PROTOCOLS

FOR

THE SOUTHERN TIER

CHILD HEALTH AND SAFETY TEAM
(A CHILD FATALITY REVIEW TEAM)

Revised 2013

SOUTHERN TIER CHILD HEALTH AND SAFETY TEAM PROTOCOL

New York State Social Service Law allows a child fatality review team (CFRT) to be established at a local or regional level, with the approval of the Office of Children and Family Services (OCFS).

A. Mission of the Southern Tier Child Health and Safety Team (CHST)

The mission of the Southern Tier Child Health and Safety Team (a child fatality review team) is to prevent future child deaths and promote child safety. The CHST will review child fatalities, recommend corrective action by the local Departments of Social Services (LDSS) and community agencies and recommend measures to prevent future child fatalities and promote overall child safety.

B. Purpose of the Southern Tier Child Health and Safety Team

The purpose of the Southern Tier Child Health and Safety Team (CHST) is to prevent future deaths and promote child safety through a thorough, comprehensive, multidisciplinary examination of the cause, manner and circumstances of child deaths in Allegany and Cattaraugus counties. The CHST is authorized to review the investigative activities of the Allegany County and Cattaraugus County Departments of Social Services (LDSS) and review the activities and protocols of other community agencies, as applicable. The CFRT is authorized to recommend corrective action(s) for the Allegany County and Cattaraugus County LDSS and community agencies, as applicable and recommend measures to improve practice, promote overall child safety and prevent future child fatalities.

Pursuant to SSL §§ 20(5) and 422-b (see Appendix B), the CFRT may prepare and finalize a Child Fatality Review Report on the fatalities specified below that occur within its jurisdiction; however, it is not a requirement. Through the multidisciplinary review process, a CFRT can provide a valuable perspective and contribute to the writing of the Fatality Review Report. Fatality Review Reports can only be **issued** by OCFS.

Category A: Section 20(5) Fatalities and Fatality Reports

Check the categories that will have the Fatality Review Report completed by the team. An OCFS approved CFRT must review each of the categories of deaths, as set forth in SSL §§ 20(5), listed below.

Note: Pursuant to SSL §§ 422-b(5)(a)(ii), a local or regional CFRT may only have access to confidential information, i.e. sealed, unfounded Child Protective Services (CPS) reports, Foster Care or any Family Assessment Response (FAR) case history, for the purpose of preparing a fatality report, pursuant to that same section.

Review X Report __ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child;
Review X Report __ A child who at the time of his/her death was in the care and custody or the guardianship and custody of DSS or a voluntary authorized agency located in Allegany County or Cattaraugus County;
Review X Report __ A child for whom at the time of his/her death LDSS has an open CPS case;

Review X Report __ A child for whom at the time of his/her death has an open preventive services case in Allegany County or Cattaraugus County.

Data entry of Section 20(5) fatalities will go into the National Center for the Review & Prevention of Child Deaths (NCRPCD) data collection system until the NCRPCD is replaced by a New York State data collection system. This data entry will be completed by the **Buffalo Regional Office of the Office of Children and Family Services.**

Category B: Non-Section 20(5) Fatalities

SSL 422-b(1) also authorizes an OCFS-approved CFRT to investigate any unexplained or unexpected death of any child under the age of 18.

Note: A local or regional child fatality review team may NOT have access to any confidential information, i.e. CPS, Foster Care, Preventive, Temporary Assistance (TA), FAR etc, when reviewing a Non-Section 20(5) fatality.

Review X Any unexplained or unexpected death of any child under the age of 18 years old, not otherwise included in the categories noted above.

The criteria for determining which non-section 20(5) cases the CFRT will review are as follows:

- The decision to review unexplained or unexpected non-section 20(5) child deaths will be determined on a case-by-case basis by team members during quarterly CFRT meetings with particular emphasis on cases where the sleep environment is believed to be a factor.

The data entry of non-Section 20(5) fatalities into the NCRPCD data collection system will be completed by the CFRT.

