Exhibit F

Child Death and Near Fatality Multidisciplinary Review Committee

Annual Report for SFY2016 and SFY2017

October 2017

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Background

Arkansas established the Child Death and Near Fatality Multidisciplinary Review Committee (CDNFMRC) during the 90th General Assembly's spring session in 2015. Under Ark. Code Ann. § 9-25-105, the primary goals of the Child Death and Near Fatality committee are 1) to review the circumstances of the child fatalities and near fatalities in order to gain a better understanding of their causes and 2) to recommend changes in policy, practice, and procedures to improve the practice and reduce future injuries and deaths.

Review Eligibility

The committee reviews the following two categories of child deaths and near fatalities:

1) all child deaths and near fatalities of children under eighteen (18) years of age who had contact with the Division of Children and Family Services of the Department of Human Services within twenty-four (24) months before death as determined by comparing records of deaths from the Division of Vital Records with information in the Children's Reporting and Information System, and

2) all deaths and near fatalities of children that have been reported through the Child Abuse Hotline.

Summary of Findings

Arkansas Child Deaths in State Fiscal Year 2016

During State Fiscal Year 2016, eighty-six child deaths were mandated for review by the CDNFMRC. Of the eighty-six, fifty-eight were accepted for investigation. There was a true finding for maltreatment related to 66% of the deaths that were investigated. The Department of Human Services Division of Children and Family Services had involvement with the child or a sibling to the child in the prior 24 months in 61% of the deaths.

SFY2016 Child Deaths Reviewed			
	DCFS Involvement in Prior 24 Months	No DCFS Involvement in Prior 24 Months	Total
Number	52	34	86
Percentage	61%	39%	100%
	Accepted for Investigation	**No Investigation**	**Total**
Number	58	28	86
Percentage	67%	33%	100%

Table 1.

Category of Circumstances Surrounding the Child Death

During State Fiscal Year 2016, 21 percent of the reviewed deaths were related to unsafe sleep environments, which was the most prevalent category found by the committee. The category of circumstances surrounding the child death was determined either by the type of allegation of maltreatment, if investigated, or by the narrative in the death assessment. The following chart lists the child death categories identified by the related abuse and neglect allegation or the death assessment narrative.

Category	Percentage of Deaths Reviewed
Unsafe Sleep Environment	21%
Medical Condition	19%
Injury	16%
Vehicular Accident (Car and ATV)	11%
Sudden Unexplained Infant Death (SUID)	11%
Drowning	9%
Fire Arm	5%
Fire	4%
Suffocation	2%
Related to Premature Birth	1%
Suicide	1%
Undetermined Cause	1%

Table 2.

Child Characteristics

Age

When compared to characteristics of children involved in true investigations of maltreatment, the age of a child reviewed by the CDNFMRC was disproportionately younger. For example, during the fourth quarter of SFY 2016, 45 percent of children listed as the victim in true reports of maltreatment were under the age of six. However, of the child deaths reviewed in SFY2016, 47 percent were under the age of one, and 73 percent were under the age of five.

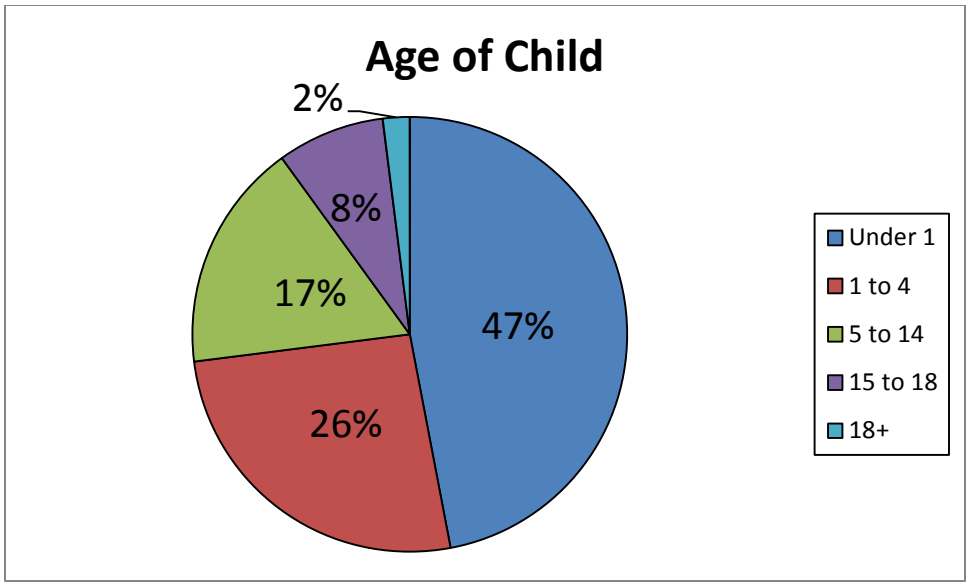

Chart 1.
Note: 2 youth reviewed were 19 years old as foster children.

