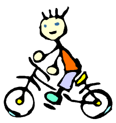
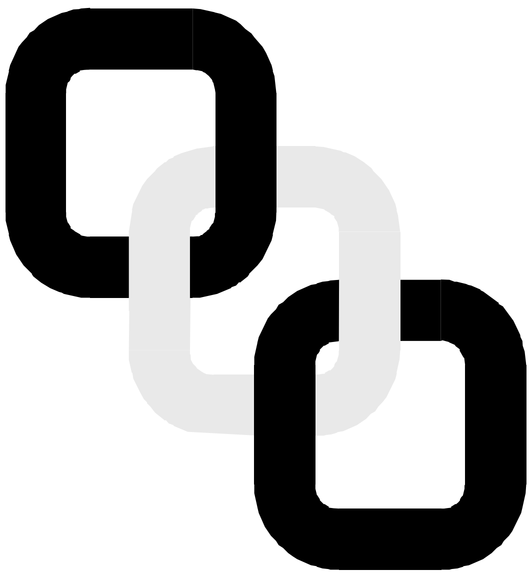
How to Start a Local Child Fatality Review Team

A Guidelines for Local Child Fatality Review in Colorado@









Injury Prevention Program of the Colorado Department of Public Health and Environment
and
Child Welfare Services of the Colorado Department of Human Services

State of Colorado

How to Start a Local Child Fatality Review Team

"Guidelines for Local Child Fatality Review in Colorado"

Compiled by:

Injury Prevention Program of the Colorado Department of Public Health and Environment
and
Child Welfare Services of the Colorado Department of Human Services

State of Colorado

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Acknowledgments

Appreciation is extended to members of the Colorado Child Fatality Review Committee (CFRC) for their commitment in reviewing child deaths since 1989. Each committee member, with his or her many obligations and responsibilities, has demonstrated a dedication to this process and to children.

Thanks to the local child fatality review teams currently operating in Colorado for their insight, input and participation in the process.

In 1993, the Colorado Departments of Human Services and Public Health & Environment created the first edition of this manual entitled: "*How to" Manual for Local Child Fatality Review*. This current edition has been updated by the Colorado Department of Public Health and Environment - Injury Prevention Program. Additional copies can be obtained from:

Colorado Department of Public Health and Environment
HPDP-IP-A2
4300 Cherry Creek Drive South
Denver, CO 80246-1530
(303) 692-2573
(303) 691-7720 (fax)
e-mail: cfr.committee@state.co.us
www.cdphe.state.co.us/pp/cfrc

Introduction

During the years 1993-1997, an average of 715 children (ages 0-17) died each year in Colorado. Many of these deaths, particularly those that resulted from injuries, could have been prevented.

The Colorado Child Fatality Review Committee (CFRC) is a multi-disciplinary team of professionals which, since 1989, has been reviewing every child death that occurs in Colorado with the following goals:

- to describe trends and patterns of child death in Colorado;
- to identify and investigate the prevalence of risk factors surrounding child death;
- to characterize high-risk groups in terms compatible with the development of public policy;
- to evaluate the service and system responses to children and families who are at high risk and to offer recommendations for improvement in those responses; and
- to improve the quality and scope of data necessary for child death investigation and review.

While a state review committee can include a review of systemic problems, identification of policy issues, and statewide data collection, it cannot bring the same vitality to the area of prevention, which a local review process can. Bringing agencies together at a community level offers the greatest potential for strengthening intervention and prevention efforts on behalf of children and families. The capacity to translate review into action is most effective at the local level.

Local child fatality review teams are formed for a variety of purposes. Some common goals for local review teams are:

- to improve a community's response to at-risk families;
- to identify preventable social and family circumstances which contribute to child fatalities;
- to promote cooperation and communication among agencies;
- to identify cause of death, where possible;
- to share information about advances in the field of investigation, intervention, prevention, and prosecution of child death; and
- to heighten community awareness through education and prevention strategies.