Category C: "Expected" and "Explained" Deaths and Near Fatalities

A CFRT may also choose to review child fatalities that are considered to be "expected" or "explained" deaths. However, OCFS does not require, expect, or fund, a CFRT to review these deaths, as they are not referenced as one of the categories of cases authorized for review either under Section 20(5) or 422-b of the Social Services Law (SSL).

Note: Nothing precludes a CFRT from reviewing near fatalities or "expected" deaths, however they will not have access to any confidential information, such as Child Protective Services, FAR or Foster Care records, nor any of the other protections and rights under Section 422-b of the SSL.

Review ____ Expected and Explained Review _____ Near Fatalities

C. Goals of the Southern Tier Child Health and Safety Team

Child fatality reviews in these counties must:

- Examine the manner, cause and circumstances of a child's death;
- Examine the investigative actions of the LDSS(s) and other community agencies as applicable;
- Identify risk factors and trends in child deaths;
- Identify specific barriers and systems issues involved in the deaths of children;
- Increase public awareness, through education and advocacy, of the issues identified as affecting the health and safety of children; and
- Promote policies and practices and expanded efforts in child health and safety to prevent child deaths.

The Team will also pursue the following highly recommended goals, developing strategies to improve:

- Accurate identification and uniform, consistent reporting of the cause and manner of every child death.
- Communication and linkages among local and state agencies and coordination of efforts.
- Agency responses in the investigation of child deaths.
- Agency responses to protect siblings and other children in the homes of deceased children.
- Criminal investigations and the prosecution of child homicides.

- Delivery of services to children, families, providers and community members, where appropriate.

- Identification and advocacy for needed changes in legislation, policy and practices and expanded efforts in child health and safety to prevent child deaths.

The CFRT will also prepare and submit an Annual Report to OCFS, summarizing the team's activities and recommendations at the end of each calendar year.

D. Membership of the CFRT

The team must be comprised of team members in accordance with SSL § 422-b(3). Specifically, this team will consist of a designated representative of the following statutorily mandated agencies who must serve on the team:

A. Mandatory Members

- The child protective service of the Allegany County and Cattaraugus County Departments of Social Services (hereinafter "DSS");
- The New York State Office of Children and Family Services (hereinafter "OCFS");
- The Allegany County and Cattaraugus County Departments of Health (hereinafter "DOH"), if the county does not have a County Department of Health, local Health Commissioners or his or her designees or the local Public Health Directors or his or her designees;
- The Allegany County and Cattaraugus County Medical Examiners (hereinafter "Medical Examiner"), and/or the Allegany County or Cattaraugus County Coroners offices (hereinafter coroner);
- The Offices of the Allegany County and Cattaraugus County District Attorneys (hereinafter "District Attorney");
- The Offices of the Allegany County and Cattaraugus County Attorneys (hereinafter "County Attorney") or an attorney from Allegany or Cattaraugus County(ies) DSS;
- A representative of local police department(s) in Allegany and Cattaraugus counties;
- A representative of the New York State Police;
- A representative of the Department of Emergency Services (EMS) in Allegany and Cattaraugus counties; and
- A pediatrician or comparable medical professional, preferably with expertise in the area of child abuse and maltreatment or forensic pediatrics.

B. Permissive Members

As permitted by SSL § 422-b (3), the team may also include, on an ongoing (O) or case-specific (CS) basis, a designated representative from the following agencies:

Discipline	Name of Agency	Ongoing	Case-Specific
Local DSS	Allegany County & Cattaraugus County Departments of Social Services	Ongoing	
Mental Health	Any mental health agency in Allegany or Cattaraugus counties that had contact with the child or non-offending caregivers		Case-specific
Domestic Violence	Any domestic violence agency that had contact with the family		Case-specific
Substance Abuse	Any substance abuse treatment agency that had contact with the child or non-offending family members		Case-specific
Hospital	Cuba Memorial Hospital; Jones Memorial Hospital; Olean General Hospital	Ongoing	
Schools	Any school in Allegany or Cattaraugus counties that had contact with the child		Case-specific
Family Court	Allegany County or Cattaraugus County Family Court		Case-specific

C. Other Members

OCFS recognizes the value of having professionals with specific knowledge of a child or family, or with general knowledge about child mortality, at child death reviews. As a result, the CFRT also includes the following agency(ies):

Discipline	Name of Agency	Ongoing	Case-specific
Child Health and Nutrition	WIC Program	Ongoing	
Child and Family Advocacy	Sudden Infant and Child Death Resource Center	Ongoing	
Child Advocacy Center	Southern Tier Child Advocacy Center		Case Specific

D. Member Roles and Responsibilities:

Responding to press inquiries and issuing statements to the press will be completed by CHST Coordinator Donna Kahm.

