Statement of Consideration (SOC)

The following comments were received in response to SOP drafts sent for field review. Thank you to those who reviewed and commented. Comments about typographical and grammatical errors are excluded; these errors have been corrected as appropriate.

1. **Comment:** What does it mean by “DCBS involvement”? (Does this include a history of referrals that do NOT meet criteria?)

**Response:** Yes, prior DCBS involvement does include referrals that do not meet criteria.

1. **Comment:** Who participates in the MDT?

**Response:** See System Safety Review Process Manual page 7 under section III.

1. **Comment:** What if there are no cases to present that month? (Does the regional group still meet?)

**Response:** If there are no cases, the meeting will be cancelled**.**

1. **Comment:** When talking about MDT looking at the case to determine if further analysis is recommended, is that the local MDT?

**Response:** No, this is a state level meeting. This is not the same as the multi-disciplinary or GUS team.

1. **Comment:** Intake section: It’s unwise to split intake policy out in this section. An intake SOP already exists. Having two sections risks a reader not finding the right SOP for their task. Consolidate into the existing intake SOP.

**Response:** Change will be made to SOP 2.3 to reference the fatality/near fatality SOP 2.14.

1. **Comment:** Intake section: It’s not been the historical practice for CI to make the sole decision on what should or shouldn’t trigger a fatality investigations. The fatality program is ultimately operated by DPP, and procedure should require a consult with DPP. Nine regions with multiple specialists and clinical associates will NOT result in **consistently accurate** intake determinations statewide, and it’s not appropriate for this particular program to be susceptible to that inconsistency. These cases go public, and having a substantiation on a case that didn’t even meet criteria is a real risk that will be hard to defend and WILL create exceptional problems with regard to public perception at a systems level.

**Response:** Clarification is added to Practice Guidance for Receiving and Accepting the Report.

1. **Comment:** Mapping teams- who will be the front line workers (will it be in the investigator or co-workers). I feel like we are adding more meetings but maybe the names are changing?

**Response:** There will be no new additional meetings, thenew process will take the place of the previous regional review meeting.

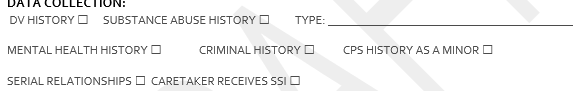
1. **Comment:** These procedures require that a finding not be finalized prior to the receipt of all external reports; however, those can pend for a long, long time. The state agency should retain for itself the discretion to finalize with preliminary reports, with the ability to amend findings that note the receipt of finalized reports, affirm the original finding or modify the finding if finalized reports provide information that warrants it. The agency always retains the right to amend or modify its findings at any time under the regulation, and TWIST does accommodate that workflow.

**Response:** A case finding cannot be finalized without critical facts. Medical findings and autopsies are critical.

1. **Comment:** All of the designations for F/NF on the intake side (the front end of the report) should be staff with DPP to ensure statewide consistency and to ensure that the report truly meets acceptance criteria, and especially that the F/NF tag should be applied.

**Response:** Change will be made to include SRCA or AA.

1. **Comment**: Interestingly enough, the new policy does not require a Central Office review of the finalized ADT. This is a double edged sword. It’s great for the regions because some of the feedback from CO has been unrealistic in my opinion. However, the bonus of having them review it is that there is some consistency across the board about the findings, when the D/ND finding is used and appropriate, etc. This creates more consistent, more reliable data on the back end. Additionally, on the SAR sheets under “data collection”, this section has historically ALWAYS been completed by the child fatality liaison again to ensure consistency in the data. If you have 9 regions determining the data, and Central Office still being the gatekeeper of entering that data, ultimately to ensure consistency, then Central Office should be the gatherer of that data.



This section alone is straight forward and could be done by the regions because it aligns with the ADT:

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However, with no Central Office review, again, there will be inconsistency in is ultimately checked here in the finalized version of the ADT.

I personally feel like our region will be fine with managing this task, as we have super strong staff in place on this program. However, not all regions can say the same I’m sure.

**Response:** The SRCA/AA who approves the fatality/near fatality ADT will collect the data.