These goals can be achieved by gathering pertinent information on fatalities, reviewing the material to determine what response(s) might have prevented the fatality, develop strategies to address the problems and educate the community concerning prevention strategies.

An important aspect of team membership is that the members be multi-disciplinary and multi-agency. Many families will have had some contact with a variety of professional disciplines and agencies. The comprehensive review of fatalities must include input from all related agencies.

Although a few local child fatality review teams have been operating in Colorado during the 1990's, there is a need to expand and to begin to coordinate these activities throughout the state. This manual is intended to serve as a tool for local communities who wish to develop a child fatality review process.

Background

The concept of child fatality review originated in the late 1980's in Los Angeles County, California under the guidance of Michael Durfee, M.D., a child psychiatrist, who directs the child abuse prevention program for the Los Angeles County Department of Health. While studying the coroner's findings, Durfee became convinced that many probable child maltreatment deaths were being missed.

He found that frequently what was known to one agency, such as the hospital or social services, was not known to others. There might be suspicions raised about a death by a doctor or nurse or children's services worker, but there was no avenue for sharing the information in order to ensure a complete investigation.

Currently, some form of child fatality review is taking place in almost every state in the United States, at either the state and/or the local level. Despite variation in scope and process, all of these review teams have the common purpose of developing a better understanding of how and why children are dying in order to respond more effectively to prevent these deaths.

In January 1989, the Colorado Department of Health (now Public Health and Environment) and the Colorado Department of Social Services (now Human Services) jointly formed an ad hoc Child Fatality Task Force after becoming concerned that the child death statistics, kept by each department, did not accurately reflect nor adequately describe the circumstances of child deaths. A multi-disciplinary group representing medicine, law enforcement, public health, social services, and coroners was convened and recommended the establishment of a formal child death review process. An interagency agreement was developed between the Department of Health and the Department of Social Services, which formalized the Colorado Child Fatality Review Committee (CFRC).

Since that time, the state CFRC has been reviewing all deaths to children under age 18 in Colorado. The CFRC conducts a retrospective review to collect accurate statewide data to identify systems and policy issues that can be addressed at the state level, and to develop prevention strategies from a broad perspective.

Local Review

In addition to the statewide child fatality review process, a number of local child fatality review teams have been developed. Each existing local team operates independently of the state team. This has resulted in processes that vary widely in such areas as membership, case identification and selection, and data collection. Consistency in core functions among local child fatality review teams would be of value to currently existing local teams, developing local teams, the state CRFC, and ultimately to the children of Colorado.

Local teams are critical to the fatality review process as they are able to respond, in a timely manner, to a child’s death and share the prevention message with the community.

The recommendations in this manual are an attempt to provide consistency to the review process for both existing and new teams. Unifying the review process will improve team communication, data collection and prevention efforts. This exchange of information also builds trust among the participating agencies and nurtures working relationships as the perspective of others are understood and valued.

The purpose of the review process is not to assign blame to an agency, discipline or individual but to better understand where changes can be made and, in the end, prevent the needless deaths of children in Colorado.

Frequently Asked Questions

1. What are the differences in function between state and local child fatality review process?

State teams are organized to:

- identify and review systemic problems;
- make recommendations regarding needed policy or legislative changes;
- promote better communication among agencies at the state level;
- improve communications between state and local agencies; and
- examine statewide trends and issues.

Local teams are organized to:

- identify and review systemic problems;
- improve communication among agencies;
- improve coordination among agencies, especially with regard to child death investigations;
- examine local trends and issues, including gaps in services;
- devise investigation protocols;
- devise interagency agreements to improve reporting and review procedures;
- provide access to available information to improve child death investigations and ensure
- accurate reporting;
- ensure that anyone responsible for a child=s death be held accountable;
- review deaths in a timely manner; and
- provide community education and promote awareness of prevention strategies.