Gender

The gender of children reviewed by the CDNFMRC was 57 percent male and 43 percent female. Compared to the characteristics of children involved in true investigations of maltreatment, there were a greater proportion of males. For example, during the fourth quarter of SFY 2016, only 47 percent of victim children in true reports of maltreatment were male. According to the National KIDS COUNT data in 2016, 51 percent of children in Arkansas are male and 49 percent are female.

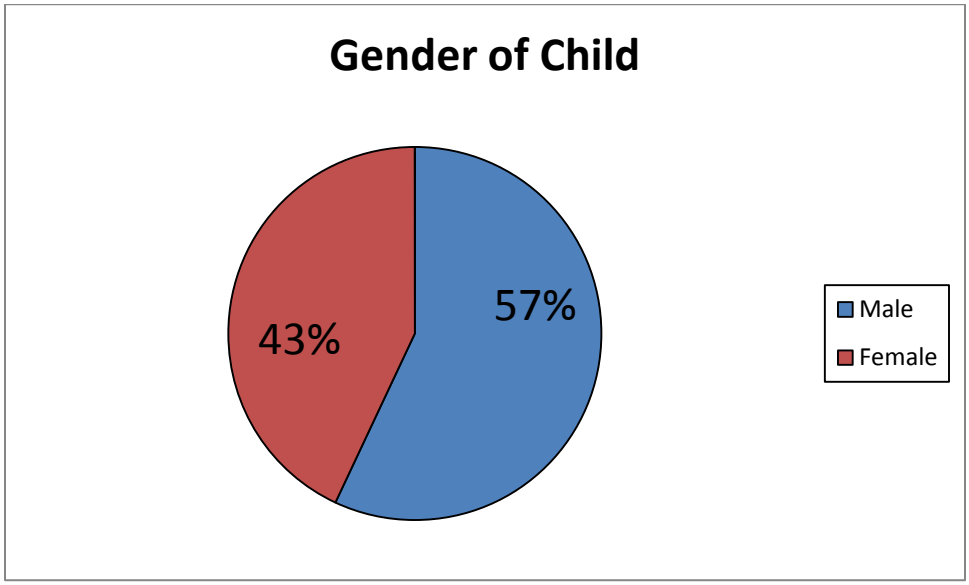

Chart 2.

Race

More than two-thirds (70 percent) of all deaths involved white children followed by 23 percent of deaths involving black children. Comparatively, of the victim children involved in maltreatment investigations found true during the fourth quarter of 2016, 69 percent were white and 16 percent were black. According to the National KIDS COUNT data in 2016, 64 percent of children in Arkansas are white and 18 percent of children are black.