Team Coordinator

The CFRT Coordinator will coordinate all of the activities of the Team, and will specifically:

- Determine, according to Team criteria, which cases to review;
- Schedule Team meetings, inviting all ongoing and case-specific members;
- Establish and distribute each meeting's agenda, reflecting the topics and/or cases to be discussed, including any matters that require follow-up;
- Chair and facilitate Team meetings that respect and encourage participation and input from all team members;
- In accordance with the confidentiality and document handling sections of this protocol, and applicable statutes and regulations, make documents available for Team member use at team meetings;
- Collect any copies of documents distributed at meetings and properly dispose of the same;
- Securely maintain any documents that will be retained for future use of the Team;
- Reinforce Team members' obligations to the confidentiality agreement they have signed and address any breach of confidentiality by a Team member;
- With input from Team members, assign tasks and/or establish sub-committees as necessary to conduct effective child fatality reviews or to develop the Team's recommendations and prevention initiatives;
- Facilitate resolution of interagency disputes related to the CFRT process;
- Recruit and orient new Team members, facilitating relevant training for Team members;
- Prepare, or participate in preparing, any Fatality Review Report the Team elects to write;

- Circulate any non-section 20 Fatality Review Reports or Informational Releases for public education purposes prepared by the Team;
- Implement a case tracking system to compile annual statistics concerning child fatalities within the County(ies) and prepare an Annual Report reflecting the Team's activity;
- NCCDR- related tasks as follows: complete NCCDR data collection form; and
- Other county-specific activities as follows: Handle press inquiries, work with community leaders to enhance the review team, develop partnerships with other child health and safety organizations and guide the team's outreach and community engagement efforts.

The Department of Social Services (Child Protective Services):

The designated representatives of the Departments of Social Services must:

a) Educate the team concerning the function and operation of the LDSS and the SCR;
b) (i) Provide copies of pending and indicated SCR reports to the team for any child fatality review, as authorized by SSL § 422(4)(A)(w), whether the CFRT is preparing a fatality review Report or not. (ii) Unseal unfounded SCR reports in accordance with SSL §422(5)(a)(ii) and provide the team with copies of these reports, **only if** the team is preparing and finalizing a Fatality Review Report in accordance with SSL §§ 20 and 422-b;
c) If the CFRT is preparing a Fatality review Report in accordance with SSL §§ 20(5) and 422-b, comprehensively report about the receipt of any prior SCR reports, investigations that DSS conducted, foster care placements or preventive services treatment plans pertaining to the deceased child, siblings or other children residing in the home, and/or the child's parent(s) or other person(s) that were legally responsible for the deceased child;
d) Describe in detail any investigation conducted by DSS as a result of the child fatality and make available for team consideration all relevant documents and records created or in the possession of DSS, as permitted by applicable statutes and regulations, including but not limited to SSL §§ 20(5), 422(4)(A), 422(5) and 422-b;
e) Consistent with applicable statute, supply any other information or documents, included in the CPS case record, relevant to the team's investigation of the child fatality.

