March 13, 2012

Dear Governor Daniels:

Effective immediately I am tendering my resignation as chair of the State Fatality Review Team. As you know, I have served on this team since October 2004. I have taken this assignment very seriously and have worked for years to ensure that our team is using the most evidence based, best-practices approach to understanding child fatalities. I have sought counsel and guidance on improving our processes both at the state and local level from national experts on child fatality review. I have attempted to work with the Department of Child Services on these processes by offering guidance on legislation to improve our processes as well as through offering recommendations through our team's Citizen's Review Panel work.

The men and women that make up the State Fatality Review Team have worked tirelessly over the last 8 years, committing dozens and dozens of volunteer hours to the grueling task of reviewing horrific tragedies that have occurred to children in our state. The recent publicity of "record low deaths" counted as child abuse or neglect fails to recognize the fact that hundreds of children died preventable deaths in our state. There is no success story in being able to re-categorize them as not the responsibility of the Department of Child Services. I can no longer participate in a process that is unable to work effectively in this state. Preventable child deaths are a public health issue. Every death of a child is a tragedy and every preventable death is a lesson that must be learned so that others will not have to suffer the loss that so many of our Hoosier families have endured.

I am gravely concerned about the legislation that has been passed and is awaiting your signature, Senate Enrolled Act 286. Within this legislation are new requirements for fatality review in the state of Indiana similar to legislation proposed last legislative session. During the previous legislative session, I discussed my concerns with Director Payne specifically that regional teams have not been shown to be effective nationally, even in counties that have very few child deaths. Further, I strongly expressed my concern about his direct involvement in choosing members of *all* regional teams.

I am concerned about the true independent functioning of teams that will be created through appointments made by the Director. Child Fatality Review Teams are meant to serve the public through their in-depth review of child fatalities in order to understand how to prevent other child deaths. Teams should not assign blame nor exonerate but rather they gather objective data about child fatalities. Only truly objective review can produce meaningful information with substantive value. The review and the data should be free from political interference. Reports and recommendations from the local and state team should be made directly to the interested parties—those who can institute prevention efforts as well as the legislative body. They should not be filtered through any agency.

Child fatality review has been used for more than two decades around the country and many states have made truly important advances in child safety as a result. Indiana is not following best practices and further, we are instituting failed practices that other states used years ago to no avail.

I do not feel that child fatality review process is able to help children in Indiana given the current legislative language, nor the new language that is awaiting your signature. I cannot continue to serve in a role that is not able to effectively improve the condition of Hoosier children.

Sincerely,

Antoinette L. Laskey, MD, MPH, FAAP

Cc: State Fatality Review Team Members via email
Michael Chartier, Intergovernmental Affairs
J. Smelko, Policy Director