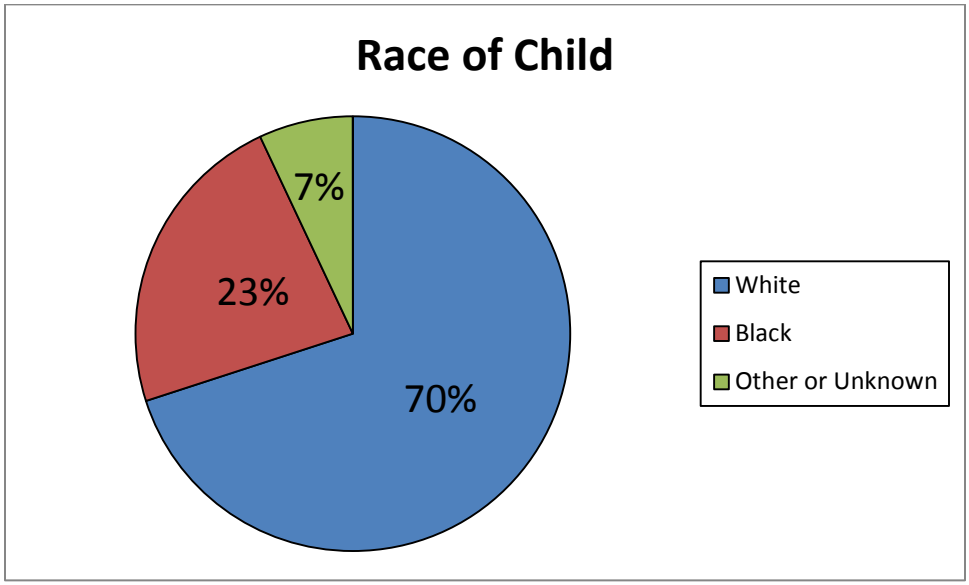

Chart 3.

Near Fatalities in SFY 2016

There were two near fatalities reported during SFY2016. Both were reported as near drownings.

Arkansas Child Deaths in State Fiscal Year 2017

During State Fiscal Year 2017, ninety-five child deaths were mandated for review by the CDNFMRC . Of these 95, fifty-nine were accepted for investigation. There was a true finding for maltreatment related to 71% of the deaths that were investigated. (Seven investigations are still pending). The Department of Human Services Division of Children and Family Services had involvement with the child or a sibling to the child in the prior 24 months in 62% of the deaths.

SFY2017 Child Deaths Reviewed			
	DCFS Involvement in Prior 24 Months	No DCFS Involvement in Prior 24 Months	Total
Number	59	36	95
Percentage	62%	38%	100%
	Accepted for Investigation	**No Investigation**	**Total**
Number	59	36	95
Percentage	62%	38%	100%

Table 3.

Category of Circumstances Surrounding the Child Death

During State Fiscal Year 2017, 20 percent of the reviewed deaths were related to the child's medical condition, which was the most prevalent category found by the committee. The following chart lists the child death categories identified by the related abuse and neglect allegation, if investigated, or by the death assessment narrative.

Category	Percentage of Deaths Reviewed
Medical Condition	20%
Injury	16%
Unsafe Sleep Environment	12%
Drowning	12%
Fire Arm	10%
Sudden Unexplained Infant Death (SUID)	8%
Suicide	7%
Vehicular Accident (Car and ATV)	4%
Fire	4%
Undetermined Cause	3%
Suffocation	2%

Table 4.

Child Characteristics

Age

When compared to characteristics of children involved in true investigations of maltreatment, the age of a child reviewed by the CDNFMRC was disproportionately younger. For example, during the fourth quarter of SFY2017, 46 percent of children listed as the victim in true reports of maltreatment were under the age of six. However, of the child deaths reviewed in SFY2017, 55 percent were under the age of one, and 72 percent were under the age of five.

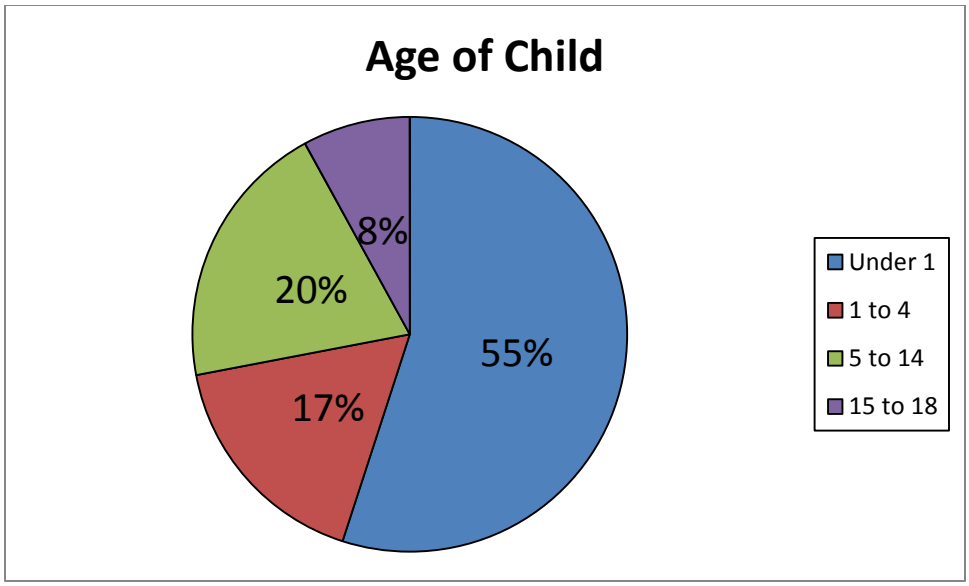

Chart 4.