The Office of Children and Family Services:

The designated representative of the Office of Children and Family Services must:

a) Pursuant to SSL §§ 20(5) and 422-b, attend and participate in any fatality review conducted concerning the death of a child that was the subject of an SCR report, a child for whom there is an open child protective services or preventive services case and/or relating to a child who died while in the care and custody or the guardianship of the LDSS or a voluntary authorized agency located in Allegany or Cattaraugus county(ies);
b) Be invited, but is not mandated to participate in any child fatality review that the team conducts that is authorized, but not required by SSL §§ 20(5) and 422-b, as noted above;
c) For any fatality under review, be invited but not mandated to participate in, team discussions concerning corrective measures to be taken by an agency other than LDSS or a voluntary foster care or preventive service agency and/or discussions regarding recommended State or local policy changes;
d) Identify, review and monitor corrective action plans for LDSS or any other agency subject to the supervision or regulation of OCFS;
e) Share statewide data, as appropriate, concerning child deaths;
f) Provide advice and instruction to the team concerning the child fatality review process and report writing and may assist in drafting appropriate sections, i.e. the service history section of the Fatality Review Report;
g) Review for approval any Fatality Review Report prepared in accordance with SSL §§ 20(5) and 422-b;
h) Act as liaison for OCFS Home Office/Legal review of a Section 20(5) Fatality Review Report;
i) Function as the sole distributor of such Fatality Review Reports and respond to any requests for information concerning Fatality Review Reports, whether such requests be case specific or non-case specific; and
j) Review any Informational Release or fatality prevention materials, prepared or created by the team, for the purpose of public education or the elimination of systemic barriers, prior to its release to the public.

The Allegany County and Cattaraugus County Departments of Health:

The designated representative of this agency must:

a) Educate the team concerning the role and function of the agency and provide definitions and insight concerning any medical condition relevant to the child fatality review under review;
b) To the extent permissible by law, and as relevant to a child fatality under review, provide information concerning any contact the agency had with the deceased child, his/her siblings, other children in the home, or the deceased child's parent(s) or other person(s) who had been legally responsible for the child;
c) Provide statistics or other documents in the agency's possession to assist the team in formulating plans for corrective action or suggesting policy changes;

d) In response to the team's review, in accordance with the individual agency's mission and protocol, facilitate and coordinate community education programs to prevent future child deaths and injuries.

The Allegany County and Cattaraugus County Medical Examiner or Coroner Offices:

The designated representatives of the Medical Examiner or Coroner must:

a) Educate the team concerning medical issues, medical terminology, concepts and practices and instruct the team regarding general procedures followed by the Office of the Medical Examiner in investigating a child's death;
b) Specific to the fatality under review, explain to the team the medical findings revealed by the autopsy/toxicology report and any related procedures. As authorized by statute, provide the team with copies of relevant medical records of the deceased accessed as a part of the autopsy and provide the team with a copy of the autopsy report.
c) Provide statistics concerning the death of any child less than eighteen years of age who resided in Allegany or Cattaraugus counties.
d) The Medical Examiner or Coroner must issue a preliminary written report within 60 days of the date of the child's death absent extraordinary circumstances. **(SSL §418)**

The District Attorney's Offices:

The designated representatives of the District Attorney's Offices must:

a) Educate the team concerning applicable criminal law, the nature of criminal proceedings and the prosecutor's role and function;
b) Secure the appearance at the team meeting of the necessary local law enforcement representatives who investigated the specific child fatality under review by the team;
c) Disclose prior criminal convictions and pending criminal charges pertaining to the accused; in conjunction with the local police department and any other law enforcement agency that investigated the child fatality, present information concerning the investigation to the extent that such disclosure does not compromise the criminal investigation, an arrest or the integrity of the prosecution of a criminal action or a family court proceeding;
d) Discuss the status of the criminal proceeding, including any disposition achieved;
e) Maintain statistics concerning homicides of children and disclose same to the team;

The County Attorney/LDSS Attorney:

The designated representatives of the County Attorney's Offices/LDSS Attorneys must:

a) Educate the team concerning Family Court proceedings and the County Attorney's role in such proceedings;
b) As legally permissible, provide information including the status of any pending or prior Family Court proceedings relevant to a particular child fatality in which the County Attorney's Office participated or of which it is aware;
c) If an Assistant County Attorney participated in or observed the interview of any witness, family member, and/or surviving sibling conducted in connection with a child's fatality, provide the team with an oral summary of the interview including admissions, if any, made by the child's parent(s) or other person(s) legally responsible for the child;

Local Law Enforcement Agencies and the State Police:

In conjunction with the District Attorney's Office, present information and facts concerning law enforcement's actual investigation of the child fatality to the extent such disclosure does not compromise the investigation, impede an arrest or affect the integrity of the criminal prosecution or the presentment of the case in Family Court.