2. Who should be involved in the development of a local child fatality review committee?

Often, a particular child death will trigger interest within a community. In other cases, contact with either the state CFRC or another local team will encourage an individual or agency to initiate the development of a local team. It may be useful for the county health department to take the lead role due to authority the agency has to access records that are vital to the review process.

3. What geographic region should a local child fatality review team be responsible for reviewing?

Most public agencies who are involved with children or with child death investigations operate at the county level. However, counties with relatively small numbers of child deaths could establish a regional team.

4. What ages are included in child death review?

The state reviews all deaths that occur at birth through age 17. Children in this age range are still under the care of a parent or guardian**.** A local team may choose to review fetal deaths and/or deaths of young adults to identify trends and develop prevention strategies.

5. Who should serve on a local multi-disciplinary child fatality review team?

At a minimum, these teams require representation from all agencies in the child protection system and from those agencies who are involved in child death investigations. Other members can be added as need for representation is recognized or in response to issues brought forward by specific cases.

Example
Core Team Members:
- Public Health
- Department of Human Services
- Coroner/Forensic Pathologist
- District Attorney
- Law Enforcement (police, sheriff, state patrol)
- Pediatrician(s)
- Mental Health
- Emergency Medical Services
- Hospital Personnel

Additional Team Members:
- Domestic Violence Prevention Program
- Schools/Pre-schools
- Treating Hospital Physicians
- Drug/Alcohol Treatment
- Parole
- Traffic Safety
- Injury Prevention Specialist

6. What are the duties of individual team members?

Each team member is responsible for providing necessary information available from his or her respective agency. The team relies on each member, as an agency representative, to provide perspective and insight from the vantage point of their agency. Team members discuss and recommend prevention strategies.

7. What sort of cases and issues do local teams consider?

Ideally, local teams should review all child deaths. Reviewing all deaths can assist the team in their prevention efforts. Some of the issues addressed include:

- child abuse and neglect fatalities;
- deaths where prenatal substance abuse or external violence may have caused a fetal or postpartum child death;
- other deaths that are problematic but not clearly identified/recognized as child abuse or a criminal act (for example, where abuse may have contributed to the act of suicide or a firearm was easily available to a child); and
- unintentional deaths (motor vehicle, drowning, strangulation, poisoning, falls, choking).

8. What records are relevant for conducting reviews?

It is important to have all information regarding the child and family including, but not limited to, child welfare reports, autopsy reports, ambulance trip reports, law enforcement reports, health department vital records and reports, and hospital/medical records. Often teams begin the review process with the coroner=s report, death certificates from the county vital records office, followed by other team members adding information from their respective agencies. Teams may consider interviewing and/or inviting professionals with expertise in a specific area to a review meeting.

9. How can we be sure all relevant data are collected on each case?

A standard data collection tool has been developed and is available, at no charge, to any current or future team. Collecting data provides an opportunity to look at child death, identify trends and plan prevention strategies. For a copy of the data collection tool, please call (303) 692-2592.

10. What about confidentiality?

Local teams may consider having members and case-specific attendees sign a confidentiality statement. A sample is provided in the appendices. A placard, set out at each meeting, will remind attendees that confidentiality procedures will be followed. Contact the county or district attorney for additional advice.

11. What is done with review findings?

Teams may choose to issue written reports, findings and recommendations on an annual basis or more often if necessary. Reports can be used to identify emerging trends, to serve as an ongoing statement of progress (or lack of it) toward needed systems modification and reform, and to provide public awareness and education.

The results of the review process can be significant. Review teams and agencies have circulated written reports to educate local and state officials on certain issues. Media can be utilized to educate the public regarding child fatalities. Case review can provide direction for future implementation of prevention strategies.

Local information shared with the state CFRC can be compiled to produce a report on child fatality in Colorado. The information can also be used as a basis for policy formation and legislative action.