Gender

The gender of children reviewed by the CDNFMRC was 64 percent male and 36 percent female. Compared to the characteristics of children involved in true investigations of maltreatment, there were a greater proportion of males. For example, during the fourth quarter of SFY 2017, only 47 percent of victim children in true reports of maltreatment were male. According to the National KIDS COUNT data in 2016, 51 percent of children in Arkansas are male and 49 percent are female.

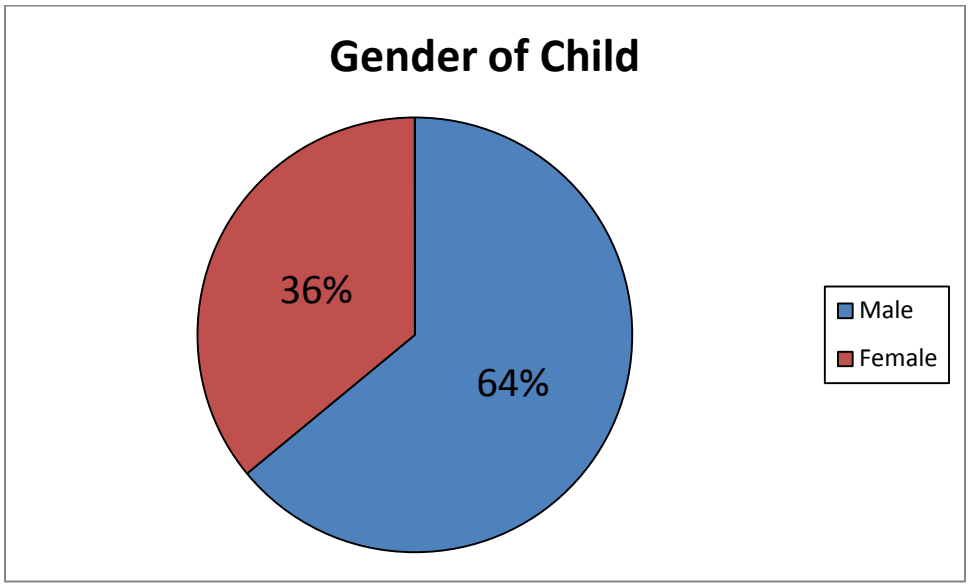

Chart 5.

Race

More than two-thirds (73 percent) of all deaths involved white children followed by 25 percent of deaths involving black children. Comparatively, of the victim children involved in maltreatment investigations found true during the fourth quarter of 2017, 68 percent were white and 17 percent were black. According to the National KIDS COUNT data in 2016, 64 percent of children in Arkansas are white and 18 percent of children are black.

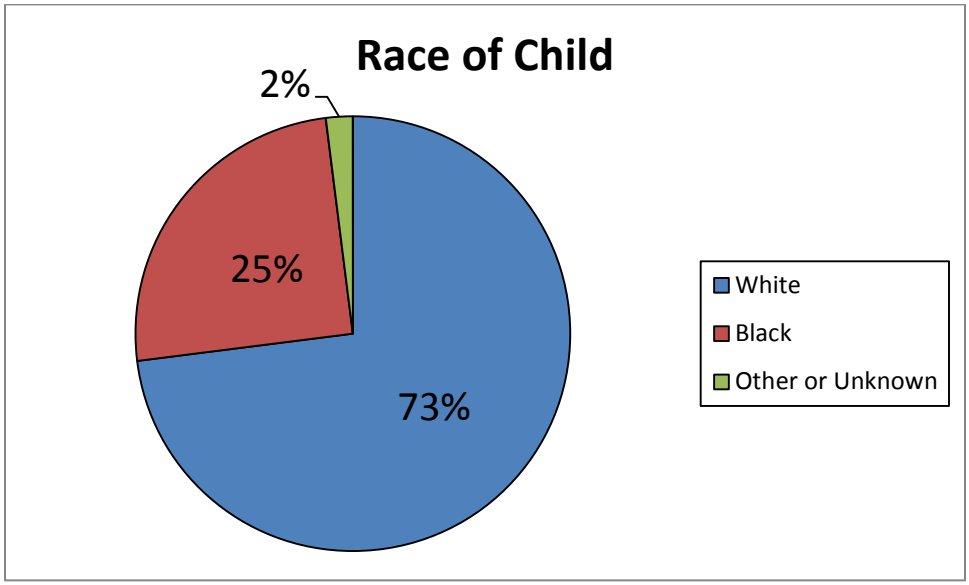

Chart 6.