Emergency Medical Services:

A designated representative(s) from Emergency Medical Services must;

a) Discuss procedure for responding to calls for assistance generally;
b) Serve as a liaison between EMS providers and the team;
c) To the extent possible, assist in obtaining copies of 911 tapes and other documents prepared by individual EMS providers in connection with the provision of services in connection to any child fatality under the team's review;
d) In response to the team's review, in accordance with the individual agency's mission and protocol, facilitate and coordinate community education programs to prevent future child deaths and injuries.

The Team Pediatrician:

A pediatrician or comparable medical professional shall be selected to serve on the team. It is preferable that this individual be a Board certified pediatrician licensed to practice medicine in New York State and that this individual have expertise in the area of child abuse and maltreatment or forensic pediatrics.

The Team Pediatrician must:

a) Educate the team concerning medical issues, medical terminology, concepts and practices and instruct the Team regarding common causes of child fatality and near fatal injuries;
b) Subject to the permission of the Medical Examiner, observe the autopsy of any child less than eighteen years old and/or any other procedures specific to such autopsy;
c) In accordance with applicable standards relating to client privacy, provide the team with information concerning any prior contact or physical examinations that the pediatrician conducted on the deceased child and/or his/her siblings and/or upon other children who had resided in the same household as the deceased child;
d) Review and interpret any medical records or documents presented or secured in connection with any child fatality under review;
e) Offer an expert medical opinion concerning or relating to the child's injuries or illnesses revealed by any forensic examination.

Permissive Team Members:

The designated representatives of these agencies must:

a). Educate the team concerning their professional role and function and provide definitions and insight concerning any condition or aspect relevant to the child fatality under review;
b). To the extent permissible by law, and as relevant to the child fatality under review, provide information concerning any contact the permissive team member had with the deceased child, his/her siblings, other children in the home, or the deceased child's parent(s) or other person(s) who had been legally responsible for the child;
c). Make referrals or, as appropriate, provide services to assist the surviving siblings, other children in the household, and/or the parent(s) or other persons who had been legally responsible for the child who dies and/or to others in need as a result of the loss;

d). Provide statistics or other documents in the agency's possession to assist the team in formulating plans for corrective action or suggesting policy changes;
e). In response to the team's review, and in accordance with the individual permissive team member's mission and protocol, facilitate and coordinate community education programs to prevent future child deaths and injuries.

Case-Specific Invitees:

Listed below are the roles/expectations of case-specific invitees:

The invitee's role will be determined by the contact the member had with the deceased child, his/her siblings, other children in the home and parent(s) or other person(s) who were legally responsible for the child. It is expected that case specific invitees will share information and documents with the team to the full extent permitted by law.

These individuals are subject to the same confidentiality requirements as other team members, including, but not limited to, the requirement to sign a confidentiality agreement. Any information, documents and/or materials shared by these individuals will be maintained as confidential. These invitees will not have voting rights.

E. CFRT Review Process

Notification of Child Fatalities:

The CFRT review process begins when the Coordinator is advised of a child's death that falls under the Team's purview. Notification of child deaths to the Coordinator will come from:

- The designated representative of the Office of Children and Family Services
- The County Departments of Social Services (Child Protective Services)
- The County Attorney's Offices or District Attorney's Offices
- Any team member who learns about a child fatality

The notification process is as follows:

- A CFRT member from the Allegany County or Cattaraugus County Departments of Health will forward copies of death certificates for children 17 and younger to the CFRT Coordinator within one week of a child's death. The Coordinator will then contact the Child Protective Services (CPS) CFRT representative to determine if a child's death falls under the Section 20(5) guidelines.
- For all Section 20(5) deaths, the CPS CFRT representative will notify the CFRT Coordinator once the CPS and law enforcement review is complete. **The CFRT Coordinator will notify all CFRT team members of the Section 20(5) death within one week of the close of the official investigation by law enforcement, CPS and the District Attorney's Office.**

- The Coordinator will add the case review to the CFRT's agenda for the team's next meeting. The case review will be added to the CFRT Coordinator's electronic outlook planning calendar to ensure the case "does not fall through the cracks."
- The CFRT Coordinator will remind team members of upcoming Section 20(5) child fatality case reviews not less than two weeks prior to the next CFRT quarterly meeting.

