME's Dir Opioid Response eval options for inc naloxone in homes where kids and opioids are present, make appropriate recommendations

3. Exec Comm to work with ME's Opioid Clin Advisory Comm to optimally address Rec 1

4. DHHS/CDC develop data tracking/monitoring mechanism of all ingestions to inform more complete understanding

5. DHHS/CDC (+/- OAG/OCME) resume pub health messaging on safe sleep, with recent guidance and recs from AAP

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Recommendations (Systemic)

6. OCFS should view incidents in context, not just assess intent in single episode

7. OCFS/CDC should partner for more pub health messaging re: seasonal or trending injuries

8. OCFS should continue provision of lockboxes- both secondary and tertiary prevention measures

9. Governor/Legislature should propose/appropriate adequate funds to reestablish MIPP

10. OCFS should continue use of safety science in reviews of adverse case outcomes

11. DHHS should develop comprehensive, statewide, inter-dept, CA/N prevention plan with data monitoring and outcome measures to ensure prevention activities are achieving desired goals

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Recommendations (Systemic)

12. OCFS should continue efforts to recruit/retain after-hours investigators

13. OCFS/LE should continue efforts to develop/deliver interdisciplinary training to OCFS and LE around ME

14. OCFS should develop protocol for in depth review of chronically maltreating families

15. OCFS/OBH/OAG should work to develop functional system of evaluators for complex CM cases around ME

16. Peds PCPs should develop protocols for review of repeated missed well-visits, including outreach resources and consideration of report to OCFS

17. OCFS should view repeat missed well-visits as sufficient cause to investigate a child's safety more thoroughly when additional risk factors exist

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Questions?

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