Getting Started

When a multi-disciplinary team is being created, it may help to address the following issues:

- determine the lead agency - local health departments have authority to access vital and medical records
- how often will the team meet - consider location, time and duration of meetings
- who will take minutes and send meeting reminders
- who will collect data, how will it be used and where will it be stored
- how can prevention efforts be implemented yet, respect confidentiality requirements (check with county or district attorney)
- will the team review current or past deaths

Counties with large populations will most likely have numerous deaths to review and may choose to meet on a regular basis. However, counties in which there are comparatively small numbers of child deaths within their jurisdiction may choose to create a regional team. Several counties with similar concerns and demographics could convene and review child deaths on a periodic basis. A system such as this could provide an opportunity for a more in-depth look at areas of particular interest, such as farm-related deaths, motor vehicle crashes, suicides, gang-related deaths, drowning, etc. A county with relatively few deaths can still benefit from the review process in terms of improved investigations, coordination, communication and prevention strategies.

Case Identification and Selection

The following cases are suggested for review at the local level:

1. Those cases which fall under the Coroner's jurisdiction.

2. Where possible, all child deaths (birth through 17) would be reviewed in order to determine the exact nature and cause of death and identify possible prevention strategies. However, constraints of time and resources in some jurisdictions may make this impractical or impossible. If a team decides that only certain deaths will be reviewed, there must be an awareness that there will be a limited view obtained as to why children are dying in their community and how agencies are functioning to prevent deaths. (A listing of total child deaths by county is provided in the Appendices and can assist in the determination of the breadth of the review.)

3. At a minimum, deaths in which any of the following factors are present would warrant review:
    a. Cause of Death Undetermined (after investigation)
    b. Head Trauma

c. Malnutrition (including failure to thrive)
d. Drowning
e. Suffocation/Asphyxia
f. Drug Ingestion
g. Poisoning
h. Fractures
i. Blunt Force Trauma
j. Homicide/Child Abuse/Neglect
k. Burns
l. Gunshot Wounds
m. Suicide
n. Sudden Infant Death Syndrome (SIDS)
o. Injury Deaths

4. The death certificate utilizes only six categories for signing out the manner of death (Homicide, Suicide, Natural, Accident, Undetermined and Pending Investigation). The selection of cases should not be based upon the manner of death. For example, a case may be signed out as "Accident" or "Natural" and after review, by the team, the death would be determined to be related to parental neglect.

Local Review Team Membership

The most important aspect of team membership is that representatives be multi-disciplinary and multi-agency. Many of the families will have had some contact with a variety of professional disciplines and agencies. The comprehensive review of fatalities must include input from all related agencies.

Recommendation: The review team includes representatives from the following agencies (add others as needed):

- Public Health
- Department of Human Services
- Coroner/Forensic Pathologist
- District Attorney
- Law Enforcement
- Pediatrician(s)
- Mental Health
- Emergency Medical Services
- Local Prevention Coalitions
- School Representative

The team chairperson and each of the core team members have a specific role in the review process. These roles stress coordination and communication among agencies as well as the perspective of the individual agency.

Team Member Roles and Responsibilities

A. Chairperson

The chairperson is responsible for assuring that the following functions are performed:

1. Determine, from available resources, and according to the team's criteria, which cases to review (distribute the list of cases to team members).
2. Arrange to have the necessary investigative reports, medical records, autopsy reports or other items available for team members during the review process.
3. Schedule the upcoming review meeting and notify team members.
4. Chair the fatality review meeting.
5. Serve as liaison with other agencies and the State Child Fatality Review Committee.
6. Complete data collection as cases are finished.
7. Forward the recommended state data sheets to the Colorado Child Fatality Review Committee for addition to the state database: *Colorado Child Fatality Review Committee, Colorado Department of Public Health and Environment, HPDP-IP-A2, 4300 Cherry Creek Drive South, Denver, CO 80246 - 1530 (303) 692-2592.*

B. Public Health

The role of the Public Health official is to assure the following:

1. Liaison/referral to prevention/intervention systems.
2. Assist in the discovery and review of public and/or private health care and medical records.
3. Provide vital statistic data (birth and death records) to assist in the review process i.e., whether birth was premature.
4. Use data and case histories from the child death review to develop prevention programs and/or public awareness campaigns.
5. Establish and maintain the database.