Frequency and Purpose of Team Meetings:

OCFS requires that CFRTs meet a minimum of quarterly during the contract year.

The coordinator must schedule additional meetings, as necessary, so that the number of fatality review meetings is commensurate with the number of child fatalities in the county.

An effective Team review is best achieved when the team has the information necessary for the review, including:

- The facts and circumstances leading to the child's death including the cause of death as determined by the Medical Examiner/Coroner;
- Access to all available relevant documents maintained by the County(ies) DSS, as authorized by statute;
- All relevant contacts by any LDSS, and other service providers, with the deceased child and/or siblings of that child as well as other children who resided in his/her household and/or with his/her parent(s), step-parent(s) or other persons who were legally responsible for his/her care;
- The opportunity to identify or assist with any necessary corrective action; and
- The opportunity to discuss whether recommendations for local or State administrative or policy changes would be appropriate.

Access to Information and Handling of Documents:

As set forth above in this protocol and as mandated by SSL §§ 422(4)(A), 422(5), and 422-b (6), all materials received and discussed by the team are confidential.

As permitted by law and as necessary for comprehensive child fatality reviews, mandatory and permissive members as well as case-specific invitees must provide the Coordinator with copies of any documents and reports relevant to a particular child fatality review. Information is provided to the Coordinator in the following way(s):

- CFRT members share information with the CFRT Coordinator via telephone, email and in person.
- CFRT members sign a confidentiality agreement at the beginning of each meeting. The confidentiality agreement is part of the team's sign-in sheet.
- CFRT members who bring documents to the CFRT meeting will share information from those documents with other team members during the case review process, retain the documents and return them to their agency(ies) for secure storage.

- Any confidential case-review information retained by the CFRT Coordinator will be destroyed by the CFRT Coordinator via shredding following case review and the closure of a case.

Conducting the Review:

In light of the confidentiality restrictions imposed by applicable statutes, all team meetings are limited to mandatory, permissive and case-specific team members and/or their designated representatives.

Each child fatality shall be discussed separately. Any fatality review conducted pursuant to SSL §§ 20(5)(b) and 422-b should:

- Share, question and clarify all case information (refer to NCCDR Case Reporting System for the scope of case information)
- Discuss the investigation (including the investigative practices of LDSS and other agencies that are represented on the Team)
- Discuss the delivery of services and assistance provided to the child and/or the child's family prior to the fatality and since the fatality occurred
- Identify risk factors
- Recommend system improvements
- Identify and take action to implement prevention recommendations.

Team members who have information concerning previous or pending law enforcement contacts or concerning matters pending in criminal or Family Court will share this information within legal limits, insofar as doing so will not compromise the integrity of the case.

Team members are encouraged to ask questions of, and seek clarification from, any presenting team member. With due consideration to the presenter's preference, inquiries may be made during a member's presentation or at its completion. If a team member lacks sufficient information to answer a particular question, that presenting member must make every effort to obtain the necessary information for presentation at a follow-up meeting.

The CFRT will review cases:

_____ **Immediately** (within ___ hours/days of notification of the death)
_____ **Concurrently** with an open CPS and/or Law Enforcement (LE) investigation(s)
____X_____ **Retrospectively** (after CPS and/or LE investigation is done), but within one year of notification of the child's death
___X___ **Other:** Please describe <u>The team will retrospectively review Section 20(5) child deaths even when the law enforcement and CPS investigation takes more than one-year to complete.</u>

The process and case selection criteria for these types of reviews are as follows:

The Southern Tier Child Health and Safety Team will conduct retrospective reviews of all Section 20(5) child deaths that occur within Allegany County or Cattaraugus County. The team will meet on a **quarterly basis** and review child deaths in chronological order.

