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**Report to  
The Vermont Legislature**

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**Report of the Child Fatality Review Team  
2020 Report to the Legislature**

In Accordance with Act 103 (2018), An Act Relating to Establishing the Child Fatality Review  
Team

**Submitted to:** The Vermont General Assembly  
Governor Phil Scott

**Submitted by:** Commissioner Mark A. Levine, MD

**Prepared by:** Sally Kerschner, RN, MSN - Chair  
Division of Maternal and Child Health  
MCH Injury Prevention  
Vermont Department of Health  
Chair, Child Fatality Review Team

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Howard Center  
Vice-Chair, Child Fatality Review Team

**Report Date:** November 15, 2020



**AGENCY OF HUMAN SERVICES**

**Department of Health**

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**INTRODUCTION**

The purpose of the Child Fatality Review Team (CFRT) is to review and analyze the deaths of Vermont children in order to monitor population-level child hazards at a system-level, including those reflecting health equity and social determinants of health, and make specific recommendations to the Legislature to address such identified hazards.

**2020 ACTIVITIES**

**Covid-19 Response**

The work of the CFRT has been interrupted by the Covid-19 pandemic, resulting in significant delays in reviewing cases. The Team held its regular meetings in the fall and early winter of 2019-2020. Due the Coronavirus pandemic, the Team cancelled its March 2020 meeting and did not meet again until a virtual meeting was arranged in September 2020. The Team plans to continue its regularly scheduled meetings beginning in October 2020 using a virtual format.

Most of the Team members have been involved in the overall Vermont response to the pandemic, via professional roles and settings such as mental health, public health, law enforcement, Medical Examiner, social work, and so forth. Team members have been involved in developing public education and messaging, front-line patient care, testing, supporting mental health needs of Vermonters that result from the stress of the pandemic, providing guidance and strategic planning for containment and re-opening, contact tracing, as well as other elements of addressing this public health crisis.

**Fatality Review Meetings**

During the period of September 2019 through September 2020, the team met for a total of six meetings. The Executive Team held several check-in meetings over the summer 2020 to help maintain progress and focus and review best practices and resources for conducting online meetings. The Team’s usual practice is to meet monthly with smaller workgroups meeting more frequently as needed to examine deaths due to specific topics or systems issues. These smaller workgroups perform more in-depth evaluations of cases and more closely examine issues facing children and families that contribute to childhood fatalities, such as youth suicide or infant safety. This process help guides the group to a better understanding of child safety risks and to create more effective recommendations for systems improvement and prevention strategies.

***Table 1. Child Fatality Cases Reviewed (09/2019 to 09/2020) \****

0	Sudden Unexplained Infant Death (SUID)
2	Suicide
	0 - Hanging
	1 - Gunshot

	1 - Fall
2	Thermal Burns – Home Fire
0	Natural
0	Undetermined
0	Drowning Accidental
0	Sudden Unexplained Death of a Child (SUDC)
<b>4</b>	<b>Total Cases Reviewed</b>

\*During this time period there were a total of 15 cases queued for review. The remaining cases will be reviewed during the 2020/21 review period, or once released for review by investigating agencies.

**Table 2. Child Fatality Cases Queued for Review in 2020/21**

6	Ready for CFRT Review
5	Active Law Enforcement Investigation/Pending Autopsy Results
<b>11</b>	<b>Total Cases Queued for Review</b>

**Continued Data Collection:**

Updated cumulative statistics for 2019-2020

# Cases Reviewed = 4

# of Cases queued for review in 2021 = 11

These include 5 cases that have yet to be cleared for review because they are under investigation by law enforcement or pending completion of autopsy results with the Office of Medical Examiner.

Additionally, a Data Analyst from VDH Health Surveillance Division has been assigned to ongoing work with the Team to continue to review long-term data reports spanning a 10-year period, and to assist with data recording in a manner that allows relevant evaluation and comparison amongst regional and national cohorts.