C. Department of Human Services

The role of the Department of Human Services is as follows:

1. Provide case management information regarding past and/or current interventions with the child and his/her family.
2. Follow-up on those cases referred by the team in which circumstances surrounding the death suggest that other children in the home may be at risk.
3. Provide information, and consultation, regarding the juvenile court process and the appropriateness of court intervention to protect or intervene with surviving siblings.
4. Provide feedback from the team to the State Human Services Administrator on issues related to child protection.

D. Coroner/Forensic Pathologist

Since the County Coroner is notified of every sudden or unexpected death in the county, this position is the logical one to provide information to the child fatality review team regarding the death. The county coroner or his/her designee is in a key position to provide valuable information to the child fatality review process. The Coroner can provide the team with:

1. Medical history of the decedent.

2. Cause and manner of death.
3. Investigative information relative to the death inquiry.

In conjunction with the Coroner, a Forensic Pathologist can provide the following:

1. Interpret growth and development of the child.
2. Interpret injuries.
3. Interpret the number of events and time of events.
4. Differentiate natural disease from abuse or neglect.
5. Interpret autopsy findings, particularly in regards to mechanism of death.
6. Provide consultation about potential expert testimony for any legal action.

E. District Attorney

The District Attorney's role in the process is:

1. Provide legal definitions and explanations.
   a. Answer questions about specific cases and the likelihood of involvement in the criminal justice system.
   b. Define legal terminology that may impact what is identified or described as suspicious vs. abuse.
   c. Evaluate whether the case meets the threshold of a crime.
2. Obtain criminal history appropriate to the case.
3. Provide assistance/guidance for further investigation to participating agencies.
4. Assist in the communication between participating agencies.
   a. Provide training on pertinent legal issues.
   b. Serve as a liaison with other legal representatives such as the County Attorney.
5. Provide feedback on child fatality review cases which have entered the criminal justice system as to the cases' disposition.

F. Law Enforcement (police, sheriff, state patrol)

Law enforcement representatives can provide the team with the following data:

1. Reports containing witness information and witness statements.
2. Scene photographs, physical evidence, measurements and sketches.
3. Background information on involved parties and resources to conduct further inquiry suggested by the team.
4. Suspect information.
5. Interpretation of laws and ordinances.
6. Prevention efforts.

G. Pediatrician

The role of the pediatrician is as follows:

1. Provide information about the process of normal infant and childhood growth and development.
   a. Assist in the identification of cases where findings are inconsistent with normal growth and development.
2. Provide information regarding the diagnosis of child abuse, expected course of disease, medical conditions of infancy and childhood, and assist in the interpretation of case findings in this context.
3. Review the case and provide information about the expected outcome and complications of various treatments and interpret case findings.
4. Provide information in the area of community standards of medical care.
5. Serve as a liaison with the medical community.
6. Provide the team with current information from the medical literature pertinent to the case or topic under discussion.
7. Assist in the discovery and review of previous health care/medical records.

H. Mental Health

The role of the mental health representative on the child fatality review team is as follows:

1. Provide information or answer questions about mental health and treatment, which may come up in the course of case review.
2. Provide an understanding of individual and family psychodynamics and psychopathology.
3. Review previous treatment records for information that may be relevant to the prevention, identification, management or treatment of child death.
4. Provide an in-depth review and feedback to the mental health community about completed suicides of children.
5. Make sure that mental health support is provided to families and professionals who have been traumatized by the death of a child. Support should also be extended to classmates/school staff of victims of sudden, unexpected death; and to the babysitter or care provider of the child victim.
6. Provide an understanding of the intense personal emotions associated with the death of children to help the team maintain its equilibrium and concentration.