The team may also choose to review unexplained and unexpected child deaths. The decision to review unexplained or unexpected deaths will be made on a case-by-case basis by members of the Southern Tier Child Health and Safety Team. The case of an unexpected or unexplained child death will only be reviewed if a majority of team members agree case review is necessary.

Case demographic information including the ages, genders and relationships of those inside the home at the time of death is sent to each team member via email or regular mail. This non-identifying information regarding the case helps prepare team members for the case-review process. The Coordinator will contact team members involved in the CPS and law enforcement investigation to ensure they bring documents for the team to review.

As a retrospective child fatality review team, the team only reviews a child's death once law enforcement, CPS and the District Attorney's Office have concluded their investigations and closed their cases. For the purposes of the Southern Tier Child Health and Safety Team, a case is closed once the team has issued its recommendations to involved agencies and issued recommendations to the community or concludes a community outreach educational campaign.

When there is no case to review, team members will discuss threats to child safety in the community and design outreach and awareness campaigns designed to enhance child safety and address those threats.

F. Informational Releases

The most important reason to review child deaths is to understand and identify factors related to the health and safety of children and to prevent other children from dying.

An OCFS-approved CFRT, as a result of child fatality reviews, may identify local patterns or trends regarding child death. Consistent with the team's goals of preventing future child fatalities and promoting overall child safety, a CFRT may elect to publish information to educate the public, recommend preventive measures or corrective action beyond that specifically authorized by SSL §§ 20(5)(b)(vi) and 422-b.

Such release or report may not contain any client identifiable information.

- All informational releases will be drafted by the CFRT coordinator when the coordinator, in consultation with CFRT members, determines that an informational release is required to enhance the safety of children. All informational releases will be

sent to the Office of Children and Family Services for review and approval prior to their release to the public.

- Seasonal releases will be issued regarding pool safety, vehicle safety, fire safety, Halloween safety, school safety, etc. by the team to the community.

F. CFRT Annual Child Fatality Report

The CFRT coordinator will submit an Annual Child Fatality Report to OCFS Home Office by December 31 of each calendar year, in accordance with the format prescribed by OCFS, which may include a minimum of the following information:

- Number of deaths reviewed, including the four categories of SSL § 20(5);
  a) Reported to SCR;
  b) Open Child Protective Services;
  c) Open Preventive Services;
  d) Care and custody or custody and guardianship of Authorized Agency; and
  e) Unexpected or Unexplained, not falling into the Section 20(5) categories (Non-20);
- Number of team meetings, including whether a review was immediate, concurrent, retrospective or "other";
- Number of Section 20(5) Fatality Review Reports finalized and Informational Releases published **by the CFRT**;
- Data from team reviews, including existing patterns and trends, subsequent findings and identified recommendations for improved or best practice for the LDSS, community interventions and the practices and functioning of the team.

G. Confidentiality Statement

In accordance with all applicable federal and state statutes and regulations, including but not limited to SSL §§ 422(4)(A), 422(5) and 422-b(6), all members of the team, whether mandatory, permissive or case-specific, must maintain strict confidentiality with respect to all materials received and matters discussed by the CFRT.

No information may be disclosed to the public, by the members of the CFRT, unless such disclosure is authorized by applicable statute or regulation, including, but not limited to the confidentiality standards set forth in SSL §§ 20(5), 422(4), 422(5) and 422-b(6).

CFRT members, whether mandatory, permissive or case-specific, must sign a confidentiality agreement. A brief confidentiality statement should be included as part of the CFRT sign-in sheet.

Southern Tier CHST members sign a confidentiality agreement at the beginning of each quarterly meeting.

H. Dissolution of the Child Fatality Review Team

If the CFRT decides it will cease its existence as a fatality review team or decides it will cease writing fatality reports, the coordinator must notify the appropriate OCFS Regional Office representative, in writing, within two weeks of making that determination.