Near Fatalities in SFY 2017

There was one near fatality reported during this time period. This was reported as a near drowning.

Findings for SFY2016 and SFY2017

Over state fiscal years 2016 and 2017, the Child Death and Near Fatality Multidisciplinary Review Committee reviewed a total of 171 child deaths. Through the reviews, the committee's objective was to identify trends or issues that occurred and could be changed in order to reduce future child deaths. Over the two year review period, the committee found that the overarching issue tied to the circumstances surrounding the death was public awareness of threats to child safety. All child deaths are a tragedy. The death reviews did not reveal a pattern of agency fault or egregious missteps by a provider, but rather an increased need for education and awareness. Even though the scope of the reviews is different, the committee found that its

reviews produced the same or similar conclusions as the findings from the DCFS internal reviews regarding the specific circumstances of the child's death.

The most common categories related to the deaths reviewed over the two year period were medical condition, injury, and unsafe sleep environment. Over both years, those categories were the top three but changed order with unsafe sleep environment being the most prevalent category during SFY2016 and becoming the third most prevalent in SFY2017. Over the two year period, there was an increase in the number of deaths attributed to fire arms, suicide, and drowning. The three near fatalities were all reported as due to near drowning. The number of child deaths attributed to vehicular accident and to SUID both declined in SFY2017.

Recommendations

The effort to reduce child deaths requires a collaborative approach utilized by a variety of disciplines. The committee recommends the following strategies to reduce deaths and near fatalities of children who are at a similar risk of harm.

Recommendation 1: Among all disciplines, increase public policies and education for safe sleep practices, the danger of substance abuse, gun safety, and water safety awareness. Education for water safety awareness needs to increase during the swimming season.

The basis for this recommendation is the need to increase public awareness on the threats to child safety, especially for areas in which there was an increase over the two year period and for safe sleep practice that still accounts for one of the top three categories related to child deaths. Even though not listed as a category, substance abuse issues by caregivers were often involved in the child deaths with unsafe sleep practices.

Recommendation 2: Continue to encourage law enforcement, hospital staff, coroners, and medical examiners of the mandate to report any death suspicious for maltreatment and ANY unexplained OR unexpected death in children under 18 years of age to the Arkansas Child Abuse Hotline for investigation or death assessment.

The basis for this recommendation is to comply with the state mandate and initiate appropriate investigations or death assessments to better identify issues in the state leading to child fatality.

Recommendation 3: Expand the service array to include available and effective substance abuse treatment in all parts of the state.

As listed above, the basis for this recommendation is the prevalence of caregiver substance abuse issues that are linked to child deaths that occur due to unsafe sleep practices.

Recommendation 4: For DCFS, continue to coach and mentor staff on effective investigative techniques to include sufficient documentation, locating families, and contacting other states, when needed; to obtain medical records and interview medical professionals when encountering a family with medical neglect allegations or medically complex children; and to increase service referrals during the investigation, when appropriate.

The basis for this recommendation includes the need for sufficient documentation especially when an investigation is being reviewed for patterns or policy implications, e.g., by the CDNFMRC. An investigator needs as much information about the family as quickly as possible in order to assess effectively, especially when dealing with complex medical issues that can be accurately described only by medical professionals. Families at risk need to receive help as soon as the agency becomes involved.

Recommendation 5: Consider a legislative change to increase the number of near fatalities reported.

The basis for this recommendation is the difficulty in capturing the near fatality data in order to properly review those cases to make statewide recommendations. The committee knows that there are many near fatalities that are not reported because of the reporting requirements and the nature of a near fatality that may come in as the serious injury instead.

Recommendation 6: Require all unexplained and unexpected child deaths to be referred to the Medical Examiner for autopsy.

The basis for this recommendation is the need for more information about these child deaths and their causes in order to implement strategies for prevention.

Recommendation 7: Continue the work of the Child Death and Near Fatality Multidisciplinary Review Committee in accordance with DCFS policy.

The basis for this recommendation is the value of the committee's work and the need to extend the multidisciplinary approach to reviewing child deaths past the two year statutory time frame.