**Topical Subcommittees:**

In 2019, subcommittees were established for focused review and recommendation development in the areas of suicide, unsafe infant sleep, and fatalities in child caregiving settings. In 2020-2021, the Team will continue to review these three areas, and others, to explore systems issues that may affect deaths from these causes and to offer further recommendations.

**Regional Activity:**

In May 2020, Sally Kerschner and Karen Lapan participated in a virtual Annual Meeting of the Northeast Region, hosted by Marc Clement of the New Hampshire Child Death Review Team, and the National Center for Child Death Review. The meeting was an opportunity to network and connect to each other regarding COVID-19 impact on teams (very minimal at this point). There was additional discussion about creating a regional online site that would allow more open communication among the teams. The National Center will look into creating that tool. In the meantime, they are coordinating Regional quarterly online meetings to continue networking and coordination of information.

## **CONCLUSION AND FUTURE ACTIVITIES**

### **Future Areas of Focus for 2020**

- The Team will continue to meet monthly to review cases and, using information from these reviews, develop recommendations for prevention and systems improvements for prevention of child deaths (to fulfill our legislative mandates).
- Review the findings from the 2019 Legislative report and add further information or recommendations so as to further our understanding of the health and safety risks related to infant safe sleep, childcare, and youth suicide.
- As a result of the death reviews processed in 2021, identify other significant risks to children such as drowning (swimming pools and open bodies of water) and articulate findings and prevention recommendations.

## ADDENDUM A – CFRT Members

Representative	Title
Allen, Chief Douglas	Chief of Police, Colchester Police Department
Bell, Rebecca MD	Pediatric Critical Care Physician, University of Vermont Medical Center
Borden, Sally	Co-Chair Vermont Citizen’s Advisory Board Executive Director, KidSafe Collaborative
Bundock, Elizabeth MD, PhD	Deputy Chief Medical Examiner, Vermont Department of Health
Evans, Rob	Vermont School Safety Liaison Officer for the Vermont Agency of Education and Public Safety
Fassler, David MD	Child Psychiatrist, Otter Creek Associates
Hanson, Carolyn	Assistant Attorney General, State of Vermont Co-Chair, Domestic Violence Fatality Review Committee
Haskins, Debby, MS, LADC	Center for Health & Learning, Suicide Prevention Specialist Association of Student Assistance Professionals of VT, Board member
Hill, Cpt. Jeremy	Bureau of Criminal Investigation Commander, Vermont State Police
Katz, Benjamin	Detective Sergeant, Vermont State Police
Kerschner, Sally RN (Team Chair)	Maternal and Child Health/Injury Prevention, Vermont Department of Health
Leduc, Courtney, RN	RN Clinical Supervisor, Northwester Medical Center
Lucier, Kate	Assistant Attorney General, State of Vermont Director, AGP Department for Children and Families-Family Services Unit
McCorkel, Charlotte LICSW (Team Vice-Chair)	Senior Director of Client Services, Howard Center
McGivern, Laurie	Assistant Medical Examiner Coordinator Vermont Department of Health
Metz, James MD	Division Chief, Pediatric Specialty Center, Child Abuse Physician, University of Vermont Children’s Hospital
Miller, Nancy	Child Safety Manager Operations Division, Vermont Department for Children and Families
Patno, Karyn MD	Child Abuse Pediatrician ChildSafe Program/Clinic @ UVMHC VT Citizen’s Advisory Board (VCAB)
Pine, Merrill	Program Manager, Emergency Medical Services for Children, Vermont Department of Health
Rettew, David MD	Medical Director, Department of Mental Health
Shapiro, Steven MD	Chief Medical Examiner, Vermont Department of Health
Trefry, Sharonlee RN	Nurse Program Coordinator, Vermont Department of Health
Wagner, Tracey, RN	Nurse Clinician-Child Safe Program, UVM Children’s Hospital
Wells, Tanya	Injury Prevention Chief, Vermont Department of Health

Data Analysis provided by Caitlin Quinn, Vermont Department of Health, Health Surveillance Division