The CFRT may be dissolved by OCFS upon prior written notice to the CFRT Coordinator. Dissolution shall take effect within forty-five (45) days of the issuance of such notification. The notice of dissolution shall include the ground or grounds for dissolution and an OCFS contact person available to respond to inquiries regarding such dissolution.

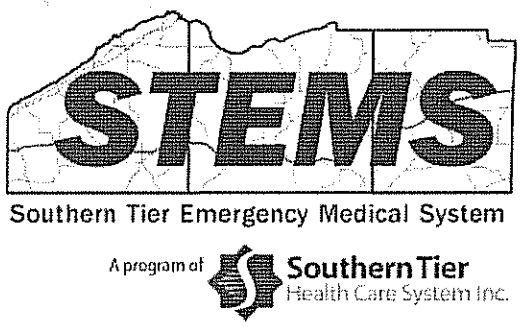
Submission of this signed protocol implies agreement to all conditions and requirements stated herein.

Submitted for Approval by: Donna Kahm

Title: Southern Tier Child Health and Safety Team Coordinator

Date Submitted for Approval: January 16, 2014

Submitted to: Dana Whitcomb
Regional Director, Buffalo Regional Office
NYS Office of Children and Family Services



Southern Tier Emergency Medical System (S.T.E.M.S.)

Southern Tier Emergency Medical System (S.T.E.M.S.) is a program of Southern Tier Health Care System, Inc. that is the EMS program agency for the Southwestern Regional EMS Council (SWREMS).

As the program agency, we are responsible for researching and coordinating educational seminars to meet the needs of the EMS agencies in Allegany, Cattaraugus, and Chautauqua counties. We are contracted by the New York State Department of Health Bureau of EMS to provide a specific set of "deliverables," which are required goals for us to meet. S.T.E.M.S. also supports the Western Regional Medical Advisory Committee (WREMAC) and the SWREMS as needed.

S.T.E.M.S. serves the 93 New York State Certified EMS agencies that cover over 260,000 citizens in the three-county region of Southwestern New York. This area spans over 3,400 square miles.

S.T.E.M.S. strives to promote the cooperation of the EMS organizations and encourages networking to promote fluidity in the continuum of care. Patient care is a top priority for S.T.E.M.S. and by working to further educate the members of the prehospital team in our region, we will move toward truly superior patient care.

Goals set by S.T.E.M.S. include:

- ✓ Meet the Needs of the EMS System: S.T.E.M.S. researches the needs of our region's EMS system. We accomplish this through communication with the EMS providers, hospitals, medical directors, and EMS supervisory organizations. We determine what improvements can be made to benefit both the team and patient care and move toward meeting those needs.

- ✓ EMS Education: Working with the Southwestern Regional EMS Council and local course sponsors, a regional plan of EMS education has been developed and implemented. This plan addresses the EMS community's educational requirements. By working together within the region we efficiently use the resources available to best meet these needs. S.T.E.M.S. is a Specialty Course Sponsor certified through the State Department of Health. This allows us to coordinate EMS instructor training so that personnel are available to train our region's EMS providers.

- ✓ Prehospital Care Report Management: S.T.E.M.S. is responsible for distributing prehospital care reports (PCRs) to the New York State Certified ALS first response and ambulance EMS agencies within the region. We also collect the completed PCRs for evaluation and forward them to the New York State Department of Health for scanning into their SPARCS data system.

- ✓ Quality Improvement: Developing, executing and perpetuating a strong program of quality improvement (QI) will ensure the excellence of documentation and patient care in the region. When weaknesses or problems are found, S.T.E.M.S. makes every effort to educate EMS community and resolve the issue. Our goal is 100% cooperation and quality throughout the pre-hospital team, the QI program will help us meet that goal.

- ✓ Regional System Coordination: Coordinating the communication and work of the SWREMS Council, the WREMAC and all regional EMS agencies, S.T.E.M.S. improves the overall functionality and efficiency of our regional EMS system.

- ✓ Networking and Communication: Providing our website, online forum, Facebook page, and added opportunities for interaction throughout the region, S.T.E.M.S. encourages networking and communication of the EMS providers and all pre-hospital team members.