Confidentiality

It is important to recognize that confidentiality concerns need to be addressed as part of the team process. The following procedures are recommended for local teams:

- Utilize a confidentiality statement that each team member and guest will sign. A sample form is included in the Appendices.
- Data will be reported to the public in aggregate form only.
- No identifying material may be taken from the team review. Identifying material will only be returned to the agency which provided it.

As long as individual case confidentiality is respected, it may be of value to define team guidelines for sharing information locally with the media. Statistical information, general comments on policy protocols and prevention messages may be of value to alert the public concerning abuse and injury prevention issues. It is helpful to designate a spokesperson who will handle such media requests. No case specific information gained through the review process should be shared with the media or the public. Placards can be displayed during each meeting to remind team members of the confidentiality guidelines.

Data Collection

Data collection can provide valuable information to the local review process. Collecting data offers a systematic approach for compiling information, identifying issues, setting priorities and implementing prevention strategies. When each case is reviewed and documented, the local team has a well-defined "road map" to assess trends in child fatality. Using a standardized tool allows each of the individual review teams to collect data in a uniform manner and provides a vehicle to assess and address statewide issues.

Case management issues, such as coordination of agencies during the investigation, protection of siblings, and identification of existing problems in service delivery systems, can be addressed more systematically when guided by uniform data collection efforts. For instance, data collection techniques can help identify strengths and weaknesses of each agency involved and facilitate a remedy for existing issues or potential issues which can occur when multi-disciplinary efforts and community collaboration takes place.

Data can lead the way to prevention efforts. When risk areas are identified, the Team can target specific populations with prevention messages and safety equipment (car seats, bicycle helmets, life jackets, firearm safety locks, etc.).

Current Data Collection Efforts

Methods of data collection are varied and there is inconsistency between individual teams concerning the data categories they collect. Most data elements will fall into the following categories:

Deceased Information
- Deceased child's identifying data
- Deceased child's medical history
- Deceased child's school history

Death Information
- Place of death
- Category of death
- Type of maltreatment
- Circumstances surrounding the death
- Death review team documentation
- Death risk factors

Agency Information
- Coroner/medical examiner information
- Child protective services information
- Law enforcement/legal information

- Health system information
- Other service data
- Other state data

Information on Significant Others

- Family background
- Suspect/perpetrator background

Localities without adequate data collection will be less likely to uncover existing patterns and emerging trends, which will impede their ability to prevent further abuse, maltreatment-related deaths, unintentional incidents, suicides and homicides.

Recommendations for Local Data Collection

Included in the Appendices is a standardized data collection set and/or a computer disk for local review teams to collect their data. Two data sets are recommended for this effort. The first data set form is a comprehensive listing of all suggested elements believed to promote and improve case management efforts in child fatalities, which was adopted from the Oregon Review Model. The second form is an abbreviated version, which can be sent to and utilized by the Colorado Child Fatality Review Committee to help identify state wide trends and policy issues relative to child fatality. All of these data collection tools will aid in child fatality prevention efforts.

Using these data sets can benefit local review teams as they begin or continue their work in child fatality review as outlined in the ***Case Identification and Selection*** section. Deaths that initially appear to be accidental or natural may later be determined by the fatality review team to be suspicious or maltreatment-related.

Once completed, please send copies of the collected data to: *Colorado Child Fatality Review Committee, Colorado Department of Public Health and Environment, HPDP-IP-A2, 4300 Cherry Creek Drive South, Denver, CO 80246-1530. If you have questions, please call: (303) 692-2592.*

The Colorado Child Fatality Review Committee reviews all deaths of children ages 17 and under and will compile all local data into a statewide report of child deaths which will identify patterns and policy issues. It is anticipated that the local data will provide a greater accuracy and thoroughness to the current state efforts in data collection, and can enhance the opportunity to impact policy, procedures and legislation. This data will also be made available to national organizations that are collecting data on the incidence of child maltreatment deaths, such as the National Committee for the Prevention of Child Abuse. More accurate information can help to uncover the magnitude of the problem of child maltreatment, as well as, to identify at-risk families and guide prevention efforts.